CHILD NEGLECT AND PATHWAYS TRIPLE P

AN EVALUATION OF AN NSPCC SERVICE OFFERED TO PARENTS WHERE INITIAL CONCERNS OF NEGLECT HAVE BEEN NOTED

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October 2015
Impact and Evidence series

This report is part of the NSPCC’s Impact and Evidence series, which presents the findings of the Society’s research into its services and interventions. Many of the reports are produced by the NSPCC’s Evaluation department, but some are written by other organisations commissioned by the Society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.
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ACKNOWLEDGEMENTS

The author would like to thank:

• The parents who consented to take part in the evaluation and to complete questionnaires through the programme

• The parents who consented to take part in the interviews and share their insights about the programme

• Team managers, practitioners and administrative staff in the PTP service centres of Belfast, Cardiff, Glasgow, Grimsby, Hull, Peterborough, and Southampton who have all supported the implementation of the evaluation by explaining its importance to parents and ensuring that data has been gathered for analysis.

• Members of the IPIP Commission Delivery Group for their advice, encouragement and promoting the evaluation within the service

• Matt Barnard and Richard Cotmore for reviewing the evaluation plans and reports

• Susan Purdon of Bryson Purdon Social Research for statistical consultancy
KEY FINDINGS: YOUNG PERSONS VERSION

Triple P is for parents of children who have behaviour problems. The NSPCC is testing how good Triple P is where there are concerns about child neglect in families. The families have children between 2 and 12 years old. Triple P is done with families in their home.

Key Findings

- Children had very high levels of problems at the beginning of Triple P. There was a big improvement in these by the end.
- The amount of change for children was very similar to a previous NSPCC service.
- Parents said they saw improvements in their parenting and in how well they got on with their children by the end of Triple P.
- Parents said that getting on well with their NSPCC worker was really important in helping bring about positive changes. At the moment we don’t know for sure if the positive changes parents told us about were because of Triple P – we would need to do more research on that.
KEY FINDINGS

Triple P® is a widely known, well researched, multi-level programme of family interventions for parents of children who have, or are at risk of developing, behavioural problems. The NSPCC is for the first time testing the effectiveness of Pathways Triple P (PTP) where there are specific concerns about child neglect in families of children aged between 2 and 12 years. In this context, Triple P is delivered for families in their home on an individual rather than a group work context.

Key Findings

• Children had very high levels of emotional and behavioural difficulties at the beginning of the PTP programme. There was a large improvement in these by the end of the programme.

• The amount of change for children was very similar to a historical comparison group who had received an NSPCC family support service. The patterning of outcomes did vary between the two programmes however.

• Parents experienced a lot of challenge in their parenting role but there were many improvements in the effectiveness of their parenting and in the quality of their relationships with their children by the end of the programme.

• The quality of the relationship between parents and practitioners was identified by parents as a key factor in promoting change. The approach and style adopted by the practitioner were seen as significant for this.

• Further evaluation would be needed to test the effectiveness of PTP in the context of neglect with a more robust evaluation design.
EXECUTIVE SUMMARY

Background

The Pathways Triple P (PTP) version of the Triple P programme was one of two programmes introduced by the NSPCC to work with families where there were concerns about neglect. This followed an earlier evaluation of the existing family support service which had recommended that the NSPCC should adopt a more structured approach. There is a large evidence base on the effectiveness of the Triple P programme in bringing about change for parents and families, but not specifically for the PTP programme in the context of neglect. The inclusion criteria included: families should have children between the age of 2 to 12 (initially it had been 4 to 10 but this was extended); and the child should not be on a child protection plan. Hence this programme was targeted at families who had not yet met the threshold for child protection interventions.

Methodology and aims

The aims of the evaluation were to measure the impact of the programme and to map the implementation and explore the barriers and facilitators to success.

The impact evaluation measured three outcomes with children and parents using standardised scaling measures: the Strengths and Difficulties Questionnaire (SDQ); the Parenting scale; and the Parent child relationship inventory (PCRI). There was also a comparison group for children’s outcomes, formed of children in families who had received the previous NSPCC family support service. There was paired data for before and after the programme for 100 families on the parenting scale; 69 families on the SDQ; and 47 on the PCRI. There was similar data for the SDQ for the comparison group for 54 families.

The process evaluation addressed the following issues in relation to the NSPCC PTP service: what worked well; barriers to implementation; factors that positively influenced the implementation of the interventions; the facilitators and barriers to achieving positive outcomes; and understanding the experiences of parents who received the programme. Interviews were conducted with 10 parents who had completed the programme. The parents were sampled purposively in an attempt to generate a sample that would reflect the diversity and range of experience of the PTP programme. This sampling strategy was not entirely successful however, with only 2 parents whose measure scores did not improve through the programme.
Key findings

Child outcomes

Children had fewer emotional and behavioural difficulties following Triple P - almost three-quarters (74%) of the children were experiencing severe problems at the start of the programme (according to the SDQ), but by the end of the programme under half (45%) reported severe problems.

There were significant improvements for children in their emotional symptoms, behaviour problems, hyperactivity and pro social behaviour, as well as for the total difficulties score.

The findings from the comparison with the historical NSPCC family support service show similar levels of impact overall, although there was a very different patterning to the outcomes with greater change: for conduct problems, hyperactivity and pro social strengths for the PTP programme; and for emotional symptoms and peer problems with the comparison group. These findings show the value of having a comparison group, as it allows for a more complex and nuanced picture to emerge.

Parenting and relationship outcomes

Parenting problems improved following Triple P - almost two thirds (65%) of the parents reported severe difficulties in their parenting at the start of the programme (according to the Parenting Scale), but at the end of the programme this had reduced to around a fifth (21%).

There were improvements in the following aspects of parenting and parent-child relationships: understanding of child’s needs; parenting capability; parental commitment to child; greater parental sensitivity; and helping to meet the child’s developmental needs.

Qualitative findings

Parents gave descriptions of a wide range of outcomes for themselves and their families. These included changes for: their parenting behaviour; their relationship with their child; relationships within the family; child wellbeing; and parental wellbeing. They spoke powerfully of the impact of these changes.

Their descriptions also conveyed how parents felt that the different outcomes could reinforce each other. An example was where a parent was able to use a strategy to calm themselves down, which led to more effective parenting and this in turn resulted in greater self confidence. In this way there was an added value from the qualitative insights in this mixed methods study, not just from providing a richer description of the outcomes, but also from a focus on how those outcomes may be related to each other.
In addition to the outcomes, parents were able to reflect on factors that contributed to their achievement. Key to this was the relationship with the programme practitioner and in particular the practitioner’s: communication style; approach; experience; flexibility; and their supportive encouragement.

Through the work with the practitioner parents talked of the following as helpful for achieving the outcomes above: gaining a clearer understanding of the parenting role and its responsibilities; having clearer expectations for their children; and taking a broader perspective that could help in sorting out how to respond in a given situation.

Worryingly, parents described their early experience of trying to find appropriate support with their parenting. They could feel desperate and did not find it helpful that things would have to be so bad before they would get a service. In addition, the ways in which they found out about the available services could feel something of a lottery. School nurses were identified as a helpful source of information, partly because they are a universal service and hence not as stigmatising as some.

**Implications**

**For services**

Children were reported as having very high levels of need on entry into the programme. Given that the service was targeted at families where the child did not have a child protection plan and hence at an earlier stage of intervention, it is concerning that so many children appear to be suffering harm.

The suggestion that those children may not be appropriately safeguarded by professional systems was strengthened by the parents’ descriptions of their struggles to access an appropriate service. This study would suggest that there is some way to go to make information about local services available to families who need them.

Almost half of children still had clinical levels of need by the end of the PTP programme. This suggests that further support may be required.

**For evaluation**

The historical comparison group was helpful for creating a more complex and nuanced picture of child outcomes. Despite the statistical and clinical significance of the findings about child outcomes following PTP, the comparison group achieved similar levels of change, albeit with a different patterning of outcomes. A stronger evaluation design would be required in order to be able to make claims of effectiveness for the PTP service in the context of neglect.
Chapter 1: Introduction

This report is an evaluation of Pathways Triple P (PTP), one of two programmes that were offered by the NSPCC to parents where there were concerns expressed over potential neglect. The other programme offered was Video Interaction Guidance which will be the subject of a subsequent report. This chapter sets out the plans for the evaluation of PTP.

1.1 Background

Neglect is different to other categories of child abuse in that it is the absence of care rather than the presence of certain forms of abuse that sets it apart. The NSPCC describes neglect in this way:

Neglect is the ongoing failure to meet a child’s basic needs. A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care. A child may be put in danger or not protected from physical or emotional harm. They may not get the love, care and attention they need from their parents. A child who’s neglected will often suffer from other abuse as well. Neglect is dangerous and can cause serious, long-term damage - even death.


The definition of neglect in the four nations of the UK is based on common principles, though as each nation is responsible for its own policies and laws on education, health and social welfare, there are some differences in wording (see Appendix 2). Neglect is the most common reason for a child being on a child protection plan in the UK:

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>42</td>
</tr>
<tr>
<td>Scotland</td>
<td>41</td>
</tr>
<tr>
<td>Wales</td>
<td>42</td>
</tr>
<tr>
<td>N Ireland</td>
<td>33</td>
</tr>
</tbody>
</table>
* Jutte et al (2015). Both Wales and Northern Ireland collect information where neglect only is the reason for registration and also record the number of cases where neglect is one of several reasons for registration. If all cases are considered then neglect features in 50% of registrations in Wales and 47% in Northern Ireland.

It is noted that these definitions of official ‘neglect’ can underestimate an experience that is both wider and deeper than these figures suggest. Brandon and colleagues’ work on the evidence of neglect in over 800 case files reviewed for Serious Case Reviews in England where a child has died or suffered very serious harm, found at least 60% of cases in 2003-2011 had neglect present within them, even if the first category of registration or concern was another form of child abuse (Brandon et al 2013).

In a population prevalence survey the NSPCC has estimated that child neglect has been experienced by 10% of the 11 to 17 years population (Radford et al 2011). The impact of child neglect can include a lack of stimulation and interaction as a baby which leads to:

- poor attachment with a parent or care giver
- increased social and emotional difficulties
- mental health problems from a lack of feeling cared for
- feelings of low worth or depression, and may lead to
- actions of self harm or anti-social behaviour.

It is into this context of child neglect that the NSPCC has offered two well-researched programmes for parenting. The service offered is a development of an earlier programme of Quality Parenting and Family Support (QPFS) services within the NSPCC in 2000-2005 which provided child and family centres, outreach and home-based services and parent education programmes. The evaluation of QPFS recommended: providing a range of services that demonstrably achieve objectives and provide evidence of impact; developing methods to replicate success; and a wider study of structured parenting training in a number of locations with a controlled evaluation (Gardner and Bunn 2005). Evaluation data was collected from families referred to the NSPCC due to concerns over neglect in the period 2006-2009 and are used as a comparison group for the current study.

The NSPCC offered a choice of approaches to referrers as well as parents. The programmes were Pathways Triple P (Sanders and Pidgeon 2005) which teaches parents behavioural approaches to improve the parent child relationship and their availability to the child, and Video Interaction Guidance (VIG), designed to help parents view their interactions with their child and become more attuned to their child’s needs. The two programmes were designed to address
poor parenting where neglect or other harm presents as a risk. Both programmes were initially estimated to be 10 to 14 weeks in duration, and were offered to separate samples of referred children with similar needs. The criteria for inclusion was initially that: the target child was aged from four to ten years; a Common Assessment Framework (CAF) in England or an equivalent assessment in Scotland, Wales and Northern Ireland was used to establish that this was a child in need where parental unavailability or neglect were active concerns and were likely to result in emotional harm or behavioural difficulties; the target child has never been subject to a protection plan; and that no sibling has been subject to a protection plan within the previous two years. After one year of the service the criteria were amended to a wider age range of two years to twelve years, and that the target child should not be subject to a protection plan at the time of the service starting. For further information on the eligibility criteria see Appendix 1.

PTP is disseminated by the University of Queensland with clear protocols for its use by other institutions. The Triple P evidence base, maintained by its developers, lists over 500 articles on the five levels of Triple P and the 14 different interventions including Pathways Triple P. Wiggins et al (2009) reported the use of Pathways Triple P to a sample of Brisbane parents of children aged 4 to 10 years with borderline to clinically significant relationship disturbance and child emotional and behavioural difficulties. Sixty parents were randomly allocated into group work PTP or a waiting list control group. Significant intervention effects were found for improving parent-child relationships and reducing behaviour problems which were maintained at three month follow up.

The current study applies this approach to families individually rather than in groups, focuses on concerns of possible neglect and does so with parents of children aged from 2 to 12 years in the UK. Triple P level 4 has also been evaluated as part of the Parenting Early Intervention Pathfielder in the UK (Lindsay et al 2011) where it was found to produce significant improvements for: parenting style, satisfaction and self-efficacy; parental mental well-being; and significant improvements in child behaviour and emotional difficulties. Further information on the modules within Standard Triple P level 4 and Pathways Triple P level 5 are contained in Appendix 1.

The decision to provide PTP or Video Interaction Guidance was made early on in most cases. The referrer stipulated PTP in about two thirds of cases, as its description of teaching behavioural approaches to the parent-child relationship accorded with the difficulties that parents were expressing to referrers. In one eighth of cases the NSPCC first line manager allocated the case to PTP, due to consideration of the views of parents and the nature of PTP. In a smaller number of cases parents expressed their desire for help with parenting strategies with
their child. Some parents did not want to be filmed as would be required by receiving VIG.

1.2 Theory of change

The theory of change is a way of providing a framework for the evaluation design and is the foundation for the evaluation questions and methodology section. It shows how the different elements of the design relate to the way in which the programme is thought to work. It was developed by the evaluator with the internal commissioning group for the service. Figure 1 illustrates the theory of change for Pathways Triple P in the context of neglect.

The theory of change conceptualises the programme in terms of inputs, activities, and outcomes. It does this in order to delineate different parts of the intervention so that it is clear how one element links to another. The intention is also to be clear about what the outcomes of the programme are, and what parts of the programme are intended to link to which outcomes. The third reason for considering the programme’s theory of change is to understand the proximity of the different outcomes to the intervention and therefore help estimate the degree of change that could be expected. The outcomes vary according to their distance from the intervention, so the primary outcomes are on parents having greater understanding of what is expected of them, a greater understanding of their child’s needs, a greater commitment to their child, greater sensitivity and greater parenting capability. For the child the primary outcomes are that their developmental needs are met and their emotional and behavioural problems reduce. The secondary outcomes are actions that the programme is expected to indirectly affect, so are described as changes in parental behaviour and for children a reduced risk of harm. The tertiary outcomes are those outcomes which are affected by many factors, not just the programme, and include the physical safety of the child which is also influenced by their peer group, the behaviour of other family members, housing and other environmental factors experienced by the family. Further information on the theory of change is in Appendix 1.
Parents inclusion criteria:
- CAF indicates concern over neglectful parenting
- child aged 2 to 12 years and not subject of Child Protection Plan
- no previous Child Protection Plan for any other child in family in previous two years

PTP Programme
- behavioural approaches to parent-child relationship
- availability to the child

Parent change in
- understanding what is expected of them
- understanding of child’s needs
- commitment to child
- parental sensitivity
- parenting capability

Parents
- change in parenting behaviour

Children
- child’s developmental needs met
- child’s emotional and behaviour problems reduced

Children
- risk of harm reduced

Child kept safe
- physical safety
- emotional needs met

Figure 1: Theory of Change for Pathways Triple P within the NSPCC
1.3 Aims and Methodology

The aims of the evaluation were to measure the impact of the programme (impact component) and to map the implementation and explore the barriers and facilitators to success (process).

The impact evaluation measured three outcomes with children and parents using standardised scaling measures. There was also a comparison group for children’s outcomes, formed of children in families who had received the previous NSPCC family support (QPFS) service. The comparison group was similar to the PTP intervention group as children were referred due to concerns over neglect but which had not reached the level of a child protection plan.

The process evaluation looked at the different elements of the service and how they were implemented in the context of NSPCC services in a number of different areas. The following issues were explored in relation to the NSPCC PTP service: what worked well, barriers to implementation; factors that positively influenced the implementation of the interventions; the facilitators and barriers to achieving positive outcomes; and understanding the experiences of parents who received the programme. This allowed for the possibility that the programmes were implemented fully but had not had the impact desired on parents and children. Interviews were conducted with parents who had completed the programme.

Evaluation measures

Parents were asked to complete evaluation measures for Time 1, prior to beginning the work. The evaluation measures at Time 2 were completed by the same parent or parents at the end of the work.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (Goodman 1997) is a brief behavioural screening questionnaire about 2–17 year olds. It has versions for parents, child self-report and teacher or other adult to complete to meet the needs of practitioners and researchers. It is available in over 80 languages.
Parenting Scale

The Parenting Scale is a rating scale that measures dysfunctional discipline practices in the parents of young children. It can be used for children aged from two to ten years, and reports on three aspects of parenting attitudes and behaviour – laxness, over-reactivity and verbosity. For children aged 11 and 12, there is an adolescent version of the scale which has 13 items and reports on two subscales, laxness and over-reactivity.

Parent Child Relationship Inventory (PCRI)

The PCRI reports on how parents view the task of parenting and how they feel about their children. Its 78 items cover domains such as parental support, satisfaction with parenting and involvement. It can be completed in about 15 minutes. Seven sub scales are parental support, satisfaction with parenting, involvement, communication, limit setting, autonomy and role orientation (Gerard 1994).

The SDQ, Parenting Scale and PCRI have been completed by parents and administered by practitioners in all cases where the parent gives their informed consent to participation in the evaluation study.

The three measures reflect different areas of the service; the SDQ reports on the parents’ perceptions of the behaviour of the child; the Parenting Scale enables parents to reflect upon their own parenting practice; the PCRI enables parents to reflect upon the nature of the relationship that they have with their child. The choice of these three measures was also related to the outcomes sought for the service in the theory of change above. These outcomes and the relevant evaluation measures are shown in Table 2, together with the number of paired measures analysed.

Further details of each of the measures are contained in Appendix 3.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Tool</th>
<th>Perspective</th>
<th>Number of Time 1 &amp; Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>To show understanding of what is expected of them;</td>
<td>Parenting Scale (PS)</td>
<td>Parent</td>
<td>100</td>
</tr>
<tr>
<td>To show understanding of child’s needs;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To show parenting capability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To reduce children’s emotional and behavioural issues</td>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td>Parent</td>
<td>69</td>
</tr>
<tr>
<td>To show commitment to child;</td>
<td>Parent Child Relationship Inventory (PCRI)</td>
<td>Parent</td>
<td>47</td>
</tr>
<tr>
<td>To show greater parental sensitivity;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The child’s developmental needs are met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were just over 700 families accepted and assigned to PTP. Parents’ completion has been estimated as 40% or 280 parents. The number of paired questionnaires varies between the three measures. There were some SDQs at Time 2 that could not be paired with Time 1 data, either because a different parent had completed the T1 questionnaire, or due to some missing items within the questionnaire. There was greater accuracy with the Parenting Scale data, perhaps due to the service being focussed on parenting and parents feeling happier to complete that measure. The third dataset, the PCRI, is a longer questionnaire than the other two and practitioners noted more parental non-completion for this reason. There are also validity indicators within the PCRI that meant that the evaluator had to discard some paired data due to inconsistent responses or unusually high, socially desirable responses.

For means of comparison the current PTP dataset has been compared to a historic dataset from NSPCC family support services from 2006 to 2009. These services included home-based work by practitioners with parents and in 54 cases the presenting concern was child neglect. The average time period of the intervention was six months, as compared to five months for the PTP sample. To make a valid comparison of the two datasets a statistical weighting process was carried out on the comparison dataset so that both datasets had similar statistical properties at Time 1. This was due to the comparison dataset having lower difficulties scores at T1 than the PTP dataset.
Sample of parents selected for qualitative interviews

Parents were selected to enable the evaluation to describe and understand the range of views and experiences within the study population. The purposive sampling involved setting quotas using criteria that are based on dimensions that reflect key differences in the study population that are relevant to the study’s objectives, rather than trying to ensure that the sample is statistically representative.

The main criterion in selecting parents to be interviewed was whether they perceived an improvement on one of the standardised measures or not. The study used the SDQ score for overall difficulties to measure this. Few parents had scores that fell between T1 and T2, and fewer were prepared to be interviewed on their experiences, hence the number of families where children’s difficulties had improved was much higher than where the level of needs had remained the same or got worse (see Table 3).

Table 3: Number of parents or carers interviewed based on pre-post change

<table>
<thead>
<tr>
<th>Pre-/Post- change reported on measures</th>
<th>Parents/ carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>8</td>
</tr>
<tr>
<td>Same/Got worse</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>

The second criterion that was considered in choosing a diverse range of participants was the gender of the parent or carer. In most cases the parent was a mother but three fathers were interviewed.

Table 4: Gender of interviews with parents or carers

<table>
<thead>
<tr>
<th>Parents/carer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>

Finally, the sample was selected from different locations across the UK as outlined in Table 5.

Table 5: Distribution of interviews according to location

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Parents/Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow</td>
<td>2</td>
</tr>
<tr>
<td>Hull</td>
<td>2</td>
</tr>
<tr>
<td>Peterborough</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>

The interviews were done individually face to face with the evaluator, at the parent’s home in eight cases and at the NSPCC service centre in two cases and lasted from 25 minutes to just over an hour. The interview schedule is attached in Appendix 4.
Ethics

The main ethical considerations of the evaluation were:

• the informed consent for parents and carers to participate in the evaluation;
• parents made aware that they could withdraw from the evaluation or any part of it, including withdrawing data before its analysis;
• confidentiality and its limitation for child protection reasons were understood by parents;
• that harm to parents as a result of the evaluation was reduced whilst explaining measures or conducting the interviews;
• parents had access to advice or support related to the evaluation; and
• the evaluation officer had access to debrief sessions to process any concerns raised through the evaluation.

Before the study started it was approved by the NSPCC’s Research Ethics Committee (REC). The REC includes external professional experts and senior NSPCC staff members. This ethics governance procedure is in line with the requirements of the Economic and Social Research Council (ESRC, 2005) and Government Social Research Unit (GSRU, 2005) Research Ethics Frameworks. A note on the ethical considerations is attached in Appendix 4.

Analysis

The responses to the evaluation measures were analysed using a range of statistical tests to determine if the changes were due to random chance, and the report uses the convention that a change is considered statistically significant if there is less than a five per cent chance of it happening randomly (p value <= 0.05). Further information about the analysis of measures is outlined in Appendix 5. Two validity indicators to indicate possible inconsistency in responses or socially desirable responses are part of the PCRI measure and were used to exclude questionnaires where there was a lack of confidence in the accuracy of parental responses. The qualitative data from the parent interviews were analysed using a Framework ‘case and theme’ approach. The list of themes used is attached in Appendix 5.
Limitations of the Research

This report uses a comparison dataset of SDQ data taken from parents who received an NSPCC Family Support service between 2006 and 2009 and whose main reason for referral was neglect. A stronger comparison would be a contemporary ‘business as usual’ sample from parent referrals generated at the same time as the Pathway Triple P service but it was not possible to generate such a sample. The PTP programme was compared on change between pre and post measures with the historic dataset rather than with the Video Interactive Guidance service that was being offered at the same time. This was in part because the assignment between PTP and VIG was not random but was based on three way discussion between referrers, parents and NSPCC manager. The number of evaluation returns of the Parent Child Relationship Inventory from parents was lower than for the SDQ and Parenting Scale, due to parents being more likely to complete questionnaires of 25 and 30 items respectively but not one of 78 items. Interviews with parents were conducted at three sites, despite attempts to recruit interviews from all seven service sites. In addition, a large majority of interviews were conducted with parents who felt there had been an improvement in the level of their child’s difficulties, despite an attempt to recruit more of a balanced sample. The interviews were conducted with parents who had completed the programme, hence we do not gauge the views of parents who had stopped receiving the service prematurely.
Chapter 2: Outcomes for Children

The programme’s hoped for outcomes for children are for a reduction in their emotional and behavioural problems. Data from the Strengths and Difficulties Questionnaire has been used to measure the parents’ perceptions of the behaviour of the child who is the focus of the referral. The SDQ was completed by parents at the start and end of the PTP programme. This chapter examines the extent to which outcomes for children have been achieved at the end of PTP.

2.1 Change in emotional and behavioural problems

Parents’ perspective: SDQ

The SDQ measures children’s behavioural difficulties over four sub-scales (conduct problems, emotional difficulties, hyperactivity and peer problems) and one pro-social (helpfulness) scale. It provides an insight into children’s level of emotional and behavioural difficulty. The SDQ is completed by one or both parents or the carers with whom the work has been conducted. There are 69 paired SDQs that made up the evaluation sample of Time 1 (before the programme started) and Time 2 (at the end of the programme).

There was a decrease in mean SDQ scores from 20.6 pre programme to 15.6 at the end of the programme. This change in mean score on the SDQ is statistically significant, indicating a trend in scores reducing over the course of the programme and reflecting an overall reduction in emotional and behavioural problems experienced by children and young people at the end of PTP. These are shown in Table 6.

Table 6: Change in mean SDQ sub scale scores, pre and post PTP (n=69)

<table>
<thead>
<tr>
<th>SDQ sub scale</th>
<th>Mean at T1</th>
<th>Mean at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>3.6</td>
<td>2.8</td>
<td>0.004*</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>5.6</td>
<td>3.7</td>
<td>0.000*</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>7.6</td>
<td>5.8</td>
<td>0.000*</td>
</tr>
<tr>
<td>Peer problems</td>
<td>3.7</td>
<td>3.3</td>
<td>0.0600</td>
</tr>
<tr>
<td>Pro-social</td>
<td>6.1</td>
<td>6.7</td>
<td>0.035*</td>
</tr>
<tr>
<td>Total score</td>
<td>20.6</td>
<td>15.6</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Statistically significant at p=0.05
There were statistically significant reductions in three of the four ‘difficulties’ sub-scales, with a decrease in conduct problems reported by parents, such as temper tantrums, fighting with other children, stealing and lying. The decrease in hyperactivity includes phenomena such as fidgeting, lacking concentration and restlessness. The decrease in emotional symptoms observed by parents in their children includes such items as fewer headaches, worries or fears. The decrease in peer problems was not statistically significant but nevertheless showed an average reduction in solitary behaviour, having few friends or being picked on or bullied by other children.

The ‘strengths’ of the SDQ includes items on being considerate, kind and helpful. This sub-scale showed a significant increase over the time of the programme.

**Change in level of difficulties experienced by children**

The SDQ has been normed by Goodman and has defined cut-off points for scores that identify varying levels of difficulty for children. Cut-off points are used to define very high need, high need, slightly raised and close to average levels of difficulty.

A clinical level of difficulty is a total score of overall difficulties in the SDQ that fell within the ‘very high need’ scoring band. Figure 2 indicates that almost three-quarters of the children fell within the clinical range of difficulty at the start of the programme, but at the end of the programme under half (45%) had a clinical level of difficulty and that this reduction is statistically significant.

**Figure 2: Proportion of children in clinical and normal ranges in SDQ pre and post PTP (n=69)**
Goodman and Goodman (2011) have indicated that 5% of the general population score ‘very high need’ on the SDQ, so the change in children within this PTP sample is going from 15 times the national average to nine times the national average. This indicates that the PTP sample is a very high need sample compared to the population at large and there is considerable change reported by parents from the start to the end of PTP. There is still however, a high level of need amongst this sample group at the end of the programme, meaning that it is likely that other family support services will be required to maintain this decrease in very high need over time.

### 2.2 Comparison with previous family support data

Details of the SDQ scores for the historic family support comparison group are provided in Appendix 5. As with the PTP intervention group, there were reductions in all of the difficulties sub scales and the total difficulties score, although the pro social scores remained the same between the beginning and end of the service. There was also a significant reduction in the proportion of children in the clinical range of need. The analysis of change between the PTP intervention group and the historic family support comparison group found differences in the patterning of outcomes, as shown by Figure 3:

- more change for conduct problems, hyperactivity and pro social strengths in the Pathways Triple P programme,
- but more change in the emotional symptoms and peer problems in the Family Support service.

**Figure 3: Comparison of mean differences on SDQ subscales between Time 1 and Time 2 for PTP programme and comparison group of NSPCC historic Family Support services**
When the four difficulties subscales are combined into one overall difficulties score there is little difference between the change reported across both interventions. This was further investigated by running a linear regression analysis on the overall difficulties score, which confirmed that the impact of both interventions upon the strengths and difficulties of children appears to be similar, from the parents’ perspective (see Appendix 5 for details).

In summary, the key findings from the quantitative data on outcomes for children indicate that:

- there are statistically significant decreases across emotional symptoms, conduct problems and hyperactivity amongst children between the beginning and the end of PTP, as well as the total difficulties scores;
- there is a statistically significant increase in pro social strengths amongst children between the beginning and the end of PTP;
- there is a shift in the proportion of children experiencing difficulties at a very high level of need to a lower level of need, from 74% to 45%;
- the findings for the PTP programme show similar levels of impact to those from a comparable dataset of NSPCC family support services in 2006-2009, although there was a very different patterning to the outcomes.
Chapter 3: Outcomes for parents

This chapter evaluates the changes for parents or carers related to their parenting attitudes, skills and strategies. It reports on the data produced from the completion of the Parenting Scale and the Parent Child Relationship Inventory before and after the PTP programme.

3.1 Parents’ perceptions about changes in their parenting: the Parenting Scale

There was a significant decrease in mean scores between pre- and post-programme across all three subscales of the parenting scale as well as the overall score, as shown in Table 7.

Table 7: Changes in mean scores on the Parenting scale between pre and post PTP (n= 100)

<table>
<thead>
<tr>
<th>subscale</th>
<th>Mean at T1</th>
<th>Clinical cut off</th>
<th>Mean at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laxness</td>
<td>3.21</td>
<td>&gt;=3.2</td>
<td>2.16</td>
<td>0.000*</td>
</tr>
<tr>
<td>Over-reactivity</td>
<td>3.28</td>
<td>&gt;=3.1</td>
<td>2.20</td>
<td>0.000*</td>
</tr>
<tr>
<td>Verbosity</td>
<td>4.05</td>
<td>&gt;=4.1</td>
<td>2.90</td>
<td>0.000*</td>
</tr>
<tr>
<td>Overall</td>
<td>3.51</td>
<td>&gt;=3.2</td>
<td>2.47</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Statistically significant

The Parenting Scale has clinical cut-off scores, indicating that the PTP parents have high levels of need at Time 1: the mean score for laxness, over-reactivity and for overall parenting all being over the clinical cut-off point. The mean scores for all sub scales and the total score are below the clinical cut off at Time 2. Table 8 shows that there were reductions in need amongst those with the highest levels of need at Time 1. Almost two-thirds of parents scored as having high clinical need at Time 1 for their overall parenting score and this reduced to about one fifth by Time 2. Large reductions were particularly noted for over-reactivity and verbosity scores.

Table 8: Proportion of parents in a clinical range of high need on the Parenting Scale before and after PTP (n=100)

<table>
<thead>
<tr>
<th>subscale</th>
<th>Pre programme</th>
<th>Post programme</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laxness score</td>
<td>50%</td>
<td>36%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Over-reactivity</td>
<td>62%</td>
<td>23%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Verbosity score</td>
<td>50%</td>
<td>10%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Overall score</td>
<td>65%</td>
<td>21%</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Statistically significant
3.2 Changes in relationship with child: the Parent Child Relationship Inventory

The mean scores of the six PCRI sub-scales all showed improvements between before and after the PTP programme, as increases in scores indicate improvements. The improvements in five of the sub scales were statistically significant, as shown by Table 9.

Table 9: Change in mean PCRI scores between pre and post PTP (n= 47)

<table>
<thead>
<tr>
<th>Mean at T1</th>
<th>Mean at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Support</td>
<td>23.6</td>
<td>26.9</td>
</tr>
<tr>
<td>Satisfaction with parenting</td>
<td>35.0</td>
<td>35.7</td>
</tr>
<tr>
<td>Involvement</td>
<td>40.7</td>
<td>44.2</td>
</tr>
<tr>
<td>Communication</td>
<td>25.6</td>
<td>28.2</td>
</tr>
<tr>
<td>Limit setting</td>
<td>27.7</td>
<td>35.0</td>
</tr>
<tr>
<td>Autonomy</td>
<td>25.0</td>
<td>26.4</td>
</tr>
</tbody>
</table>

* Statistically significant

The PCRI also gives an indication of scores that are likely to indicate that parents are feeling very stressed or over-burdened by their parenting task. Table 10 shows where parents have moved from high levels of need to within the normal range across different aspects of parenting between the beginning and end of the programme. Examples include: involvement in the lives of their children, which shows a reduction of parents with high levels of need from just over half to a quarter; and communication, showing a reduction from well over half (57%) of cases to one third in the high need category.

Table 10: Proportions of parents with high needs on PCRI scales at the beginning and end of PTP (n=47)

<table>
<thead>
<tr>
<th>Pre programme</th>
<th>Post programme</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Support</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Satisfaction with parenting</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Involvement</td>
<td>54%</td>
<td>26%</td>
</tr>
<tr>
<td>Communication</td>
<td>57%</td>
<td>33%</td>
</tr>
<tr>
<td>Limit setting</td>
<td>25%</td>
<td>2%</td>
</tr>
<tr>
<td>Autonomy</td>
<td>18%</td>
<td>10%</td>
</tr>
</tbody>
</table>

* Statistically significant

In summary, the quantitative data collected from parents on their parenting and on the relationship with their child indicated that parents perceived a reduction in ineffective parenting practices and improvements in their relationship with their child. There are improved scores for parents across all the PTP objectives and the implications of the findings are spelt out according to the theory of change in chapter 5. How the programme has helped parents is the focus of the next chapter.
Chapter 4: Views from parents on change and the factors that helped them achieve change

Parents’ experiences of the PTP service are explored in this chapter. The initial focus is on the referral process and how parents initially engaged with the service. Factors that enabled change are outlined, as well as barriers to change. The changes themselves are also described.

4.1 Parents’ experiences of the referral process

It was expected that parents would come to the service from three main sources – referred by a social worker, referred by a member of staff from the school attended by their child or self-referral by the parent. However the boundaries of these three categories were often blurred. There were parents who felt that they were desperate for any help that could be provided, whether it meant admitting to experiencing great difficulty in their parent-child relationship or the compulsory intervention of social work services. For example a parent might have gone to the school in a state of desperation with other issues such as depression and mental health issues that were affecting them and their parenting capability, and have then found out about the parenting service and have gone to discuss the service with the NSPCC. Typically a school nurse would be the person to suggest the parenting service in the context of providing an opportunity for the parent and child to receive some extra help:

She was the one he’d been speaking to and trying to do things with his weight and height and trying to get information from him, which she couldn’t get so she had heard about this and she was like, “I will see what I can find if you are interested.” So I said, “Yes,” anything for sure.

(mother of 10 year old)

Parents expressed the view that they would not have contacted the NSPCC directly as their perception was that the NSPCC take children away as a child protection agency, rather than provide help to families with managing child behaviour:

NSPCC is good to work with. It’s just a bit easier if people know that it’s not just about taking your kids off you sort of thing.

(mother of 10 year old).
For some parents an incident, such as a father hitting the child for ‘being naughty’ had been observed and acted upon by someone within the school, and this had led to a multi-agency assessment and the service was offered as a possible solution to their problems. In other cases a child had been the one to report such an incident to a member of school staff who had then acted in accordance with local safeguarding procedures:

We were struggling with (child’s) behaviour, and one morning I dragged her across the road because she was misbehaving, and I’ve caught her wrist wrong, she’s run to school saying, “Mummy’s broke my wrist”, and the school had to then write a report to Social Services.

(mother of 9 year old)

Although parents spoke about the great difficulties that they were facing within their families, none of the parents used the word ‘neglect’ in the interviews. They were more likely to describe the behaviour of the child as causing or adding to stress within the family, and that they were disappointed that they had been begging for help and they had almost come to breaking point before they received a positive, supportive and constructive service for their family. Sometimes this challenging behaviour of the child was in situations outside of the home and showed the scale of the need that the child and family had:

Whether you were shopping, he’d always ruin a shopping day.
We’d as a family go to tenpin bowling or go for a nice meal. He’d kick off. You’d end up coming home or you wouldn’t even get there. He wouldn’t do anything.

(mother of 12 year old)

For one parent it felt that the service needed to be offered at the right time but that that time is not when at breaking point. Some parents were prepared to accept whatever description agencies gave to their family relationships in order to get a service, even if they were apprehensive about it:

I was a bit reluctant at first because I didn’t really know what I was getting myself into. But as a sinking person you sort of clutch onto straws and whatever you can, so I agreed for mine and my husband’s sanity. That’s how we found out about the PPP course.

(mother of 7 year old)
For parents who had referred themselves into the service it was not a straightforward process of going to somewhere where they would expect to find relevant information on parenting support, receive it, consider it and then come to the NSPCC. One parent described receiving the information about the programme only with hindsight after having contact with the NSPCC:

Yeah. I started noticing their leaflets about the PANTS talk, that kind of thing. The NSPCC worker got a couple of leaflets out, but it was after that that I started noticing around the hospital and stuff.

(mother of 10 year old)

It helped parents to have someone who could describe the programme and its potential benefits so that the parent could make an informed choice about whether to participate or not. The way that someone described the programme was important; if it is warmly recommended to improve things the parent is more likely to decide to do the programme.

Parents did not comment on the involvement of their children in the decision to accept a particular service.

The context for parents at the beginning of the programme

Some parents felt that they could not do what they needed to do for their child, due to a range of factors, including relationship breakdown. When one mother and father separated and mother started a new relationship and moved house, it was only with hindsight that she was able to see the impact on the behaviour of her child that the school had noticed. For other parents domestic abuse had affected the parent-child relationship. This was noted by a subsequent partner of a parent who had experienced domestic abuse in a previous relationship:

The relationships she’s been in, domestic violence, the rape side of it and everything else. She was going through a stressful time. I didn’t actually realise the full extent of how it was affecting her and the kids. She didn’t realise how much she’d been affected and especially how (child) got affected. You don’t think as a child that he remembers half of the stuff.

(father of 11 year old)
Parents described the way that their health had been affecting the management of their child’s behaviour, and acknowledged that they knew their parenting had been inconsistent and had not been helpful for their child; it had been unable to provide the firm boundaries that help a child to know and feel where the limits of acceptable and unacceptable behaviour are:

But for me it’s what I needed because I used to give in and give in to him all the time just for peace, quiet, no argument, no quarrels.

(mother of 12 year old)

Parents described the stress that they had experienced by living in an extended family in a house that was not big enough to be comfortable for all the people living in it. This had the effect of increasing stress and providing the motivation of seeking a solution:

It was ten of us in a four bed roomed house really with six being children: three of theirs and three of mine. So, I think she came to the conclusion that I was finding it really difficult to cope with the situation.

(mother of 7 year old)

4.2 Facilitators that helped parents change

NSPCC worker’s approach and relationship with family

Parents reported the important role played by the NSPCC worker and the aspects of the relationship that were valued included good communication, approachability, experience, flexibility, and instilling trust.

Communication with the NSPCC worker was described as excellent by the parents interviewed, especially in terms of timeliness, clarity and calling back in a timely way that meant a parent was not left wondering what was expected of them and when the next meeting would be:

Even if there was, (a problem), he’d call me back if he was out or at a meeting. He’d just call me straight back. To be honest as well, if he wasn’t there, there would be another worker what I knew who I’d just be able to speak to.

(father of 11 year old)
Parents described their NSPCC worker as being easy to approach, not easily shocked by what the parent might describe, always helpful, full of ideas for the parent to try, and patient in explaining aspects of the programme that perhaps the parent had not grasped easily:

Yes and if you didn’t understand something she would always say to you, if you don’t understand stop me and I’ll go through it again. So she was good like that as well. Like she doesn’t just keep going on and on and on and then thinking, oh that’s all right, you’ve got that then, yeah? She sits there and she’s like, if there’s anything you get confused with or anything we need to just recall let me know and I’ll do it straight away.

(mother of 8 year old)

Sometimes this approachability and the lack of judgemental attitude was contrasted with the experience of parents approaching other agencies:

I felt that I could talk to her about problems I had and she wouldn’t judge me on these problems. You know, I could talk to her when I had a problem with social services at first.

(mother of 7 year old)

The approachability of the worker was seen as being appropriate and balanced, professional and doing the right thing and not being over friendly. Parents reported a high level of trust in their worker to deal with information appropriately, while knowing that absolute confidentiality around the information that they would share could not be offered by the worker as there was always the possibility that a concern over the safety of a child would have to take priority.

It was clear to parents that although they had become familiar with meeting their worker regularly every week they still had a professional relationship. This approachability included having a demeanour that put parents at their ease and the result was that having contact with the worker, even on the telephone, was a positive experience for the parent:

CSP was really nice, smiley. I could hear her smile from the end of the phone really. She was very interested, you could tell from her body language, in whatever I told her, very interested in whatever I told her. She would take mental notes and everything. Basically you could tell from her body language that she was listening to me.

(mother of 7 year old)
This friendly approachability was commented on even when the parent and child had not managed to complete agreed tasks. The professionalism of the worker meant that on occasion they would push the parent forward in doing the work together, yet still in a respectful manner:

She was open and honest with us as well. She worked at our pace, and then every now and again if she felt that there wasn’t enough going into it, she’d set us bits and pieces to work towards, a little bit of a push in the right direction, which I think sometimes you need. It wasn’t forceful or anything like that, it was just the way she delivered it and put it over. Can’t fault her really. Really good, really kind.

(father of 9 year old)

As well as this approachability that helped to encourage the parent to be open about their parenting, the worker also respected the parent as an adult and brought possible solutions for the parent to try with their child. Parents appreciated the skills and experience of their worker who was able to draw on suggestions and examples for the parent and child to try when in a difficult situation. One parent described the journey of puzzling over a suggestion made by their worker, and then describing how it went with their child:

He was very clever at what he did. Some of the stuff you’re thinking, “why is he telling us to do this?” Or, “why is he doing this?” It seemed a bit strange until you actually did it and had a go and saw the results of it.

(mother of 12 year old)

The worker would be able to make practical suggestions that the parent could follow, even if the parent knew that they were being gently steered away from negative or punitive methods:

‘To defuse the situation don’t shout at your child. Use the timeout. Use the quiet time. Use the family rules. Do the rewarding. Always praise your child and say that they’re doing well’. All that I never used to do but shout at your child and tell them to go away.

(father of 9 year old)
Flexibility, timing and location of the work

Parents described the benefits of the work taking place at their home rather than at an NSPCC service centre or at some other public facility. This was helpful in reducing transport costs and logistics and also in providing the help in the actual place where most of it will be implemented and lived out for the family. Workers made appointments at times to suit the parent and in some cases into the early evening in order to include parents with daytime work responsibilities. Parents gave examples of the worker changing times and dates of appointments in accordance with the lifestyle of the parent or to fit in with developments that made a change to the session timing unavoidable:

The worker was pretty good with times, she worked it around us. At the time I was working until half-five/six o’clock, so we always arranged it for six o’clock. My wife was always here anyway, sometimes I was a little bit later with work commitments and travel and that, but she was always, “It’s not a problem”. It was really good, pretty convenient.

(father of 9 year old)

Parents reported other examples of their worker getting other practical items for the family, such as getting food and presents in for Christmas by accessing budgets for short term urgent help for families.

4.3 Barriers to change for parents

Busy schedules of parents

The flexibility of the worker, the timing and the venue noted previously meant that there were very few comments made about logistical issues being a barrier to the service. Parents have noted the way that workers have timed their visits to help fit in with their family timetables. Parents noted that work arrangements, and having an employer with little understanding, made fitting in the service more difficult. As well as work there are activities and clubs that their children attend that mean fitting everything in feels a big challenge:

Yes, they kept going to 101 clubs; (child) has at least one for him on Monday to Friday and it’s a good day when he only has one on. So Monday and Thursday I think he’s got two.
I’m pretty much his taxi. He’s a couple of the clubs are in school, which is not so bad and then he’ll have other ones that are normally like a quick change and something to eat and back out.

(mother of 10 year old)

Issues in the Pathways Triple P programme

Parents have found some aspects of the programme difficult. One parent identified doing role play as a stumbling block to her participation in the sessions:

I don’t do role play. Literally, it just does my head in. It’s like trying to explain to somebody and without sounding like an absolute idiot it was like, I’m not – but to the point where I was nearly in tears. I can’t, I just can’t do it.

(mother of 10 year old)

Parents made comments about the Australian accents in the DVD being funny and that sometimes the portrayal of family life in it, such as playing nicely with lego that is all neat and tidy, is not very realistic for them.

For parents who had tried to implement the programme some parts of it were not as effective as they had hoped for:

The timeout sometimes, when I’ve put (child) on the step he wouldn’t sit there for as long as he was supposed to. I’m not so sure about the timeout.

(mother of 10 year old).
The range of impacts

4.4 Parents’ descriptions of change

Parents described in greater detail the changes they had experienced or perceived, for themselves as parents, for their children and for their relationships.

More effective management of child’s behaviour

Parents reported several changes to their approach to managing their child’s behaviour and were able to identify ways in which these changes had occurred. There were examples of different strategies being used to manage their child’s behaviour. One example was when a parent was on the telephone and the child attempted to cut across their conversation. The parent reflected that previously they would have shouted at their child, but following the suggestion and modelling of the worker, they responded differently:

For example, me and the worker were speaking and because it was when the children were at home they kept coming in and interrupting us and she said to me, she said now if you just say to them, be polite, just go in there and say to them, please go in your room for one minute, I am just speaking and you are being ever so good by doing that for me. And if you let me carry on speaking I will come and see you in a minute. And then come back and sit down. You don’t understand how much of an impact – that does actually really work.

(mother of 9 year old).

Parents wanted to move away from negative methods of parenting, such as shouting or hitting, because they could be ineffective:

I understand that if I shout at her you’ll just get nowhere because she will just shout at you back. By hitting her you wouldn’t get nowhere because she will just smack you back. And they’ve made me understand that there is a different way of dealing with it than shouting and hitting the child.

(mother of 7 year old)

Hence those parents wished to use more positive methods such as praise, planning ahead and time out, and to be consistent in these methods. A key to this was greater clarity of expectations:
Things would be different. We got taught how to do a rota for the week on what he had to do, what he didn’t have to do. It was the way that you told them properly instead of giving them loads of warnings or giving into them. Stick to what you say. He knows the rules.

(mother of 12 year old)

Parents described that change may not come easily either to them or their child but that it had been worth making the change:

He got used to getting away with everything that he could. And as I got more aware of what I was doing in this, I got a little bit firmer and a bit stricter and put more boundaries in place. But he didn’t like it at first, we had tears, we had tantrums, everything, but it made me more strong as a parent.

(father of 11 year old)

Parents described their own journey from scepticism of the value of the programme to being more open to doing things in different ways and that some changes that they previously thought were unthinkable could be made and be beneficial for their family. Parents noted that a sense of perspective was important in appreciating how far things had changed within their family:

The programme did teach me that well you know we can have ups and downs as a parent. No parent has to be perfect, there are enough problems in parenting but the programme taught me that even though there is this problem it is only a minor problem.

(mother of 7 year old)

The service has given parents a better understanding of their role as parent and what is expected of them. It might be something as simple as ensuring that their child gets a drink on a shopping trip, or knowing that shouting or hitting them are not ways to deal with misbehaviour, or giving more attention to the children by reading to them regularly. Parents who are involved with other agencies now have a better understanding of what is expected of them by others:

I think I’ve got a better understanding now of the girls’ issues they had and that they’ve still got. I feel like I’m a lot more involved with specialists like the school; social services have been really good as well. I feel I’m, I feel that this course has done me good.

(mother of 7 year old)
Parents reported that where they could apply a strategy for calming themselves down, that this impacted on their parenting:

Yeah it has, especially when we’re outside. Sometimes they don’t listen and I need to shout their name three or four times and then some of the looks you get off passers-by and stuff, keep your kids under control sort of thing. I can calm myself down. It’s about recognising when I’m getting into that kind of step.

(mother of 10 year old)

This could have a circular effect, in that the improved parental efficacy could have a broader impact on the parent’s well being:

There are some situations where we can have a meet halfway situation; but mainly they know when they’ve done something wrong then… So, in that sense it’s made me stronger as an individual. It made me get more self-confidence.

(mother of 8 year old)

**Improvements in the parent-child relationship**

Where parents identified improvements in their relationships with their children they were also able to identify ways in which this had happened. A key factor could be their motivation, as they could want to move beyond reactive parenting and to develop a relationship with their child that would mean the child could approach them for help when they felt worried or sad or fearful:

I want her to come to me and say to me, Mum, you know, I’ve just started my periods can you help me? Rather than be too scared to tell me, do you know what I mean? I want her to be able to come to me with any problems with lads, you know, with boyfriends. So I want her to be able to talk to me about personal things that she has.

(mother of 7 year old)

The PTP programme had given parents the opportunity to reflect upon their parental behaviour and the impact of what they were saying and doing on their relationship with their children. Doing PTP has also helped parents to be able to talk about the relationship they have with their children and to reflect upon how their parenting behaviour affects the mood of their children and their behaviour:
I think it’s a relief for people to actually talk about it, because when you’re going through it you don’t tend to talk about it. I think it offloads quite a lot as well. Triple P brings all that out of you. When you start talking about it, it’s only then you start realising how it affects you and especially the kids.

(mother of 12 year old)

A feature of relationships that could change was in the amount of time parents and children spent together and in the nature of their interactions. Where parents acknowledged that they had not been very involved with their child in joint activities, they identified this as an area of change. For example they would become far more involved in joint activities and playing with their child instead of telling them to go off and do something for themselves.

The impact of changes in parent-child relationships could be profound, as here:

I treat my children like humans rather than these three things when they’re around the house.

(mother of 7 year old)

**Improved relationships within the family**

Parents described better relationships with other children within the family and noted changes such as a child confiding secrets or concerns with them rather than with their class teacher. Parents expressed the hope that their changes in sensitivity to their children would have longer term benefits, so that they would talk about any personal problems, worries or feelings with them and realise that the parent’s commitment to their child is long term.

Parents reported spending more time with their children in shared activities and with physical contact and that that time provided reassurance for their children:

We really have changed, me and (husband), since we’ve done this course. He’s spent a lot more time with the boys. There was something in this course that made us take a step back and look at us, what we were doing wrong with the kids.

(mother of 7 year old)

Parents spoke positively of the bond that had developed not just with the child but in the whole family being brought closer together through the work.
The smile they’ve got on their face once you say, “Good boy, thank you”. (Child) feels really loved, I think you can tell by the smile. (Brother) is a very affectionate boy so he always gives cuddles and tell him “I love you” and that constantly.

(mother of 10 year old)

**Change in child’s behaviour and wellbeing**

Parents commented on the behaviour of the child at the end of the service and contrasted this with the situation for the child at the start, as here:

It’s safer for her because he used to want to try and kill her but he has calmed down a lot.

(mother of 10 year old)

Parents described children who were much calmer with their brothers and sisters and their peers outside of the family, and had done little jobs at home without being asked and were more helpful within the household. Parents spoke about the improvements that they had seen in their child at school and were proud of how well their children were doing at school compared to the recent past:

When he first went up to senior school we had times where he’d kick off and he wouldn’t go. Now how it’s changed and how he loves school. What he’s getting from school and his grades - his grades now are better than his older brother.

(mother of 12 year old)

Parents were aware that their problems were not all solved however and that they needed to be vigilant at home and at school to ensure that their child continued to develop in a healthy way:

Her behaviour’s improved but she’s had a rough time at school again and the behaviour – this is what we were saying to CSP – has dipped again.

(mother of 9 year old)

In the following example, a parent identifies several changes for the child, including an improved ability to regulate their emotions and to communicate about their feelings:
He's a lot more calmer. So we'll have our little kick offs between brotherly rivalry and if there's something that's on his mind sometimes he will kick off a little bit instead of coming and speaking to me. But sometimes he does leave me little letters.

(father of 7 year old)

A better relationship with their child and improved parental understanding were also seen as giving the child more confidence in themselves that would lead to benefits in other parts of their life:

Understanding how she was feeling, with that we realised how sensitive she can be, how to work with that and boost her confidence with that as well. It's made her feel a bit more comfortable and not as frightened, I think. With some situations she feels a little bit sort of threatened and fearful. That’s eased and you can see she’s a lot more bright.

(father of 9 year old)

Parents could identify that a change in their own behaviour and approach had resulted in changes for the child:

I've learnt to calm and do my little thing so I can keep calm, he'll go and do his little thing. Then later on I'd go up and just ask, “What was all that about? Do you want to speak about it?” And if he says, "No" then I'll walk away. And, like I said, sometimes he'll leave a little note when he wants to speak and then I will go up and then I know.

(father of 11 year old)
Chapter 5: Conclusion and Discussion

Child outcomes

There are statistically significant decreases across three of the four sub scales of SDQ amongst children between the beginning and the end of PTP: emotional symptoms, conduct problems and hyperactivity. In addition, there was a statistically significant decrease in the total difficulties score and an increase in the children’s pro social strengths. There was a significant reduction in the proportion of children experiencing difficulties at a very high level of need in the clinical range by the end of the PTP programme. Hence the results have both statistical and clinical significance.

The findings from the comparison with the historical NSPCC family support service are intriguing, as they show similar levels of impact overall, although there was a very different patterning to the outcomes with greater change: for conduct problems, hyperactivity and pro social strengths for the PTP programme; and for emotional symptoms and peer problems with the comparison group. These findings show the value of having a comparison group, as it allows for a more complex and nuanced picture to emerge. There is still a challenge however in knowing how to interpret this meaningfully.

There is a large existing evidence base demonstrating the effectiveness of Triple P. This study shows the patterning of outcomes that families where there are concerns about neglect may experience. In terms of child outcomes and the SDQ measure specifically, there are significant changes, but overall the PTP programme has not been more effective in the context of neglect than the historical comparison service. The evaluation design for this study has limitations, such that we do not know what would have happened if families had not received a defined intervention and a stronger process for generating the comparison group would have been preferable. Hence claims of effectiveness of the PTP programme in the context of neglect would need a stronger evaluation design.

Almost three quarters of children had clinical levels of need on the SDQ at the beginning of the PTP programme. This is concerning, not least as the eligibility criteria included that a child should not have an existing child protection plan. Hence the programme was pitched at an earlier stage of intervention and yet these levels of need are so high. It suggests that many children are suffering harm and are not identified as requiring a child protection plan. This resonates with the findings of the How Safe report (Jutte et al 2015). A limitation of the
evaluation design was that there was insufficient follow up data, hence we do not know if outcomes were sustained or if there were further improvements or a deterioration. This is significant given that almost half of children remained at a clinically high level of need by the end of the PTP programme. This suggests that there is likely to be a need for further support in the future, unless future evaluations are able to establish that the trajectory of outcomes through time show reduced levels of need at follow up.

Parent outcomes

There were statistically and clinically significant improvements across a range of parenting and parent-child relationship outcomes, from the parenting scale and the PCRI, between the beginning and end of the PTP programme. These can be related back to the programme’s theory of change in the following way:

- understanding of child’s needs – there are improvements reported in communication with children and parental involvement in the lives of their children. Time spent in talking with their child and on having a positive concern for their well-being is associated with having a better understanding of their child;
- parenting capability – improvements in laxness and limit setting means that children will be able to feel more secure in their relationship and know when they have exceeded an acceptable boundary in their play or interaction;
- commitment to child – parental support indicates having sufficient emotional and practical resources to provide adequate care for their child and that they demonstrate their commitment to their child;
- greater parental sensitivity – less over-reactivity to behaviour or interaction from their child will give the child greater confidence in their own development and not fearing harsh or authoritarian punishments for relatively minor transgressions;
- helping to meet the child’s developmental needs – increases in providing for the autonomy of the child allows for the child to develop greater maturity within the family and in other aspects of life, such as schoolwork.
Qualitative perspective on outcomes and process

Parents gave descriptions of a wide range of outcomes for themselves and their families. These included changes for: their parenting behaviour; their relationship with their child; relationships within the family; child wellbeing; and parental wellbeing. They spoke powerfully of the impact of these changes. Their descriptions also conveyed how parents felt that the different outcomes could reinforce each other. An example was where a parent was able to use a strategy to calm themselves down, which led to more effective parenting and this in turn resulted in greater self confidence. In this way there was an added value from the qualitative insights in this mixed methods study, not just from providing a richer description of the outcomes, but also from a focus on how those outcomes may be related to each other.

In addition to the outcomes, parents were able to reflect on factors that contributed to their achievement. Key to this was the relationship with the programme practitioner and in particular the practitioner’s: communication style; approach; experience; flexibility; and their supportive encouragement. Suggestions and modelling could help parents to understand how to try a different approach in their parenting. Through the work with the practitioner parents talked of the following as helpful for achieving the outcomes above: gaining a clearer understanding of the parenting role and its responsibilities; having clearer expectations for their children; and taking a broader perspective that could help in sorting out how to respond in a given situation.

Worryingly, parents described their early experience of trying to find appropriate support with their parenting. They could feel desperate and did not find it helpful that things would have to be so bad before they would get a service. In addition, the ways in which they found out about the available services could feel something of a lottery. Schools nurses were identified as a helpful source of information, partly because they are a universal service and hence not as stigmatising as some. This study would suggest that there is some way to go to make information about local services available to families who need them.
References


Brandon, M., Bailey, S. Belderson, P. and Larsson B. (2013) *Neglect and serious case reviews*, Norwich: University of East Anglia


Overview of Triple P programme Levels 4 and 5

What is Standard Triple P? (Level 4)
Standard Triple P provides parents with broad focused parenting support and intervention on a one-to-one basis. The program supports parents who have concerns about their child’s behaviour or development across settings (e.g., disobedience in community settings, fighting and aggression, refusing to stay in bed, eating healthy meals). Over ten one-to-one sessions parents identify the causes of child behaviour problems and to set their own goals for change. They learn a range of parenting strategies to promote and develop positive behaviour for their child. The practitioner focus is on generalization-enhancement strategies to promote parental autonomy throughout the intervention process.

Who is it for?
Parents or caregivers who benefit from this intervention are those with children up to 12 years of age who are concerned about their child’s behaviour. Usually they either need or prefer a one-to-one intervention and they need to be available to commit to 10 weeks of regular one-hour sessions. The program is appropriate for children with moderate to severe levels of behavioural problems.

What is covered in sessions with parents?

*Session 1: Intake interview.* The parent is interviewed to gather comprehensive information about their child’s presenting behavioural concerns, developmental history and family circumstances. They are asked to complete further assessment in the form of questionnaires and they are taught to use monitoring forms to track a specific child behaviour throughout the following week.

*Session 2: Observation of family interaction and assessment feedback.* The practitioner conducts an observation of child behaviour and parenting excesses and deficits. Then they provide feedback to the parent from all forms of the assessment and develop a shared understanding of the nature, severity and causes of current concerns. From there, treatment is negotiated and the parent sets goals for their own and their child’s behaviour change.
**Session 3: Promoting children’s development.** During this session, the parent is presented with strategies that aim to enhance the quality of the parent-child relationship and promote a rich environment of encouragement and positive attention for the child. The parent identifies when and how these skills can be used and have the opportunity to practise.

**Session 4: Managing misbehaviour.** This session involves introducing the parent to strategies for dealing with misbehaviour, rehearsing a routine for managing non-compliance, and setting new homework tasks.

**Session 5-7: Practice and feedback.** These sessions assist the parent in using the behaviour change strategies. The practitioner observes a 10 minute parent-child interaction where the parent has set goals to practice using specific parenting strategies. The practitioner then has the opportunity to encourage the parent’s self-evaluation and goal setting to refine the use of specific parenting strategies.

**Session 8: Planned activities training.** During this session, the parent identifies high-risk home and community activities (e.g., shopping trips), they learn to develop planned activities and routines to target specific behaviours, and select one of their routines to implement throughout the following week.

**Session 9: Using planned activities training.** During this session, the parent implements planned activities routines to encourage independent play when busy and a structured play activity. The practitioner provides feedback and then observes the parent implement a final planned activities routine to get their child ready to go out.

**Session 10: Program close.** The practitioner conducts a progress review and discusses with the parent family survival tips, problem solving for the future and future goals. If it is necessary, referral options are discussed.

**What is Pathways Triple P? (Level 5)**

Pathways Triple P has been developed as an intensive intervention program for parents who have difficulty regulating their emotions and as a result are considered at risk of physically or emotionally harming their children. Pathways Triple P requires parents to have received Level 4 sessions teaching them positive parenting and child management skills. The Pathways Triple P program can be completed in either a group or on an individual basis over two to five 60-90 minute sessions. There are three core modules that provide parents with support and to learn new attributional styles and anger management techniques that will assist in improvement and/or maintenance of positive parenting skills.
Who is it for?
Parents who benefit from Pathways Triple P are those that persistently make negative misattributions about why their child misbehaves and have difficulty managing their anger when interacting with their child. They have usually completed a Level 4 program and need further personal support to improve or maintain positive parenting skills.

What is covered in sessions with parents?

**Module 1, Session 1: Parent traps.** During this session, parents learn to identify parent traps, understand the impact of their own behaviour on their children, and identify dysfunctional attributions.

**Module 1, Session 2: How to get out of the parent trap.** This session covers the reasons parents get caught in parent traps and teaches parents thought switching and breaking out of a parent trap.

**Module 2, Session 1: Understanding anger.** This session introduces cognitive behavioural strategies to recognize and understand anger, how to stop anger escalating, abdominal breathing and relaxation techniques, and planning pleasurable activities.

**Module 2, Session 2: Coping with anger.** During this session parents will learn to catch unhelpful thoughts, develop personal anger coping statements, challenge unhelpful thoughts, and develop coping plans for high risk situations.

**Module 3, Session 1: Maintenance and closure.** This final session focuses on how parents can maintain changes, problem solve for the future, and create future goals.

NSPCC IPIP programme inclusion and exclusion criteria

Original inclusion criteria from 1 October 2011

A Common Assessment Framework (CAF) or equivalent assessment will have established that this is a child in need, aged 4 to 10 years, where parental unavailability or neglect are active concerns and that this is therefore likely to result in emotional harm or behavioural difficulties in the child or children. For the purposes of evaluation, the target child in the family should have had no previous child protection plan, and no other child in the family should have had a protection plan in the last two years. The child cannot be subject to care proceedings.

Commission criteria:
- Target child aged between 4 and 10 years;
- A CAF or equivalent assessment has established that this is a child in need;
- Parental unavailability or neglect are active concerns, and that this is likely to result in emotional harm or behaviour difficulties;
- The target child has never been subject to a protection plan;
- No sibling has been subject to a protection plan within the past two years;
- Care proceedings are not underway (nor should the child be subject to a Legal Order following proceedings);
- The child should not be accommodated (S.20);
- The child should ideally have a lead worker (though the absence of a professional in this role will not exclude delivery).
Subsequent inclusion criteria from 1 December 2012

The age range of the focus child was broadened to age 2 to 12 years. The focus child or any other child in the household should not be on a child protection plan at the point of referral.

Revised Commission criteria:

- Target child aged between 2 and 12 years;
- A CAF or equivalent assessment has established that this is a child in need;
- Parental unavailability or neglect are active concerns, and that this is likely to result in emotional harm or behaviour difficulties;
- **The target child should not be subject to a protection plan** (referrals will be accepted for children coming off a plan, though work will not commence until the plan has concluded);
- Care proceedings are not underway (nor should the child be subject to a Legal Order following proceedings);
- **The child should not be accommodated** (S.20), though may have been 'Looked After' in the past, or may be in receipt of regular respite as part of a Child in Need Plan. (Referrals will be accepted for children returning home from S.20 where Neglect remains an on-going concern).
- The child should ideally have a lead worker (though the absence of a professional in this role will not exclude delivery).

These changes in criteria were introduced to increase the number of referrals that would be made to the seven service sites whilst maintaining a focus on early concerns over neglect in younger children.

Service provision

At six service sites there was a choice of one of two parenting programmes offered: Pathways Triple P and Video Interaction Guidance. The decision about which service was to be offered was made by the team manager after considering the wishes of the parent and referrer if other than a self referral by the parent. In one service site, Cardiff, Pathways Triple P was the only service offered in this programme.
## Theory of Change for Pathways Triple P within the NSPCC

### Inputs

- CAF indicates concern over neglectful parenting
- Child aged 2 to 12 years and not subject of Child Protection Plan
- No previous Child Protection Plan for any other child in family in previous two years

### Activities

- PTP Programme
  - Behavioural approaches to parent-child relationship
  - Availability to the child

### Primary Outcomes

- Parent change in
  - Understanding what is expected of them
  - Understanding of child’s needs
  - Commitment to child
  - Parental sensitivity
  - Parenting capability

### Secondary Outcomes

- Parents
  - Change in parenting behaviour
- Children
  - Risk of harm reduced

### Tertiary Outcomes

- Child kept safe
  - Physical safety
  - Emotional needs met

---

**Parents inclusion criteria:**
- CAF indicates concern over neglectful parenting
- Child aged 2 to 12 years and not subject of Child Protection Plan
- No previous Child Protection Plan for any other child in family in previous two years
Processes

- Inputs – these are the parents being referred into the service and the circumstances that make them eligible for inclusion.

- Activities – these are the programmes, and are conceptualised as leading directly to the outcomes. They are the activities undertaken by practitioners during the work and also the activities undertaken by parents themselves, that can include sharing problems, seeking emotional support and learning skills.

Impacts

Impacts have been divided into primary and secondary outcomes to indicate their closeness to the activities undertaken as part of the service.

- Primary outcomes – these are the outcomes that the programme can expect to affect directly. For the parents they are changes in their understanding of the expectations placed upon them, of their child’s needs and of their commitment to parenting. For children it is that their emotional and physical needs are met and that their emotional and behavioural problems are reduced. These are the outcomes where the greatest impact of the programme would be expected.

- Secondary outcome – parents who make changes in their parenting attitudes are likely to show changes in their parenting behaviour. For the child the risk of neglect, emotional and physical harm should be reduced.

- Tertiary outcome – Being kept safe is categorised as a tertiary outcome because there are many factors that can affect it, with the intervention being just one. ‘Safe’ includes social and emotional safety in developing healthy attachments as well as physical safety. Within the theory of change it is proposed that being kept safe will be influenced directly by the secondary outcomes. As a range of other factors, including the child’s local environment, their peer group, the role and behaviour of other family members, and their parents’ health, can affect whether a child is safe, the programme would be expected to have the least impact on this outcome.
Appendix 2: Definitions of neglect in the UK four nations

The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate caregivers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.


In Scotland neglect is:

the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child’s basic emotional needs. Neglect may also result in the child being diagnosed as suffering from ‘non-organic failure to thrive’, where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.

(Scottish Government, 2010a, paragraph 36).
In Northern Ireland neglect is defined as:

the persistent failure to meet a child’s physical, emotional and/or psychological needs, likely to result in significant harm. It may involve a parent or carer failing to provide adequate foods, shelter and clothing, failing to protect a child from physical harm or danger, failing to ensure access to appropriate medical care or treatment, lack of stimulation or lack of supervision. It may also include non-organic failure to thrive.


In Wales neglect is defined as:

the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

Appendix 3: Research instruments

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child’s behaviour over the last six months or this school year.

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Male/Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Considerate of other people’s feelings</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless, overactive, cannot stay still for long</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Often complains of headaches, stomach-aches or sickness</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Shares readily with other children (treats, toys, pencils etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Often has temper tantrums or hot tempers</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Rather solitary, tends to play alone</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Generally obedient, usually does what adults request</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Many worries, often seems worried</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Helpful if someone is hurt, upset or feeling ill</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Constantly fidgeting or squirming</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has at least one good friend</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Often fights with other children or bullies them</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Often unhappy, down-hearted or tearful</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Generally liked by other children</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Easily distracted, concentration wanders</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Nervous or clingy in new situations, easily loses confidence</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Kind to younger children</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Often lies or cheats</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Picked on or bullied by other children</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Often volunteers to help others (parents, teachers, other children)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Thinks things out before acting</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Steals from home, school or elsewhere</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Gets on better with adults than with other children</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Many fears, easily scared</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sees tasks through to the end, good attention span</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Signature ................................................................. Date ..................................................

Parent/Teacher/Other (please specify): ..................................................

Thank you very much for your help © Robert Goodman, 2005
The SDQ is available to download freely from http://www.sdqinfo.com/py/sdqinfo/b0.py in over 80 languages. The official website has much information on its development, research uses, and scoring methods. The version shown is in UK English for an adult such as a parent or teacher to complete of a child aged 4 to 17 years. The evaluation has also used a version for younger children aged 2 to 4 years which amends ‘Often lies or cheats’ to ‘Often argumentative with adults’, ‘Steals from home, school or elsewhere’ to ‘Can be spiteful to others’ and ‘Thinks things out before acting’ to ‘Can stop and think things out before acting.’
The Parenting Scale (Arnold, O’Leary, Wolff and Acker 1993)

<table>
<thead>
<tr>
<th>Instructions:</th>
<th>At one time or another, all children misbehave or do things that could be harmful, that are “wrong”, or that parents don’t like. Example include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>hiring someone, forgetting homework, throwing food, lying, arguing back, refusing to go to bed,</td>
</tr>
<tr>
<td></td>
<td>warning a cookie before dinner, coming home late.</td>
</tr>
</tbody>
</table>

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, fill in the circle that best describes your style of parenting during the past two months with the child indicated above.

**SAMPLE ITEM:**

At meal time…

<table>
<thead>
<tr>
<th>0---0---0---0---</th>
<th>I decide how much my child eats.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0---0---0---0---</td>
<td>I let my child decide how much to eat.</td>
</tr>
</tbody>
</table>

1. When my child misbehaves…

<table>
<thead>
<tr>
<th>0---0---0---0---</th>
<th>I do something about it later.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0---0---0---0---</td>
<td>I do something right away.</td>
</tr>
</tbody>
</table>

2. Before I do something about a problem…

<table>
<thead>
<tr>
<th>0---0---0---0---</th>
<th>I use only one reminder or warning.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0---0---0---0---</td>
<td>I give my child several reminders or warnings.</td>
</tr>
</tbody>
</table>

3. When I’m upset or under stress…

<table>
<thead>
<tr>
<th>0---0---0---0---</th>
<th>I am no more picky than usual.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0---0---0---0---</td>
<td>I am picky and on my child’s back.</td>
</tr>
</tbody>
</table>

4. When I tell my child not to do something…

<table>
<thead>
<tr>
<th>0---0---0---0---</th>
<th>I say a lot.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0---0---0---0---</td>
<td>I say very little.</td>
</tr>
</tbody>
</table>

The Parenting Scale (Child) has 30 items and is normed for use for children aged 2 to 10 years. It produces three sub-scores. Laxness, where items are related to permissive discipline that is characterised by avoiding the use of control, giving in, allowing rules to go unenforced and providing positive consequences for misbehaviour. Over-reactivity which has items related to authoritarian discipline that is characterised by harsh punitive responses which display anger and irritability. Verbosity has items related to parents engaging in long verbal responses which draw attention to negative behaviours and take the place of meaningful consequences. There is also a total parenting
score that uses all of the 30 items in the measure. The Parenting Scale (Adolescent) is recommended for use for young people aged 11 and 12 years and has 13 items and reports on laxness and over-reactivity only, together with a total parenting score. It has good internal consistency and test-retest reliability over 2 weeks have also been found (Arnold et al., 1993).

The Parent Child Relationship Inventory (Anthony Gerard, 1994)

The PCRI gathers information on how parents view the task of parenting and how they feel about their children. It is designed for use with mothers or fathers with children aged 3 to 15 years, and it gives a quantified description of the parent-child relationship and reports on seven distinct scales:

- Parental Support, the level of practical and emotional support that a parent feels they receive and that those receiving good support will be enabled to provide good care for their child;
- Satisfaction With Parenting, the level of enjoyment the parent gets from being a parent and so likely to be a good parent;
- Involvement in the life and activities of their child, seeking out opportunities with their child and spending time with them;
- Communication between the parent and their child, that this reflects the parent’s empathy with their child and being able to talk and listen to any difficulties that their child has;
- Limit Setting, the effectiveness of a parent’s discipline techniques;
- Autonomy, the willingness of the parent to promote age-appropriate development and independence of their child;
- Role Orientation, which is not a measure of negative and positive parenting but is a measure of different approaches to parental responsibility, from equally shared to distinct gender roles.

There are also two scales to judge if parental responses are not valid and which assess the inconsistency of response items with paired questions and also any unlikely or overly positive socially desirable responses. These checks reduced the number of valid paired PCRIs to 47 for the Pathways Triple P programme.

The PCRI is a copyrighted scale so is not reproduced here. It is available from WPS

- See more at: http://www.wpsspublish.com/store/p/2898/parent-child-relationship-inventory-pcri#sthash.vPLnLHXz.dpuf
Interviews with parents who have received Pathways Triple P or Video Interactive Guidance

PARENT’S TOPIC GUIDE

Note: Introduction to the topic guide:

This topic guide is to encourage parents to discuss their views and experiences in an open way without excluding issues which may be of importance to individual participants and the study as a whole. Therefore the questioning will be responsive to parents’ own experiences, attitudes and circumstances.

The following guide lists the key themes and sub-themes to be explored with each interviewee. Questions like `why’, `when’, `how’, are assumed.

The order in which issues are addressed and the amount of time spent on different themes will vary between interviewees by demographics and experiences.

IPIP objectives

Parents:
1. Parents better understand the needs of their children
2. Parents are clearer as to what is expected of them for their children
3. Parental engagement, sensitivity and commitment to child increases
4. The standard of child care and safety is acceptable or a clear plan based on evidence is recommended

Children
1. Child’s unmet needs, physical and emotional, are met to a greater degree
2. Child’s behaviour is managed effectively and with greater safety
3. That unmet needs and safety are sustained at one year follow up

1 Introduction

Aim: to introduce NSPCC evaluation department, the study and explain the interview process in order to assure participants understand their role.

Introduction to researcher and NSPCC evaluation dept – the names we will use.
Study is part of the NSPCC approach to testing 27 services

Explanation of the study and key aims of the research:

1. To describe how the PTP / VIG (IPIP) service has been put into practice

2. To explore the barriers and helps for parents to receive the PTP / VIG service
   - Timetable of project (2011-2014)
   - Feedback on the research findings will be provided to all participants who would like this
   - Go through the Information Sheet for Parents:
   - Explain confidentiality and anonymity
   - Explain interview length (up to 1hour) and data protection issues.
   - Remind respondent of £10 voucher as thank you for their time and help
   - Check whether they have any questions
   - Go through the Consent Form to sign
   - Check that they are happy to continue and turn on recorder

2. Finding out about the NSPCC PTP / VIG service

   Aims: To get participants talking and find out information about how they came into contact with the PTP / VIG service.

   Note: Throughout the interview allow plenty of time for each area and go at the pace of the participant. Take breaks if needed and do not persist with topics that participants do not understand or have not experienced.

1. How did you come to the NSPCC’s PTP / VIG service?
   - Self referral / referred by Social worker / Health worker / school’s worker/
   - Other / Don’t know

2. In what ways did you find out about the IPIP service?
   - Leaflet / Posters / NSPCC website / Had it explained by someone /
   - Other / Don’t know

3. Which of these ways do you think is the best way for the NSPCC to tell parents about the PTP / VIG?

4. Why did you go to the NSPCC service / were they put in touch / what was the reason? Tell me about it.
3. Experience of relationship with practitioner

Aim: to establish service users’ experience of the NSPCC worker in the service.

- Length of time they have been in contact with worker
  [IE RECAP]
- Nature of contact
  Location (Where do you meet?) Did you get to choose where to meet your worker?
  Frequency (How often approximately?)
- How they came in to contact with worker

Understanding of worker’s role:
- What do you think you can expect from your worker?
- What is their job in relation to you?
- How are they supposed to help?
- How did they help you?
- Have you had an NSPCC worker before? How do they compare?

- Overall relationship with NSPCC worker
  - How do they treat you?
  - What are they like?

What is good/ isn’t good:

Communication / How well did they keep in touch with you?
- How well do they communicate?
- How clear are they?
- How approachable are they?
- Does your worker listen to what you have to say?
- Do you feel supported by your worker?

Trust: Do you feel safe using the PTP / VIG service?
- Do you trust them? Why/why not?
- Has your worker explained the confidentiality policy with you?
- Do you know when your worker might have to break confidentiality to tell other adults? When?
- Has it been explained to you that you can get to see your NSPCC records?

Flexibility and Responsiveness
- How available are they if you need to speak to them?
Motivation to attend appointments / maintaining contact with worker
• Did you like having contact with your worker? Why/ why not?

Barriers to attending / engaging
• What stops you getting in contact with them?

Facilitators / what would stimulate engagement
• What would help you to have more/ better contact with them?
• To what extent has worker helped you achieve the change that you wanted?
• What has helped/ worked well? Are there any examples of ways that your worker has helped you? What were the things that most helped?

4. The impact of the PTP / VIG programme
Aim: To understand the way the programme has in helping parent

1. In PTP / VIG programme what has worked well for you? And not so well?

2. How has PTP / VIG helped you to understand the needs of your child?

3. How has PTP / VIG helped you to meet the expectations that there are of your parenting?

4. How has PTP / VIG helped you to engage / relate to your child?

5. How has PTP / VIG helped you to be sensitive to the needs of your child?

6. How has PTP / VIG helped you to show commitment to your child?

How could they help more – specific examples
• can you think of any specific examples of things in the PTP / VIG programme that would help?
• can you think of any specific examples of things in the PTP / VIG programme that were barriers to helping you?

Aim: To understand the way the programme has in helping focus child

1. In PTP / VIG what has worked well for your child? And not so well?

2. How has PTP / VIG programme helped the behaviour of your child?

3. Do you manage the behaviour of your child differently now?

4. Do you think your child is safer now?

5. Do you think that you manage the safety of the child better now?
Worker helping them in relation to any other issues ie different to reason first saw NSPCC worker

- *Have they done this? How?*
- *Were there any issues about your safety that came out*
- *What has helped? Any examples.*
- *How could they help more – specific examples (can you think of any specific examples of things that would help?)*
- *What could they do differently*

5. General impact of PTP / VIG programme in practice

Aim: To understanding participants’ views on the impact of PTP / VIG.

- *Has doing PTP / VIG helped you in your practical parenting?*

To provide an opportunity to summarise the key impacts of the PTP/ VIG programme and ensure that any gaps in the previous discussion are covered.

Outcomes of the PTP / VIG programme in overall impact on life:

- *Overall, how has doing the PTP / VIG programme affected your current situation?*
- *Has any other aspect of your life changed as a result of doing the PTP / VIG programme?*

Priorities

- *Which of these changes has been most important?*
- *What would you most like help with in the future?*

Further suggestions

- *Do you have any suggestions of how the PTP / VIG programme can be improved?*

6. Next steps

Aims: To discuss any other areas or questions the participants want to discuss and
let them know who to contact for further information

- *Any other areas of importance to cover*
- *Any questions now for research team*
- *Reassure confidentiality*
- *Thank them for their time.*
• Tell them that they are welcome to contact members of the research team (contact details on leaflet) to ask questions at a later date if they wish.

• Point again to Information Sheet contacts for future support

• Hand over Love to Shop gift card & voucher, signing off that have received it

Paul Whalley March 2014
Appendix 4: Ethics Overview

NSPCC practitioners delivering Pathways Triple P attended evaluation training in order to gain an understanding of how the evaluation worked and the key ethical considerations in carrying out the evaluation. The ethical issues of the evaluation are listed below:

Informed consent

There is a risk that families do not feel they have a real choice. Given they may be experiencing high levels of stress, it may be tempting for them to acquiesce, in order to please the professional. In addition, they may question whether they really will be offered the same level of service if they have refused consent for the evaluation. The “practitioner guidance” will highlight these risks and emphasise the importance of freely given informed consent. An information leaflet will be provided for families. The age range of the children in the commission is 2 years to 12 years.

Harm or upset to families

The measures may raise potentially distressing issues or at least make some distressing issues explicit to the parent. However the measures are in the context of service intervention which is intended to address concerns over parenting that is potentially neglectful and the parent should be aware of the possible consequences of engagement with the local authority and the NSPCC as part of the terms of agreement. Also parents that consent to the evaluation process do not have to answer every question, and will have a practitioner available to provide support.

Respondent burden

The number of measures to be completed at three time points in the service intervention is a considerable undertaking for parents whose parenting is being considered as potentially neglectful. However parents may welcome the use of scaling measures to help them to understand more clearly the difficulties faced by their children as their use can give a visual means of showing change in the process of the intervention. Also some of the measures are being used in the practice itself.
Data security and protection
A lot of data will be passing between the evaluation team and service teams, both within and outside of the NSPCC. The data will be anonymised, reducing the risks of sensitive data being leaked in a way that will make it identifiable.

Child safety issues overlooked
In the interviews with practitioners or in the interviews, it is possible that some concerns for children will come to light that have not been handled constructively. If the evaluation team are concerned that a child remains at risk of significant harm, they will follow the NSPCC procedures. In the first instance, this will mean discussing the concern with the head of the Evaluation department. This may then lead to the evaluator contacting the NSPCC helpline for a case discussion. Confidentiality will be provided within the NSPCC defined limits, that it is given unless information is disclosed which suggests that a child may be at risk of significant harm.

De-briefing
Interviews will end with a discussion of how the service user found taking part in the evaluation to provide them with the opportunity to ask any questions that they may have had.
Appendix 5: Statistical analysis and qualitative data management

I. Strengths and Difficulties Questionnaire data: Change in mean score, pre and post PTP and using the Wilcoxon Signed Ranks Test (n=68)

<table>
<thead>
<tr>
<th>SDQ subscale</th>
<th>Mean at T1</th>
<th>Standard Dev. at T1</th>
<th>Mean at T2</th>
<th>Standard Dev. at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>3.6</td>
<td>2.3</td>
<td>2.8</td>
<td>2.3</td>
<td>0.004*</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>5.6</td>
<td>2.2</td>
<td>3.7</td>
<td>2.1</td>
<td>0.000*</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>7.6</td>
<td>2.2</td>
<td>5.8</td>
<td>2.4</td>
<td>0.000*</td>
</tr>
<tr>
<td>Peer problems</td>
<td>3.7</td>
<td>2.1</td>
<td>3.3</td>
<td>2.1</td>
<td>0.060</td>
</tr>
<tr>
<td>Pro-social</td>
<td>6.1</td>
<td>2.1</td>
<td>6.7</td>
<td>2.0</td>
<td>0.035*</td>
</tr>
<tr>
<td>Total score</td>
<td>20.6</td>
<td>6.1</td>
<td>15.6</td>
<td>6.54</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Statistically significant at p=0.05

II. Strengths and Difficulties Questionnaire data: Proportional shift in children from a clinical level of difficulty (very high need) to a normal, slightly raised or borderline level between the beginning and end of PTP. Based on an Exact McNemar’s Test (n=69)

<table>
<thead>
<tr>
<th>Level of difficulties</th>
<th>Pre programme (per cent)</th>
<th>Post programme (per cent)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal range</td>
<td>26%</td>
<td>55%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Clinical range (very high need)</td>
<td>74%</td>
<td>45%</td>
<td></td>
</tr>
</tbody>
</table>

* Statistically significant

III. Strengths and Difficulties Questionnaire data: Comparison of PTP dataset with NSPCC Family Support services dataset 2006-2009 (n=54)

<table>
<thead>
<tr>
<th>SDQ subscale</th>
<th>Mean at T1</th>
<th>Standard Dev. at T1</th>
<th>Mean at T2</th>
<th>Standard Dev. at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>4.5</td>
<td>2.6</td>
<td>3.1</td>
<td>2.2</td>
<td>0.001*</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>3.8</td>
<td>2.6</td>
<td>3.1</td>
<td>2.4</td>
<td>0.029*</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>5.1</td>
<td>2.6</td>
<td>4.4</td>
<td>2.8</td>
<td>0.071</td>
</tr>
<tr>
<td>Peer problems</td>
<td>3.0</td>
<td>1.9</td>
<td>2.8</td>
<td>2.0</td>
<td>0.663</td>
</tr>
<tr>
<td>Pro-social</td>
<td>8.1</td>
<td>1.8</td>
<td>8.1</td>
<td>2.3</td>
<td>0.403</td>
</tr>
<tr>
<td>Total score</td>
<td>16.4</td>
<td>6.9</td>
<td>13.3</td>
<td>7.3</td>
<td>0.006*</td>
</tr>
</tbody>
</table>

* Statistically significant
IV. Strengths and Difficulties Questionnaire data: Proportional shift in children from a clinical level of difficulty (very high need) to a normal or borderline level between the beginning and end of NSPCC Family Support services dataset 2006-2009. Based on an Exact McNemar’s Test (n=54)

<table>
<thead>
<tr>
<th>Level of difficulties</th>
<th>Pre programme (per cent)</th>
<th>Post programme (per cent)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal range</td>
<td>43%</td>
<td>72%</td>
<td>0.004*</td>
</tr>
<tr>
<td>Clinical range (very high need)</td>
<td>57%</td>
<td>28%</td>
<td></td>
</tr>
</tbody>
</table>

* Statistically significant

V. Strengths and Difficulties Questionnaire data: Comparison of PTP dataset with weighted NSPCC Family Support services dataset for mean differences of subscales T1 to T2

<table>
<thead>
<tr>
<th>SDQ subscale</th>
<th>Mean differences T1 to T2 for Family Support services dataset</th>
<th>Mean differences T1 to T2 for Pathways Triple P dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>-2.11</td>
<td>-0.83</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>-1.13</td>
<td>-1.81</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>-0.96</td>
<td>-1.62</td>
</tr>
<tr>
<td>Peer problems</td>
<td>-0.73</td>
<td>-0.43</td>
</tr>
<tr>
<td>Pro-social</td>
<td>0.39</td>
<td>0.54</td>
</tr>
<tr>
<td>Total score</td>
<td>-4.91</td>
<td>-4.70</td>
</tr>
</tbody>
</table>

The T1 values for the Family Support dataset have been weighted according to the T1 values of the Pathways Triple P dataset so that a more accurate comparison of the change from T1 to T2 mean scores can be made. Once this is done the differences between the two datasets indicate more change for conduct problems and hyperactivity in the Pathways Triple P dataset than in the Family Support services dataset, and more change in the emotional symptoms and peer problems in the Family Support dataset than the Pathways Triple P dataset. This is shown more clearly in the bar graph below:
When the four difficulties subscales are combined into one overall difficulties score there is little difference between the change reported across both interventions. This was further investigated by running a linear regression analysis on the overall difficulties score, with the dependent variable being the T2 score and the independent variables being the T1 score and group membership, Family Support or Pathways Triple P.

VI. Strengths and Difficulties Questionnaire data: Linear regression analysis of T1 to T2 change of Overall difficulties score of NSPCC Family Support services dataset and Pathways Triple P dataset.

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardised Coefficients</th>
<th>P values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>3.84</td>
<td>0.049</td>
</tr>
<tr>
<td>Overall result T1</td>
<td>0.597</td>
<td>0.000</td>
</tr>
<tr>
<td>Group membership – Family Support or PTP</td>
<td>0.077</td>
<td>0.889</td>
</tr>
</tbody>
</table>

This analysis suggests that, once controlling for T1, the difference in the mean score for T2 between the two groups is only 0.077, whereas the greater predictor of T2 score was the T1 score. The conclusion is that there is not a significant difference in T1 to T2 change by the Pathways Triple P dataset over the Family Support dataset, that the impact of both interventions upon the strengths and difficulties of children appears to be similar for parents.

VII. The Parenting Scale: Change in mean score, pre and post PTP, analysis based on Wilcoxon signed ranks test (n= 100)

<table>
<thead>
<tr>
<th></th>
<th>Mean at T1</th>
<th>Standard Dev. at T1</th>
<th>Clinical cut off</th>
<th>Mean at T2</th>
<th>Standard Dev. at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laxness score</td>
<td>3.21</td>
<td>1.24</td>
<td>&gt;=3.2</td>
<td>2.16</td>
<td>0.98</td>
<td>0.000*</td>
</tr>
<tr>
<td>Over-reactivity score</td>
<td>3.28</td>
<td>0.93</td>
<td>&gt;=3.1</td>
<td>2.20</td>
<td>0.97</td>
<td>0.000*</td>
</tr>
<tr>
<td>Verbosity score</td>
<td>4.05</td>
<td>0.92</td>
<td>&gt;=4.1</td>
<td>2.90</td>
<td>0.96</td>
<td>0.000*</td>
</tr>
<tr>
<td>Overall score</td>
<td>3.51</td>
<td>0.79</td>
<td>&gt;=3.2</td>
<td>2.47</td>
<td>0.85</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Statistically significant

VIII. The Parenting Scale: Proportional shift in children from a clinical level of need to a non clinical level of need between the beginning and end of PTP. Based on an Exact McNemar’s Test (n=100)

<table>
<thead>
<tr>
<th></th>
<th>Pre programme</th>
<th>Post programme</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laxness score</td>
<td>50%</td>
<td>36%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Over-reactivity score</td>
<td>62%</td>
<td>23%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Verbosity score</td>
<td>50%</td>
<td>10%</td>
<td>0.000*</td>
</tr>
<tr>
<td>Overall score</td>
<td>65%</td>
<td>21%</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Statistically significant
IX. PCRI: Change in mean scores, pre and post PTP, analysis based on the Wilcoxon Signed Ranks (n= 47)

<table>
<thead>
<tr>
<th></th>
<th>Mean at T1</th>
<th>Standard Dev. at T1</th>
<th>Mean at T2</th>
<th>Standard Dev. at T2</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Support</td>
<td>23.6</td>
<td>5.3</td>
<td>26.9</td>
<td>4.5</td>
<td>0.000*</td>
</tr>
<tr>
<td>Satisfaction with parenting</td>
<td>35.0</td>
<td>3.9</td>
<td>35.7</td>
<td>4.1</td>
<td>0.059</td>
</tr>
<tr>
<td>Involvement</td>
<td>40.7</td>
<td>5.9</td>
<td>44.2</td>
<td>5.1</td>
<td>0.000*</td>
</tr>
<tr>
<td>Communication</td>
<td>25.6</td>
<td>3.9</td>
<td>28.2</td>
<td>3.5</td>
<td>0.000*</td>
</tr>
<tr>
<td>Limit setting</td>
<td>27.7</td>
<td>5.6</td>
<td>35.0</td>
<td>5.5</td>
<td>0.000*</td>
</tr>
<tr>
<td>Autonomy</td>
<td>25.0</td>
<td>4.7</td>
<td>26.4</td>
<td>3.9</td>
<td>0.013*</td>
</tr>
</tbody>
</table>

* Statistically significant

X. PCRI: Proportional shift in children from high need to a normal score between the beginning and end of PTP. Based on an Exact McNemar’s Test (n=47)

<table>
<thead>
<tr>
<th></th>
<th>Pre programme</th>
<th>Post programme</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Support</td>
<td>17%</td>
<td>0%</td>
<td>0.016*</td>
</tr>
<tr>
<td>Satisfaction with parenting</td>
<td>4%</td>
<td>4%</td>
<td>1.0</td>
</tr>
<tr>
<td>Involvement</td>
<td>54%</td>
<td>26%</td>
<td>0.001*</td>
</tr>
<tr>
<td>Communication</td>
<td>57%</td>
<td>33%</td>
<td>0.004*</td>
</tr>
<tr>
<td>Limit setting</td>
<td>25%</td>
<td>2%</td>
<td>0.001*</td>
</tr>
<tr>
<td>Autonomy</td>
<td>18%</td>
<td>10%</td>
<td>0.453</td>
</tr>
</tbody>
</table>

* Statistically significant

Qualitative data analysis plan themes and sub-themes

Key aims of evaluation

1. What factors affected the implementation of the service?
2. What were the barriers and facilitators to success for the service?
3. What was the range of impacts of the service?