Parenting Support Framework Evaluation

August 2009 to December 2013

FINAL REPORT

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Acknowledgements

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Thanks also to Michele McClung, Morag Gunion, Sheila Hunter, Amanda Kerr, Heather Douglas and colleagues at Glasgow City Education Services for their never-ending support, particularly in relation to SEEMIS and in contacting schools and nurseries. Thanks also to the SDQ Steering group, chaired by Morag Gunion, for help and advice.

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EXECUTIVE SUMMARY

• This report addresses the implementation of the Parenting Support Framework in Glasgow between 2009 and 2013.

• During this period a total of 730 practitioners were trained in Triple P interventions.

• Over 30,000 Triple P interventions were delivered to families (including single interventions to 12,432 families, seminars to 13,645, Primary Care to 2,527, and Group Triple P to 2,144).

• Somewhat fewer than half of families completed Primary Care and Group Triple P interventions. The number of families recruited to interventions fell during the report period, but the number of completed interventions increased.

• In general, families with greater problems than those in the general population were more likely to attend Group Triple P sessions, but those with more severe problems were less likely to complete interventions.

• Families living in more deprived areas were more likely to start Triple P interventions than those living in affluent areas but more affluent and more highly educated families were more likely to complete Triple P interventions.

• Families completing interventions reported high levels of satisfaction with Triple P, and reported improvements in parenting behaviours, emotional wellbeing and child behaviour.

• It is not possible to be sure whether these improvements were a result of the intervention or whether they represent the passage of time or ‘regression to the mean’. This uncertainty, coupled with low completion rates, renders assessment of the effectiveness of interventions impossible.

• Practitioners were generally satisfied with the Triple P approach to parenting support but some practitioners expressed negative views about a target-driven approach and some considered Triple P was inappropriate for some families.

• Some practitioners and many parents are unfamiliar with the different forms of Triple P and consequently some referrals may be inappropriate.
• There are substantial inequalities in social and emotional functioning among the population of children at ages 30 months, 5, 7, 10 and 11-14 years. These inequalities seem to increase as children get older.

• There appear to be factors specific to neighbourhoods, independent of socioeconomic deprivation, which impact upon child social and emotional wellbeing.

• Social and emotional functioning among the population of children in Glasgow is broadly in line with figures from the UK as a whole, once levels of deprivation are allowed for.

• The social and emotional functioning of the population of children aged five years did not change during the implementation of the Parenting Support Framework.

• There is evidence that the infrastructure for provision and monitoring parenting support is improving and there is good cause for optimism in relation to future service provision.

**RECOMMENDATIONS**

A number of recommendations were made following a stakeholder workshop held in May 2014 to discuss the outcome of the qualitative evaluation. These are detailed on pp141-145 of Appendix 6, and have been incorporated into the list below where possible.

• The lack of change in social and emotional functioning among the child population of Glasgow, together with the low completion rates for Triple P interventions, selective benefit for more privileged families and recent published evidence of overall lack of efficacy leads us to recommend that Glasgow should not commit to further investment in Triple P training or materials except within the context of independently conducted randomised trials of specific interventions.

• The excellent infrastructure for provision of parenting support should be further strengthened by the introduction of alternative parenting programmes and more robust systems for monitoring activity.
• All professionals working with children should be informed and kept up to date about the availability of parenting support services, their nature and the families for which they are most likely to be successful.

• Where inadequate evidence for the effectiveness of alternative plausible programmes exists, consideration should be given to rapid evaluation with pragmatic randomised controlled trials. This would require some investment in infrastructure to support such trials.

• There should be continued monitoring of population child social and emotional wellbeing using structured instruments such as the Strengths and Difficulties Questionnaire. These data allow ongoing evaluation of achievement of the second and third Stretch Aims of the Early Years Collaborative as well as assessment of the effectiveness of preschool and primary school contributions to social and emotional wellbeing.

• Consideration should be given to neighbourhood and school patterning of SDQ scores in order to identify potentially modifiable local factors promoting child social and emotional wellbeing. Improved understanding of these factors could lead to more effective targeted investment in community development initiatives along the lines already followed by Canada and Australia in relation to neighbourhood Early Development Instrument scores (Hertzman & Williams, 2009).

• The Parenting Core Group should develop an action plan based on the above recommendations.
INTRODUCTION

Triple P is a ‘parenting and family support strategy that aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents’\(^1\). It is a licensed parenting program and contains multiple levels, designed to be accessed dependent on need. For further information please see the Year 1 Report of the Evaluation for the Parenting Support Framework (http://www.gla.ac.uk/media/media_269507_en.docx) or the Glasgow Triple P website: http://glasgow.triplep-staypositive.net/. The city-wide Glasgow Parenting Support Framework was launched in August 2009 with Triple P adopted as the main parenting programme. Figure 1 shows a timeline of the implementation of Triple P in Glasgow City.

Over the period of the evaluation there have been substantial changes to the management structure of the Parenting Support Framework. The main change came in September 2012 when the management of the project moved from three area-based and one central office which oversaw the running of Triple P within the respective areas, to a centralised administrative and management team led by two new Parenting Program Managers. Alongside this came changes to the administration of the data collection and inputting, resolving many of the early issues experienced.

The Evaluation covers the period between August 2009 and December 2013. This report covers findings from the whole evaluation. An interim report is available which explores findings from the first year of the evaluation (Marryat, Thompson, White, McClung, & Wilson, 2012), although please note this covers the period from November 2009 – December 2011. In addition to assessing the implementation and short-term outcomes associated with Triple P interventions, the evaluation has also collected data from the population of children at 30 months, pre-school, Primary 3 and Primary 6. This has enabled us to assess levels of social, emotional and behavioural difficulties in the population as a whole in Glasgow City, and whether they have changed during the Parenting Support Framework implementation.

\(^1\) http://www8.triplep.net/ accessed 09/01/2013
Figure 1 Timeline of the implementation of the Parenting Support Framework

2006: Glasgow City Children’s Services Planning Executive Group established a multidisciplinary Parenting Support Group.


2009: Publication of the Scottish Government’s **Early Years Framework**

2009: **Randomized control study by Prinz, Sanders et al** suggests the feasibility and benefits of implementing a large scale parenting intervention, using a population based approach to reduce the incidence of child abuse.

2009: NHS Greater Glasgow & Clyde and Glasgow City Council publish their **joint parenting framework**, which included:

- Development of a coordinated approach to parenting support, including the appointment of parenting coordinators in each Community Health and Care Partnership (CHCP)
- Staff training in two structured systems for understanding and managing parenting problems (Triple P and the Solihull Approach)
- Assessment of need for parenting support through “active filtering” in order to optimise uptake and access to services and to address health inequalities.

**Triple P Phase 1 (2009/10 to 2010/11):** Focused on 0-7 year old children, including the antenatal period. Delivery partners include: Midwifery services, Primary Care Teams, Child and Family Care Teams, Parents and Children Together (PACT) teams, multidisciplinary Pre School Assessment Teams, Oral Health Action Teams, Health Improvement Teams, Educational establishments and Early Years services, third sector services.

2011: ‘**One Glasgow**’ adopted – a Total Place approach based on pooling resources, focusing on shared priorities and creating efficiencies. A core principle is “**Earlier intervention and a proactive approach to prevention**”.

2013: Glasgow Integrated Children’s **Service Plan** 2013-15 launched, which highlights actions to enhance the framework, such as:

- Education services through the One Glasgow/Early Interventions programme combines the development in Family Learning Centres, the expansion of Family Support with the Healthy Children Programme
- Social Work Services will ensure that parenting support is available for vulnerable families, residential unit staff, foster carers and adoptive parents
- Development of the established programmes with Glasgow Housing Association, Glasgow Life, the third sector, Glasgow CHP Health Services teams including Children and Families, Addictions, Mental Health and Specialist Children’s Services.
The evaluation of the Parenting Support Framework is guided by the Project Implementation Document, which sets out eleven areas which we intended to address over the course of the three years. The progress in each year towards answering the questions is illustrated in Table 1 which uses a traffic light system. Red [R] indicates that we have not been able to answer the question during the evaluation period while orange [O] questions are partially answered and green [G] questions are answered more fully. The Results sections of the report are grouped according to these areas of investigation.

**Table 1 Extent to which the evaluation has addressed the areas it intended to examine**

<table>
<thead>
<tr>
<th>Areas addressed by the evaluation</th>
<th>Answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pattern of emotional and behavioural difficulties in the population at 2.5, 5, 7 and 10 years;</td>
<td>[G]</td>
</tr>
<tr>
<td>The pattern of emotional and behavioural difficulties in a sample of the population at 12 to 16 years;</td>
<td>[G]</td>
</tr>
<tr>
<td>Comparison of patterns with national and international normative data;</td>
<td>[G]</td>
</tr>
<tr>
<td>Overall changes in patterns over time;</td>
<td>[O] For preschoolers only</td>
</tr>
<tr>
<td>The extent that difficulties experienced by individual children persist or change over time;</td>
<td>[O] Between preschool and P3 only</td>
</tr>
<tr>
<td>The extent to which socio-demographic factors such as geographical area, relative deprivation and school influence trajectories of emotional and behavioural functioning</td>
<td>[G]</td>
</tr>
<tr>
<td>The extent that offers, uptake and completion of Triple-P and other interventions are matched to the level of emotional and behavioural difficulties;</td>
<td>[O] Information only on uptake and completion</td>
</tr>
<tr>
<td>The extent that offers, uptake and completion of interventions are influenced by socio-demographic factors, parents’ perceptions, belief systems, etc;</td>
<td>[O] Information only on uptake and completion</td>
</tr>
<tr>
<td>The extent that offers, uptake and completion of interventions influence the persistence of difficulties;</td>
<td>[O] Information only on uptake and completion</td>
</tr>
<tr>
<td>The predictors of resolution of difficulties both among participants in parenting support interventions and more broadly;</td>
<td>[G]</td>
</tr>
<tr>
<td>The extent that the population of parents are aware of Triple P and other sources of parenting support.</td>
<td>[G]</td>
</tr>
</tbody>
</table>
2. **Methodology**

**Introduction**
The evaluation aimed to look at the experience of implementing Triple P in Glasgow City, as well as short-term and medium-term outcomes for children and their families. This chapter explains the different qualitative and quantitative methods used to explore these issues in Glasgow City.

**Qualitative Data Collection**
As part of the overall evaluation, Iconic (an independent research company) was commissioned to undertake a qualitative evaluation to investigate the views and experience of stakeholders, practitioners and parents of the implementation of the Framework. The objectives concentrate on the implementation of Triple P which dictates the focus of the research and the associated report (see Appendix 6).

Qualitative research methods serve to identify contextual issues and the views and experiences of those who took part in the research. Qualitative evaluation and research activities were conducted over the six-month period between November 2013 and April 2014, and included 74 parents, 56 practitioners, and 20 stakeholders. At the outset of the study it was agreed that the fieldwork should concentrate on the three Early Years Collaborative Test Sites in the North West, North East and South sectors of Glasgow. Key elements of the methodology are summarised in the full report (Appendix 6). The qualitative evaluation was overseen by a Steering Group comprising representatives from the University of Glasgow and NHS Greater Glasgow and Clyde.

Throughout this report we have included summary findings from the qualitative component of the evaluation, with these sections marked clearly in shaded boxes. The full report produced by Iconic, including details of methods and full explication of findings, can be found in Appendix 6.

**Quantitative Data: Intervention Level**
In terms of the implementation of the program, the evaluation explored the number of staff trained and interventions delivered, as well as the characteristics of those receiving these
interventions, using monitoring data collected by the Central Parenting Team (CPT) at NHSGGC.

Short-term outcomes were investigated using data collected by practitioners during the course of the Triple P interventions, which provided information on a range of indicators before and after the intervention. Triple P uses a variety of measures which are part of the program, with the exact measures depending on the type of intervention. The different measures used are listed in Table 2. Due to the one-off nature of many of the interventions, the majority of levels only collect information at baseline. The exceptions to this are Level 3 Primary Care and Level 4 Group interventions, where measures are collected at both pre- and post-intervention. Although practitioners were encouraged to make every effort to collect questionnaire data, parents would not be prevented from participating if they felt unable or unwilling to complete questionnaires. The evaluation data obtained from the interventions are thus reliant on parents/carers completing measures at each stage, albeit within the group setting. Response rates, and completion rates (in terms of completing the intervention), have a significant effect on data quality and the conclusions which can be drawn from the data. Further information on response and completion rates can be found later in this section. It should be noted that no measures are completed at Seminars.

Table 2 Measures used within different interventions

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Background Questionnaire</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Partial</td>
<td></td>
</tr>
<tr>
<td>Parent Experience Survey</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Partial</td>
<td></td>
</tr>
<tr>
<td>Parenting Problems Checklist</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Parenting Scale</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Behaviour Checklist (RBC)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Relationship Quality Index (RQI)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Depression, Anxiety and Stress Scale (DASS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Client Satisfaction Survey</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Response rates across the whole evaluation period are given for the two levels for which both pre- and post-intervention data were collected, based on data provided to the evaluation team by the CPT. For Primary Care interventions, 2527 clients started an intervention between August 2009 and December 2013. Of these, 46.1% completed the intervention. Data were collected at the start of the intervention for 78.4% of those who began a Primary Care intervention, and for 44.5% at post-intervention. For Group interventions, 2144 clients started an intervention and 44.9% completed the intervention. In relation to response rates for Group Triple P, data were collected at time 1 (pre-intervention) for 94.1% of clients and at time 2 (post-intervention) for 33.8% of those who started the intervention.

Table 3 2012 Response rates at T1 (pre-intervention) and T2 (post-intervention)

<table>
<thead>
<tr>
<th>No. of clients started</th>
<th>No. of clients completed</th>
<th>% completed</th>
<th>No. of T1 forms</th>
<th>% with T1 data</th>
<th>No. of T2 forms</th>
<th>% clients with T1 &amp; T2 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>2527</td>
<td>1165</td>
<td>46.1</td>
<td>1980</td>
<td>78.4</td>
<td>1125</td>
</tr>
<tr>
<td>Group</td>
<td>2144</td>
<td>963</td>
<td>44.9</td>
<td>2017</td>
<td>94.1</td>
<td>725</td>
</tr>
</tbody>
</table>

**QUANTITATIVE DATA: POPULATION LEVEL**

Medium-term outcomes were collected through population-based data. These data give information on social, emotional and behavioural difficulties for the population at 30 months, pre-school (aged 4-5), Primary 3 (aged 7-8) and Primary 6 (aged 10-11), using Goodman’s Strengths and Difficulties Questionnaire (Goodman, 1997).

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire for children aged from 2 to 16. The SDQ is available in three separate versions for completion by parents, teachers and in a self-completion version for older children (aged 11-16). There is a separate version for 3-4 year old children, which replaces the items ‘often lies or cheats’ with ‘often argumentative with adults’ and ‘Steals from home, school or elsewhere’ with ‘can be spiteful to others’. For pre-school data collection in 2010 the 4-16 year old version of the questionnaire was used. In later years this was changed to the 3-4 version following staff feedback regarding some of the items in the older version being age inappropriate. In particular, there was a view from staff that although some children may put
toys in their pockets and go home with them (essentially ‘stealing’), the intent was lacking, and so this question was not felt to be developmentally appropriate (White, Connelly, Thompson, & Wilson, 2013). This means that the 3-4 version is being used at Glasgow at 30 months and 4-5 years, whilst the 4-16 version is being used at P3 and P6.

The SDQ contains five separate scales and asks about 25 attributes of social, emotional and behavioural development. The scales are Emotional Symptoms, Conduct Problems, Hyperactivity / Inattention, Peer Relationship Problems, and pro-social behaviour. The first four scales can be added together to create a ‘Total Difficulties’ scale. The five scales each contain five statements, to which the respondent answers as to whether the statement is ‘not true’, ‘somewhat true’ or ‘certainly true’ of the child\(^2\). Standard cut-offs are provided which group children into three groups: likely difficulties, possible difficulties or no difficulties. The first two of these groups are normed so that they should each contain 10% of a reference population, with the ‘no difficulties’ group containing 80% of the population (Goodman, 1997).

**30 MONTH (2.5 YEAR) DATA COLLECTION**

During August 2011, children across North East & North West Glasgow, East Dunbartonshire and Renfrewshire were visited by health visitors for their 27-30 month review\(^3\).

As well as routine health visiting enquiry, the universal 30-month home assessment involved the use of structured instruments assessing social and emotional development and language acquisition:

- The Strengths and Difficulties Questionnaire (SDQ) as the principal measure of social and emotional wellbeing of children;
- The Law-Miniscalco two-item language screen and the Sure Start Language Measure as measures of language development\(^4\);
- These were collected together with demographic and service-related information.

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\(^2\) Further information on the SDQ can be found at [www.sdqinfo.org](http://www.sdqinfo.org).


\(^4\) Further information and results from the language screening can be found through the study website: [www.gla.ac.uk/psfevaluation](http://www.gla.ac.uk/psfevaluation). See also Sim et al 2013.
Out of a potential 543 children meeting criteria for this contact, 486 (90%) either received the 30 month contact or had attempted contacts. Preliminary findings from the 486 returned 30 month contact forms are presented below in summary form. We have partial data on 486 / 543 (90%) children and full data on 421 / 543 (78%) of the sample of eligible children who were visited.

Of this sample of 486 children, most (64.8%) were assigned to the Core Health Plan Indicator (HPI) (lowest risk status) before the contact, with 17.5% Additional HPI (intermediate risk) and 6% Intensive HPI (requiring multi-agency involvement). Just over 10% of children had missing HPI information & 1% did not have an HPI allocated. Families from a range of social backgrounds were included. About half (48.3%) were in relatively deprived areas: the most deprived socioeconomic quintile referenced to Scotland’s population. These findings have now been published (Sim et al., 2013).

**Preschool SDQ Data Collection**

Preschool data collection started in the spring term of 2010 and has been carried out on an annual basis ever since. All children in Local Authority and Partnership provider (i.e. receiving funded places for 3-4 year olds from the Local Authority) nurseries were eligible for participation. SDQs were normally completed by the Child Development Officer assigned to the child, though this was sometimes done in conjunction with other staff in the nursery.

Response rates (based on the Scottish Government census figures for preschool) for preschool SDQs remained fairly steady over the first three years, with SDQs being completed for between 66.8% and 69.5% of children who attended an eligible preschool establishment that year. In spring 2013 the response increased to 85.3%.

**P3 and P6 SDQ Data Collection**

Eight schools from different areas of Glasgow were selected for the 2012 pilot by Glasgow City Council Education Department. In 2013, this was rolled out to all Local Authority schools in Glasgow City.

All P3 and P6 teachers were asked to complete a cover sheet for every child, giving basic socio-demographic information about the child. In addition, P3 teachers were asked to complete an SDQ for each child in their class, while P6 teachers were asked to give an SDQ to each child in their class to complete. It was suggested that this was done as part of a Personal
and Social Education lesson. Teachers and Classroom Assistants were able to help children who required extra support as they would in normal class time. P3 teachers completed the SDQ on paper in the pilot and then on computer directly into the SEEMIS system (the Scottish education management information system) at roll-out. P6 pupils completed the SDQ on paper at both time points.

Response rates (again, based on Scottish Government schools census data) were similar for both age groups. In the pilot, 96.8% and 96.4% of pupils had an SDQ completed, whilst when this was rolled out to all schools in the city, this was 81.7% and 89.3%.

Table 4 Response rates (Received data by age and year)

<table>
<thead>
<tr>
<th>Age</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 months</td>
<td>486 (90%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preschool</td>
<td>4124 (67.4%)</td>
<td>4142 (69.5%)</td>
<td>4093 (66.8%)</td>
<td>5043 (85.3%)</td>
</tr>
<tr>
<td>Primary 3</td>
<td>N/A</td>
<td>N/A</td>
<td>300 (96.8%)</td>
<td>4403 (81.7%)</td>
</tr>
<tr>
<td>Primary 6</td>
<td>N/A</td>
<td>N/A</td>
<td>290 (96.4%)</td>
<td>4346 (89.3%)</td>
</tr>
</tbody>
</table>

**LONGITUDINAL DATA**

Preschool SDQs from 2010 were matched to the P3 SDQ data from 2013, in order to investigate what happens to children's social, emotional and behavioural difficulties in the first three years of school. This was done in two separate ways. For children who had Preschool data collected on paper and scanned into a database, these children were matched to their preschool data on the basis of the child’s first name, surname and date of birth. Data were matched using statistical software (SPSS) commands and then those which were not matched by this process were matched manually if possible. Duplicates also needed to be handled separately. Where there were cases of the same child having an SDQ completed at two different institutions, the institution where the child had attended the longest or, where this information was missing or the same, where the child spent the most time per week, was taken as the record for the child. Children who had their data collected electronically via the SEEMIS system in preschool were matched via their SEEMIS ID which appeared on both the preschool and P3 datasets. Of the 3105 SDQs for preschool, we were able to match 2131 (68.6%) to their P3 SDQs. This equates to 39.6% (2131/ 5387) children attending P3 in
Glasgow City in the 2012/13 academic year. Much higher levels of matching are to be expected in subsequent years than in this initial exploratory study.

Not all children who attend a preschool in Glasgow City will have a P3 SDQ completed. P3 SDQs are not completed for children who attend private schools in Glasgow or who are home-educated. This constitutes around 5% of the school population. Seventy children in the 2010 preschool database attended a preschool establishment which was attached to one of the private schools in Glasgow City. In addition, while a parent can choose to attend any preschool establishment, they must apply specially through a placing request to attend a school which is not their local school. This means that children may attend a preschool establishment in Glasgow City, even though they live outwith the city boundary, but are then likely to go on to attend a Primary School in their local area. This may also happen in reverse, with children attending a preschool outwith Glasgow City and attending their local school within the city boundary. In addition, children may move in and out of the area. Finally there is a small number of children who attend a school for additional support needs.
3. Results: The Implementation of Triple P in Glasgow City

Overall Uptake of Interventions
Table 5 gives the uptake of different levels of interventions by evaluation year based on data provided by the CPT. It should be noted that the first ‘year’ of the evaluation ran from August 2009 to December 2011. There are some notable patterns: single interventions (such as tip sheets) have been showing a year-on-year rise in use. In contrast Group interventions have steadily declined, though the longer time period in the first year of the evaluation produces an inflated figure. Primary Care interventions showed an unexpected decline in 2013, when it was expected that numbers of these interventions would go up following the introduction of the universal 30 month contact, and the pathway to Triple P for those reporting difficulties at that time. Seminar numbers reflect the difference in approach in recent years: until 2012, seminars were part of the universal school induction process and every school hosted a seminar. In 2013 this became optional and correspondingly the numbers of schools opting in and therefore parents attending can be seen to have fallen substantially. Primary Care Teen and Group Teen, as well as standard interventions and self-help Triple P are not yet fully established in the city.

Table 5 Uptake of Triple P interventions by year of evaluation

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Int.</th>
<th>Seminar</th>
<th>PC</th>
<th>PC Teen</th>
<th>Discuss. group</th>
<th>Group</th>
<th>Group Teen</th>
<th>Standard</th>
<th>Self-help</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-11</td>
<td>1,804</td>
<td>8,992</td>
<td>935</td>
<td>21</td>
<td>N/A</td>
<td>995</td>
<td>30</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>4,730</td>
<td>3,572</td>
<td>1,095</td>
<td>7</td>
<td>149</td>
<td>662</td>
<td>63</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>5,898</td>
<td>1,081</td>
<td>497</td>
<td>7</td>
<td>95</td>
<td>487</td>
<td>59</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12,432</td>
<td>13,645</td>
<td>2,527</td>
<td>35</td>
<td>244</td>
<td>2,144</td>
<td>152</td>
<td>86</td>
<td>1</td>
</tr>
</tbody>
</table>

The three year implementation of Triple P, set to run from 2010 – 2012, had three targets for the reach of interventions. These are to reach the following proportions of families:

- 60% at Level 2
- 33% at Level 3
- 9% at Level 4

The population of families in Glasgow City to be targeted for the three years was estimated to be 57,000. Between 2009 and 2014 (i.e., longer than the three year target period), 26,077 clients took part in a Level 2 intervention (either a Single Intervention, such as a Tip Sheet, or
a Seminar). This was 76.3% of the way towards the 3 year target of 34,200 people. Level 3 interventions (Primary Care and Discussion Groups) saw 2,806 clients participate (Figure 2). This means that delivery of Level 3 interventions was just 14.9% of the way towards meeting the target of 18,810 clients. It is thought by the Central Parenting team that this low level of delivery at Level 3 may be a result of several factors. It may be that this is a difficult level to understand for practitioners, in terms of its structure and delivery, and additional training of practitioners in this area may be desirable. There may also be some under-reporting of Primary Care interventions, which may be related to a lack of awareness about what constitutes a Level 3 intervention. This issue is explored later in this chapter in the qualitative work with practitioners.

In terms of Level 4 interventions (e.g. Group, Standard), 2383 people participated across the evaluation period. This equates to 46.5% of the target of 5130 (Figure 3). It should be noted that a person could take part in more than one intervention.

Figure 2 Reach of Interventions attained between 2009 and 2013 by 3-year Targets for each Level

Overall completion of interventions
Overall, 46.9% of families who started Primary Care interventions completed them whilst 44.1% completed Group interventions (parents were said to have ‘completed’ an intervention if they attended at least the first four group sessions, whereas ‘completion’ of
Primary Care was determined by practitioners. Rates of completion of the interventions, based on data provided by the CPT, varied considerably by year. Primary Care interventions showed an increase in completion rates over the three evaluation years, from 27.2% in the 2009-2011 period, to 51.1% in 2012 and 70.6% in 2013. Completion rates for Group interventions showed no particular pattern however, starting at 46.8% in Year 1 of the evaluation, and then falling to 32.6% before increasing in year 3 to 57.7%.

Figure 3 Completion rates by type of intervention and evaluation year

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>27.2%</td>
<td>46.8%</td>
<td>70.6%</td>
</tr>
<tr>
<td>Group</td>
<td>32.6%</td>
<td>51.1%</td>
<td>57.7%</td>
</tr>
</tbody>
</table>

TRAINING

TRAINING DELIVERED
Information provided by the Central Parenting Team shows that a total of 730 practitioners have been trained in at least one Triple P intervention between November 2009 and December 2013. Some practitioners have trained in more than one intervention and a total of 913 training places have therefore been used during this period.

Following the training sessions, the final step to becoming a Triple P practitioner is an accreditation process. As of November 2014, 778 of the 913 training places have led to accreditation (85%) although this figure could rise further as recent trainees complete the accreditation process. The majority of the practitioners trained are health visitors and other
health professionals although many practitioners from education, social work, and a number of third sector organisations have also been trained. The majority of training has been in Primary Care interventions.

**VIEWS ON IMPLEMENTATION OF TRIPLE P TRAINING**

Consultees reported that a collaborative approach between managers and staff has generally been applied in the last two years or so to identify Triple P trainees. In this approach professionals enrol in training when they and their manager view Triple P as being beneficial to their job and something they want to use. This approach helps to ensure that trainees and managers are fully prepared and able to accommodate the impact of training on their existing workload. Stakeholders were overwhelmingly supportive of this approach to training. Staff who volunteered for Triple P training in this way were generally positive both about training and subsequent delivery. Contrasting views were expressed from some consultees trained during the early years of the implementation of the framework, however, where it was sometimes felt that training had been imposed upon unwilling staff. There was a view among stakeholders that Triple P was being imposed without due consultation or acknowledgement of practitioners’ existing experience, skills, or workloads. There remains residual resentment of the original process which appears to colour perceptions of training and delivery of Triple P among a minority of consultees.

“Trained some of the wrong people, trained some of those people who did not want to be trained. You have to have volunteers rather than conscripts and we had a lot of conscripts at the beginning, conscripts have been unhappy in a lot of cases and that’s where a lot of bad press comes from”. (Stakeholder)

More recent experiences tended to be more positively recounted by managers, practitioners and stakeholders who described a process of negotiation rather than instruction which led to ‘happier trainees and deliverers’. Generally Triple P is now presented and recognised as something which enhances and contributes to, or underpins, existing roles. One practitioner’s comments capture the value of the way the implementation of training has evolved:

“You have to believe in it to deliver it well, therefore not everyone should have to deliver it. Anyone who wants to deliver should be encouraged to do so”. (Health Practitioner)

**VIEWS ON TRAINING**

Overall a large majority of trainees were positive about the actual content and delivery of the Triple P training. The quality of the training and the trainers was highlighted; trainers were said to be supportive, friendly and knowledgeable. Professionals who had been most recently trained were generally the most positive about the training.
There were a small number of negative comments on the training programme, including in relation to the intensity of the training, the relevance of it to their practice, and the perceived cost in terms of both time and money.

There were no discernible patterns in practitioners’ views and experiences relating to the different levels of Triple P training completed.

**IMPACT OF TRAINING ON WORKLOAD**
Trainees appeared to attend the Triple P training without it having a detrimental effect on their workload and the support of colleagues and managers was acknowledged. A small number of practitioners reported that there had been an adverse impact on their workload which they had to make up when they returned to their job. These trainees tended to be health professionals who were reluctant to attend the training. It is our impression that training is now more targeted and involves greater discussion prior to enrolment which may be beneficial in terms of both individual and service capacity.

**FUTURE TRAINING**
A number of practitioners - particularly those most enthusiastic about Triple P - were interested in being trained in additional levels of the programme.

Stakeholders highlighted forthcoming training in Triple P discussion groups for a range of staff and Level 4 and 5 for Social Work staff involved with families with children on the Child Protection register, children and families where there are kinship care arrangements, and children under statutory supervision. Both these training programmes have the potential to widen the reach of Triple P in Glasgow.

Isolated examples of practitioners dissatisfied with future training arrangements were encountered.

**CONTINUING PROFESSIONAL DEVELOPMENT**
We are aware that a Continuing Professional Development programme has been developed by the Central Parenting Team and Glasgow City Council Education Services for delivery in the One Glasgow Early Years establishments (48 nurseries striving to be Family Learning Centres) to raise awareness of Triple P. It is not Triple P training but an awareness-raising session for staff covering: what Triple P is, what the vision for the City is, and what their role in signposting parents to Triple P could be. This short session – lasting approximately an hour – is intended to raise awareness of Triple P among staff in the nurseries so they are more knowledgeable about Triple P, and how it can support parents. Some of those involved in delivery reported that the sessions had been positively received.

Given some of the later comments on awareness and reach in this report, it is our impression that a similar awareness raising programme may be beneficial in other settings if there is a desire to increase the delivery of Triple P interventions: for example, with other professionals such as social work, allied health professions, early years, primary school, and the many
different elements of the third sector that come into contact with families, including minority communities.

**SUPPORT FOR PRACTITIONERS**

Some health staff expressed a view that they receive less support since the local parenting coordinators moved to the Central Team and staffing levels reduced from five to two. While the Central Parenting Team reports that it was always the intention to embed peer support within health teams, there was a strong view among some staff that they get less support than before. Some suggested that a previous informal approach made it easier to discuss challenges or problems and also encouraged them to make efforts to free up capacity so that more delivery was possible.

A limited number of practitioners had attended the Peer Support Network and they reported that it was poorly attended in their experience and sessions were of limited use. Several practitioners described informal peer support within their teams and suggested this was sufficient. This was seen to be particularly important in the early stages of Triple P delivery immediately after the training.

Most practitioners reported receiving the newsletter although many of the practitioners said they did not read it or did so only occasionally. Feedback among those who read it was mixed with most suggesting it could be improved with more relevant content.

Practitioners said they would value information about whether or not parents engage in Triple P after they have referred them to the programme.

**VIEWS ON THE COLLECTION OF MONITORING DATA**

**THE COMPLETION OF ASSESSMENT BOOKLETS**

There were opposing views among both parents and practitioners on the Assessment Booklets. Parents who were positive about the Booklets highlighted the opportunity to look back at the responses they made at the start and practitioners felt the Booklets provided an opening to discuss parents’ aims at the start and progress at the end - these practitioners recognised the Booklets as an aid to delivery.

However, there were also negative views expressed by practitioners about the Booklets, citing problems getting parents to fill them in (including literacy barriers) and returning them.

**MONTHLY RETURNS**

The majority of practitioners consulted reported that they collated and submitted their monthly returns to the Central Parenting Team; those who did not submit the forms were non-deliverers or infrequent deliverers of interventions. There was generally an appreciation of why the information was required and a general acceptance that the level of information submitted on the forms was proportionate.
There was however a minority of practitioners strongly opposed to the submission of the monthly forms, although most did reluctantly submit the information. It was seen as a ‘tick box exercise’ and an administrative burden.

A significant number of practitioners felt pressure to meet targets, although there was a view that the pressure was less now than it had been. The pressure was also more keenly felt among health professionals than other professionals e.g. examples were reported of practitioners handing out Tip Sheets to parents with whom they have contact, not because of need, but to meet targets.

"I’m in a caring profession, not a business - this drive to meet targets goes against the work we do to try and support and provide relevant, targeted help”. (Health Practitioner)

The above experiences show that some practitioners felt under pressure to deliver Triple P and did not feel able to use their professional judgement and/or use other parenting support interventions. This experience contrasts with the Framework which stated that the Solihull approach (a largely psychodynamic structure for conceptualising the parent-child relationship based on the concepts of reciprocity, emotional containment and behaviour management) was intended as a significant component of delivery and that other evidence-based parenting support approaches such as Incredible Years could be used if staff were appropriately trained and they were deemed more appropriate or more acceptable to families. We found very limited use of other interventions among the practitioners we consulted.

Positive views about targets and the referral process centred on embedding Triple P into practice, the value of normalising the offer of Triple P and the importance of raising awareness and “planting the seed” so that parents know support is available.

**UNDER-REPORTING**

A minority of practitioners was concerned that the monitoring process under-records the level of parenting support being delivered in Glasgow and they identified different ways this can happen, including through non-completion of Assessment Booklets and less formal ways of delivering the “Triple P message”.

Some practitioners talked about “Triple P by stealth”. These practitioners reported that extensive partial delivery of Primary Care Triple P is taking place but is not recorded. This kind of delivery includes modelling positive approaches to engaging with children, sharing tips and techniques, and talking about Triple P methods without alerting parents to the fact that they are using Triple P.

“I use it to advise families, but I can’t do it formally. I have too much else on”. (Social Work Practitioner)
"I suppose we need to change the mindset of the Central Parenting Team, so that they recognise the value of these proactive interventions that we are delivering". (Health Practitioner)

“Because of the client group we have I think it’s a shame that these interventions we perform using tip sheets, where we maybe need to spend a lot of time going over the same issues, don’t seem to be as valued or counted as a level 3 intervention - because we are being proactive in our use of them”. (Social Work Practitioner)
4. RESULTS: THE EXTENT THAT THE POPULATION OF PARENTS ARE AWARE OF TRIPLE P AND OTHER SOURCES OF PARENTING SUPPORT

**AWARENESS OF PARENTING PROGRAMMES**

Approximately half of the 74 parents consulted said they were aware of Triple P before they were referred to the programme. The most common sources of information on Triple P were flyers at places such as GPs or nurseries, closely followed by having heard about it at school P1 induction seminars. Approximately 1 in 10 of the parents interviewed had been told about it by friends, a handful had seen posters in their local library and only two parents mentioned the television advertising campaign.

Those who had not heard of Triple P before their referral were asked where they would have gone for parenting support if they had not come across Triple P. Most suggested that their first instinct would be to approach their GP or Health Visitor, while others said they would look online for information or ask their Social Worker.

The handful of parents of teenage children who took part in interviews said they knew about Triple P but had the impression it was only for those with babies or young children. These parents suggested it is not widely known that Triple P is available for those with older children.

Almost every parent who participated in an interview said that families in Glasgow need support and most suggested that Triple P should be available for all and be “normalised”. Those with older children, or more than one child, often expressed regret that they had not known about Triple P sooner.

*I wish I’d come to this when my child was a baby – I feel like I’m trying to rewrite history now and maybe I’ve already done some damage, it’s hard to change habits. If I’d known this stuff from the outset things would be much easier.* (Parent)

Parents’ awareness of other support programmes was extremely limited: only two of the parents interviewed were able to name other programmes in Glasgow.

**PRE-DELIVERY INFORMATION PROVISION**

There was a view from parents that the information provided before taking part in Triple P was satisfactory and their comments on this theme typically related to receiving information on practical matters such as having sufficient detail about where and when the Groups were taking part, and a brief summary that Triple P was a programme to help parenting.

A further group of parents said they would have welcomed more information about what was actually involved in the Groups and Primary Care such as what issues it covered, how it would be delivered, and that it required them to work with their children applying the
techniques over a period of time. There was a view among practitioners, however, that providing more detailed information requested by some parents could be counterproductive and could put other parents off attending. The solution may be to ask parents more regularly if they have enough information in advance and to have material available for those who want it.

FIRST IMPRESSIONS
Most of the parents who were offered Triple P described having a positive response to the programme when it was first suggested, using terms such as “helpful”, “a good idea”, and “enthusiastic”. This was a particularly strong theme in interviews with those first offered Primary Care and parents linked this to the delivery format (that it would take place in their home) and the trusted relationship with the professional offering support (usually their Health Visitor). A small number of parents connected their positive response to a feeling of desperation, suggesting that they were simply relieved that some sort of help was available.

The programme was said to have been presented to parents in a non-threatening way - themes on first impressions included: a helpful programme for all parents; a way to understand and manage children’s behaviour; a positive way of dealing with issues; a chance to meet other parents; and a means of learning tips and tools. Despite this framing, some parents acknowledged that they were initially concerned that the offer signalled they were either a bad parent or someone who was not coping. Only after starting the programme did they feel reassured and relaxed about taking part.

“I’ll be honest with you, at first when someone says: “there’s this thing you might be interested in, it’s about positive parenting” you can get a wee feeling of oh gosh, am I not doing the right things? Am I being recommended it because I’m rubbish at this”? “I felt like the Health Visitor was saying I was not a good parent, not a good mother”.

“I was quite affronted”.

(Parents)

However comments from stakeholders and practitioners revealed a slightly different picture. There was a suggestion from staff that their colleagues had been heard to make negative comments about Triple P to parents with responses like “that’s not for you” or “you don’t need that” if they asked about it. They suggested that this dismissive attitude acts as a barrier to parent engagement and fuels a perception that the programme is not a universal service and is only for “problem” families.

SUPPORT FOR PARENTS
Significant amounts of pre-engagement support for parents were not identified, but almost all stakeholders and numerous practitioners suggested that such activity would be likely to increase the numbers who take part in Triple P.
Parents said their initial contact with the Central Parenting Team had been helpful and reassuring, noting that they valued being given a choice about the location and times of groups as well as the crèches offered. The limited number of parents who mentioned phone contact with the Team had mixed views. One view was that the person they had spoken with was reassuring and had made them feel that Triple P was likely to be a good experience. Another view was that contact with the Central Parenting Team had not been helpful and felt that Triple P sounded “very formal”.

“They kept emphasising that I would lose my place if I didn’t turn up, made it sound very strict. I expected there to be about 30 parents in a class – it sounded like school. But it was the complete opposite when I arrived. There’s only four of us and the group leader is so relaxed and friendly - I was so relieved”. (Parent)

The majority of parents said their referral to Triple P was relatively quick and straightforward. Only a minority of parents had any negative views about the length of wait for their referral and these were usually parents who took part in Triple P more than two years ago.
5. RESULTS: THE PATTERN OF EMOTIONAL AND BEHAVIOURAL DIFFICULTIES IN THE POPULATION AT 2.5, 5, 7 AND 10 YEARS

Figure 4 shows levels of ‘likely difficulties’ for children at different stages of their school career in 2013. In a normative UK sample this would contain 10% of the population. There are some notable patterns shown. In particular, levels of Emotional Symptoms start low before increasing in P6. Levels of difficulties with Pro-social behaviours start high and fall off by P3. The biggest rise in difficulties was on the Hyperactivity/inattention scale, which starts at 8.8% of children having difficulties in preschool, before peaking in P3 with 16% of children having likely difficulties, and then decreasing again towards P6. Conduct problems gradually increase from 7.2% of children having difficulties at preschool, to 8.1% at P3, before reaching 11.4% at P6. It should be noted however, that nursery/school staff completed the first two stages of data collection, with children completing the SDQs themselves at P6. Whilst there are different cut-offs provided for different raters, part of the changes in the levels of likely difficulties may still be related to the respondent rather than to changes in difficulties per se, so these findings should be taken with caution.

Figure 4 Levels of difficulties by SDQ subscale and stage of child (2013)
COMPARISON OF PATTERNS WITH NATIONAL AND INTERNATIONAL NORMATIVE DATA

NATIONAL AND INTERNATIONAL COMPARISONS WITH 2.5 YEAR OLD DATA

In relation to 30 month data, national and international comparators are available from the Growing Up in Scotland (GUS) study’s Birth Cohort at 34 months and directly from personal communications with Professor Adrian Angold in the USA, which studied pre-school children. While Glasgow is roughly on a par with Scottish and US data for the majority of scales, a comparatively high proportion (13.6% in Glasgow City vs. 5.4% in Scotland) of children appears to meet the criteria for having likely conduct problems (Figure 5).

Figure 5 Likely Difficulties SDQ Scores by Cohort

Part of the difference between Glasgow and the GUS sample, which covers the whole of Scotland, is the differential socio-economic make-up of the two groups: 48.5% of the population who received a 30 month review live in areas in the lowest Scottish deprivation quintile, while GUS, as a weighted national sample, has a much more even spread across the different deprivation groups.

Figure 6 shows likely difficulties scores on the Total Difficulties scale for Glasgow and GUS cohorts. While in the most deprived areas, Total Difficulties scores are very similar, children living in more affluent areas in Glasgow are more likely to have likely difficulties on the Total
Difficulties scores than children living in the rest of Scotland. While it may be that there is some sort of “Glasgow effect” underlying these findings, it is important to note that numbers in the Glasgow cohort, particularly in the least deprived areas, are small, and so data should be interpreted with caution. The 30 month review has now been rolled out across NHS Greater Glasgow and Clyde, and once we are able to analyse the much larger numbers resulting from this, we will be able to see if this is a true effect rather than an artefact caused by random variation.

Figure 6 Likely difficulties Scores on Total Difficulties Scale by SIMD Quintile and Cohort

Unweighted Bases: Glasgow – 421; GUS – 3994

NATIONAL AND INTERNATIONAL COMPARISONS WITH 4, 7 AND 10 YEAR OLD DATA
Preschool and P3 results were compared with the UK norms for 5-10 year old data. Preschoolers in Glasgow City had lower levels of overall difficulties (6.8% having overall difficulties in Glasgow City, compared with 9.6% of 5-10 year olds in the UK), in particular having lower levels of Emotional Symptoms, and Hyperactivity/inattention problems. This is likely to be due to the younger age of the children in Glasgow City, compared with the population used to derive the UK norms. Preschoolers in Glasgow City had similar results to UK 5-10 year olds in terms of Conduct Problems, Peer Relationship Problems and difficulties with Prosocial Behaviours.
P3 children from Glasgow City, at age 7-8, sit in the middle of the age band for the UK norms. Reflecting this, overall difficulties were in line with the UK norms for 5-10 year olds: 9.8% of children in Glasgow city having difficulties, compared with 9.6% of children in the UK. Results showed that P3s in Glasgow City had lower levels of Emotional Symptoms, Peer Relationship Problems and problems in Pro-social Behaviours, however they had higher levels of Hyperactivity/inattention difficulties by this age (Figure 7).

**Figure 7 Proportions of difficulties by SDQ domain and cohort**

Results from children in Primary 6 in Glasgow City, were compared with results from 11-15 year olds in the UK who had completed the SDQ themselves. Overall, children in P6 in Glasgow City reported almost twice the rate of difficulties as did children in the UK. It should be noted that the children are slightly younger in Glasgow City, which may account for some of this difference. In addition, results from Glasgow City are from the first year of data collection, which may result in some differences due to staff being less experienced in supporting children to complete the SDQ and some schools not returning. Differences between P6s in Glasgow City and UK 11-15 year olds were particularly pronounced on the Peer Relationship Problems scale (5.7% experiencing difficulties in Glasgow City vs. 1.5% in the UK), the Pro-social Behaviours scale (9.2% vs. 1.8%) and on the Emotional Symptoms scale (9% vs. 5.1%) (Figure 8).
OVERALL CHANGES IN PATTERNS OVER TIME

The proportion of children with difficulties in preschool has not changed substantially over the four years of the project. Levels of difficulties on the Total Difficulties scale have remained fairly constant, fluctuating between 6.2% and 7.2%. The apparent increase on the Conduct Problems scale which occurred between 2011 and 2012 was due to a change in the version of the SDQ used, from the 4-16 year old version to the 3-4 year old version: the latter version contains two slightly softer questions. Nevertheless it is notable that there may be a slight year-on-year increase, though this was not statistically significant (p=0.09). Peer Relationship difficulties, on the other hand, appear to be steadily decreasing from 8.2% in 2010 to 6.9 in 2013. These findings contrast with the Triple-P sponsored “Every Family” study in Brisbane, Sydney and Melbourne, in which both Total Difficulties and Emotional Problems subscales scores were reported to decrease significantly over time in areas with widespread Triple-P provision (Sanders et al., 2008).
The extent that difficulties experienced by individual children persist or change over time

Children were followed between preschool and P3, in order to see what happened to their levels of difficulties during this time. Overall, children who had no difficulties at preschool, mostly still had no difficulties at P3: on the Total Difficulties scale, of the children who had no difficulties at Preschool the great majority stayed in this category at P3 (91.9%) (Figure 10). The most stable scales on the SDQ were the Emotional Symptoms and Peer Relationship Problems scales, where 95.3% and 95.7%, respectively, were still in the normal range at P3. The least stable scale was the Hyperactivity/inattention domain, where 12.9% of the children moved into the ‘likely difficulties’ category at P3. This is not surprising, as hyperactivity levels have been reported to increase until children are aged seven and then to decline. At P3, therefore, when the children are aged 7-8, more children would be expected to score in the likely difficulties Hyperactivity/inattention domain than at Preschool.
In contrast, far less stability is shown for children who had likely difficulties at preschool, and far more variation was seen between scales. Overall, on the Total Difficulties scale, just under a third of children who had likely difficulties at Preschool still had these difficulties at P3 (29.8%). The most stable group between stages was the Hyperactivity/inattention domain, where 40.3% of children still had difficulties at P3. Additionally, just under a quarter of children had likely difficulties at both time points on the Conduct Problems and Pro-social Behaviours domains, with 18.2% remaining in the likely difficulties group on the Peer Relationship Problems scale. The lowest stability was on the Emotional Symptoms domain, where just 10% of children still had difficulties at P3, which may suggest that Emotional Symptoms picked up at Preschool were development-related rather than being a sign of continuing problems per se (Figure 11).
THE EXTENT TO WHICH SOCIO-DEMOGRAPHIC FACTORS SUCH AS GEOGRAPHICAL AREA, RELATIVE DEPRIVATION AND SCHOOL INFLUENCE PATTERNS OF EMOTIONAL AND BEHAVIOURAL FUNCTIONING

THE IMPACT OF GEOGRAPHICAL AREA

The impact of living in different areas was assessed by fitting statistical models predicting preschool SDQ score by area, adjusting for age, gender, area deprivation, year of school entry, pre-school establishment attended and electoral ward of residence. Correlation between neighbouring wards was incorporated to allow for clustering of scores. Data from the 2010-2012 preschool SDQ data collection were used.

Figure 12 shows the percentages of children with likely difficulties on the SDQ Total Difficulties scale (the darker the colour, the higher the level of difficulties). On the Total Difficulties scale, Shettleston electoral ward has the highest levels of overall difficulties, whilst Hillhead, Pollokshields and Linn have the lowest levels. Children in Shettleston also experienced high levels of Hyperactivity/inattention, Emotional Symptoms and difficulties with Prosocial Behaviours. There were some notable differences on the SDQ subscales. In particular, high levels of Conduct Problems were reported in Canal, Springburn and Carlton, whilst high levels of Peer Relationship problems were reported in Carlton and Govan.
Figure 11 Map of Glasgow City split into electoral wards, with the colours representing the percentage of children living in each ward who had ‘likely difficulties’ SDQ score (total ≥16; conduct problems≥4, hyperactivity≥7, prosocial behaviours≤4, peer problems≥5, emotional symptoms≥6).

However, the maps in figure 12 do not take into account the substantial variation in the demographic characteristics of these areas, for instance, Hillhead is far more affluent areas.
than Govan and many areas in the North East of the city. Factors such as amenities and crime in these areas can explain any more of the variation.

Figure 13 displays the variation in the proportions of children with likely difficulties on the SDQ by area, controlling for the demographic characteristics of the children living in the areas. Areas marked in cream are ‘average’ for their demographics, whereas areas marked in red are doing worse than anticipated for their demographics, and areas which are green are doing better than expected.

Children living in areas in the east end of the city seem to be doing worse than expected on a whole range of areas of social, emotional and behavioural development, whereas Govan, which is equally deprived, is either average or better than expected for its demographic characteristics. In contrast, Langside is a relatively more affluent area but seems to be doing worse than anticipated in all domains. Further research is currently underway to explore whether factors such as amenities and crime in these areas can explain any more of the variation.
Figure 12 Unexplained variation in total SDQ across electoral wards in terms of mean ward-level model residuals, following adjustment for age group, gender, Glasgow SIMD quintile, year of primary school entry and pre-school establishment. ‘Average score’ means that on average the total SDQ score in the ward is as expected based on its demographics; while wards that are worse/better than average have worse/better SDQ scores than expected based on their covariates.
THE IMPACT OF SCHOOLS AND OTHER FACTORS

Using the cohort of children with scores collected at preschool in 2010 and P3 in 2013, multilevel models were fitted for pupils within schools, which takes into account the fact that children within a school are more likely to be like one another than they are to be like children in a different school, e.g. they may come from similar backgrounds and have shared characteristics. Having an increasing (worsening) score on the SDQ Total Difficulties scale was predicted by being of a White UK origin, having had Looked After Status by the time the child reached preschool, being in a smaller school and having had a lower score at preschool.

Furthermore, having likely difficulties at P3 (age 7-8) was predicted by being male, having been Looked After by preschool stage, having a likely difficulties score at preschool and being in a school with a relatively high proportion of low income children (measured by the proportion of children eligible for Free School Meals).

Figure 14 shows the unadjusted and adjusted odds ratios for having likely difficulties at P3. The strongest predictor of difficulties at P3 was having difficulties at preschool: children with a likely difficulties score at preschool had odds 4.3 times higher when adjusted for other factors such as sex of the child and level of deprivation. The odds of having a likely difficulties score were also three times higher for children who had been Looked After by the time they reached preschool, and two and a half times higher for boys. In addition, a 1% increase in the proportion of children in a school eligible for Free School Meals (FSMs) was associated with an odds ratio of 1.04. Whilst this may not sound very much, this could have a substantial effect when the proportions of children eligible for FSMs in Glasgow City range from 4% to 72.7%.
Figure 13 Unadjusted and Adjusted Odds Ratios for significant explanatory variables in relation to Total Difficulties Group at Primary 3

![Odds Ratio Chart](chart.png)

**Base: 1786**

Figure 15 shows the proportions of children with likely difficulties at preschool and P3 by children’s preschool Looked After Status. Although both Looked After and non-Looked After children start at the same level in terms of difficulties at preschool, by P3, children who had been Looked After by preschool were almost three times more likely to have likely difficulties than children who had not been Looked After by preschool. It should be noted however, that numbers of Looked After children in the sample are small.

Figure 14 Proportions of Likely difficulties on the Total Difficulties scale at Preschool and P3 by Preschool Looked After Status

![Proportion Chart](chart2.png)

**Base: 1847**
6. RESULTS: THE PATTERN OF EMOTIONAL AND BEHAVIOURAL DIFFICULTIES IN A SAMPLE OF THE POPULATION AT 11 TO 16 YEARS

INTRODUCTION
In 2006/7, NHS Greater Glasgow & Clyde (NHSGGC) commissioned a school health & wellbeing survey with S1-S4 pupils across 28 secondary schools in Glasgow City. The findings from that survey supported a series of health summits across Glasgow which, in turn, supported local health improvement planning for young people.

Since the first survey was undertaken, local authorities and schools have been immersed in the implementation of the ‘Schools (Health Promotion & Nutrition) (Scotland) Act 2007’, and the effective delivery of ‘Curriculum for Excellence’, both of which have potential to improve the health & wellbeing of children and young people in the school setting. In 2010, Glasgow City Community Health Partnership agreed to support a follow-up to the 2006/7 survey. The study was commissioned by NHSGG&C in early 2010, and the fieldwork carried out by George Street Research in the autumn of that year.

Support from the Glasgow City Director of Education Services resulted in the participation of all 30 secondary schools in Glasgow. The total secondary school population in Glasgow City is around 26,000, across S1-S6. This survey is based on a sample of 9,995 (S1-S4) pupils. The aims of the study in 2010 were to gather current demographic information on the pupil population, gather trend data on key areas of health, and gain an understanding to individual pupil perceptions of their health & wellbeing.

SOCIAL AND EMOTIONAL WELL-BEING OF 11-16 YEAR OLDS IN GLASGOW CITY
Overall 22% of children aged 11-16 in Glasgow City scored in the likely difficulties range on the Total Difficulties Scale (Figure 16). The most common difficulty, in terms of likely difficulties scores, was in the area of Conduct Problems, where almost a quarter of children (24%) scored in the likely difficulties range. In addition, 18% of children scored in the likely difficulties range on the Hyperactivity / inattention scale and 15% on the emotional problems scale. Lower proportions were in the likely difficulties group for peer relation problems (6%) or on the pro-social scale (10%). On all

5 For further information please see the full report at http://www.phru.net/rande/Web%20Pages/Schools%20Survey%202010.aspx
scales, Glasgow scored more highly than the self-rated norms for a UK population of 11-15 year olds.

**Figure 15 Proportion of likely difficulties self-rated SDQ Scores in each domain by Cohort (Glasgow 11-16 year olds and UK 11-15 year olds)**

As with the P3 and P6 SDQ data, marked differences could be seen between girls’ and boys’ social, emotional and behavioural well-being.

Figure 17 shows that, overall, a quarter of girls scored in the likely difficulties range on the Total Difficulties score, compared with 19% of boys, however this was largely accounted for by the 22% of girls with emotional problems, followed closely by the 20% of girls with Conduct Problems. Boys were most likely to score in the likely difficulties range on the conduct scale (28%), with 15% scoring in the likely difficulties range on the pro-social scale. The difference between boys and girls in terms of Hyperactivity / inattention was not significant.
Figure 16 Likely difficulties self-rated SDQ Scores in each domain by Gender (Glasgow 11-16 year olds)

Unweighted base: 8271
*This difference is not statistically significant
7. Results: The extent that offers, uptake and completion of Triple-P and other interventions matched the level of emotional and behavioural difficulties

Level 2 - Seminars

In the summer terms of 2011 and 2012, parents of 3,572 children who were due to start school in the following autumn attended a Triple P seminar as part of the school induction process. In 2012, registers of children for whom a parent attended the seminar were collected and analysed. The majority of parents did not know they were going to receive a Triple P seminar at the school induction. Attendance was therefore high: 63.4% of parents of children starting school that year attended the seminar. Attendance was matched to the child’s pre-school SDQ, completed earlier that year by the child’s preschool teacher. SDQs were able to be matched to the P1 school roll in 2012 for 49.7% of children starting school that year. Results showed that children whose parents attended the school induction, and therefore the Triple P seminar, were less likely to have emotional and behavioural difficulties in all areas – except (to a minor degree) for Conduct Problems - than children whose parents did not attend (Figure 18).

Figure 17 Proportion of children scoring in the ‘likely difficulties range’ whose parents did or did not attend a seminar

Base; 2885
Other factors also predicted attendance patterns: children from more affluent backgrounds, who had never had Looked After status and who came from White-UK backgrounds were more likely to have a parent attend. Once these factors were taken into account, the only significant difference between parents who attended and did not attend, in terms of levels of emotional and behavioural difficulties, was that children with Hyperactivity/inattention difficulties, were less likely to have a parent attend the seminar.

LEVEL 3 - PRIMARY CARE
Parents who attended Primary Care interventions were asked at both pre- and post-intervention how difficult their child’s behaviour had been over the previous six weeks. The majority of parents reported having a child with moderately (35.4%) or very (32.9%) difficult behaviour, with a further 9.8% reporting their child having extremely difficult behaviour. Just 5% of parents reported that there had been no difficulties with their child’s behaviour in the past six weeks (Figure 19). This would suggest that the majority of parents were aware of difficulties with their child’s behaviour at the start of the intervention. Parents who reported their child having no behavioural difficulties were all referred into the intervention by Health Visitors (though numbers were small).

Figure 18 Proportions of parents in Primary Care interventions by reported levels of difficulties with child’s behaviour in past 6 weeks at start of intervention
There was no statistically significant difference in levels of difficulties reported at baseline between parents who had or did not have completion data for Primary Care, suggesting that the level of child problems did not influence the likelihood of a parent completing the intervention and time two data (Table 6).

**Table 6 Mean scores and related statistics for level of difficulties reported by parents, by post-intervention response status**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>n.</th>
<th>Standard deviation</th>
<th>Significance of difference between groups (p value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responded @ post</td>
<td>3.25</td>
<td>1069</td>
<td>1.003</td>
<td></td>
</tr>
<tr>
<td>Non-responders</td>
<td>3.27</td>
<td>722</td>
<td>1.026</td>
<td>0.550</td>
</tr>
</tbody>
</table>

**LEVEL 4 - GROUP**

Levels of social, emotional and behavioural difficulties were measured in Group interventions using parent-reported Strengths and Difficulties Questionnaires (SDQs). Half of parents starting a Group intervention reported their child having likely difficulties in relation to overall social, emotional and behavioural problems (50.2%). In particular, almost two thirds of parents reported their child having Conduct Problems (63%): this was in contrast to 11.4% of parents of 4-16 year olds in the UK, and 6.5% of nursery staff in 2013 in relation to preschoolers in Glasgow City, and 8.1% of teachers of P3s in Glasgow City. In addition, more than half of parents reported their child having difficulties with Hyperactivity/inattention (47.4%) and 36.3% reported Peer Relationship Problems (Figure 20). The high levels of difficulties in the intervention group, particularly on the Conduct Problems scale, suggests that the families attending Group interventions had levels of difficulties which, in most cases, were appropriate to the level of intervention. Results from a meta-regression suggests that Triple P may work better for children with higher levels of difficulties (Wilson et al., 2012).
Families for whom no data were available at the end of the intervention had children with higher levels of difficulties on the SDQ at the start of the intervention: differences between the two groups on the Total Difficulties, Conduct Problems and Pro-social Behaviours domains were statistically significant (p<0.01). Children with bigger problems therefore seem less likely than other children to have parents who complete Group Triple P interventions (Figure 21).
THE EXTENT THAT OFFERS, UPTAKE AND COMPLETION OF INTERVENTIONS INFLUENCED BY SOCIodemographic factors, parents’ perceptions, belief systems, etc;

The majority of parents attending an intervention lived in couple families (64.1% of parents in Primary Care interventions and 58.2% in Group interventions). Levels of lone parents were also similar in both interventions (30.3% and 29.9%, respectively). Higher proportions of parents/carers from other types of families, such as kinship carers and foster carers, had attended a group intervention (11.9%) than a Primary Care intervention (5.6% of parents) (Figure 22).
It appeared that parents in couple families were more likely to complete a Primary Care intervention than parents in other sorts of families: data at the end of Primary Care interventions were more likely to be available for parents who were in a couple family (61.6% of couple family parents having post-intervention data), than lone parents or parents/carers in other types of families (50.4% and 49.5%, respectively, p<0.01). The pattern was similar for parents who attended Group interventions, however differences between groups were not statistically significant. In this respect, therefore, it appears that more vulnerable families are less likely to complete Triple P interventions. This may be appropriate given the evidence that Triple P interventions may not be effective for lone parent families (Hahlweg, Heinrichs, Kuschel, Bertram, & Naumann, 2010).

Parents living in the most deprived areas of the city were both more likely to attend an intervention, and were especially more likely to attend at higher levels of intervention (Figure 23). In contrast, parents living in the least deprived areas were less likely to attend an intervention, and were substantially under-represented at level 3 and 4 interventions. This is likely to be related to the population level findings, which showed higher levels of difficulties in areas of higher deprivation, suggesting that this bias towards families in the most deprived areas taking part may be desirable in that those with higher levels of need may be accessing higher levels of support. However, this view must be balanced with findings in the qualitative study, which suggested that...
there may be referral bias, with practitioners suggesting to some more affluent parents that Triple P was not aimed at them (see Appendix 6, p15).

Figure 22 Proportion of parents attending an intervention by quintile of area deprivation (SIMD) and level of intervention

Parents were more likely to complete a Group intervention if they lived in more affluent areas: 42.9% of parents from the quintile of lowest deprivation had post-intervention data, compared with just 26.5% of those in the most deprived areas (p<0.01). There were no significant differences in relation to completion of post-intervention data by level of area deprivation in Primary Care.

The level of intervention received also appeared to be influenced by the ethnic background of the family. For seminars, data are only available for the child’s ethnic background, whereas for Primary Care and Group, data are only available for the parent attending the intervention. In Glasgow, 84% of people class themselves as white British/Scottish (2011 Census data). By comparison, 87.8% of parents attending Group interventions and 68% of parents attending seminars classed themselves as White UK. The analysis showed that the higher the level of intervention, the more likely the family is to consider itself British or of a UK background (Figure 24). As with deprivation, population level results show higher levels of difficulties for children from a White-UK background. Thus, the differences in levels of attendance by different ethnic groups may be related to this. On the other hand, data from Seminars, where data on ethnicity were available for both attendees and non-attendees, showed that parents of children from ethnic minorities were less likely to have attended
the school induction, which was intended to be universal. This may suggest that there are language or cultural barriers to engaging these families in universal services, and that extra support may be required to encourage these families to participate if this is considered desirable.

Figure 23 Ethnic background of child (Seminar) or parent (Primary Care/Group) by level of intervention

![Bar chart showing the ethnic background of participants by level of intervention.]

Participants from a non-UK background were more likely than participants from a UK background to complete the intervention and post-intervention data (69.7% of non-UK participants completing Primary Care interventions, compared with 54.2% of UK participants, p<0.01: 42.7% and 35.2%, p<0.02 for Group).

The majority of participants lived in households where English was the main language spoken (82.4% in Primary Care and 88.3% in Group – no data are available for Seminars). Parents were significantly more likely to complete Primary Care interventions if the main language spoken at home was not English: 55.4% of those whose main language was English compared with 71.2% of others, p<0.01). There were no significant differences in the prevalence of post-intervention data by language for Group participants.

Levels of educational qualifications of parents in Primary Care and Group interventions were relatively close to those in the in the working-age population of Glasgow City. There were fewer parents with Higher Grades attending than in the whole population and a greater proportion that
had Standard Grades or equivalent as their highest level of educational qualification, as well as slightly higher levels of parents with no qualifications, with the exception of mothers attending group interventions (Figure 25).

**Figure 24 Education level of parents by Intervention**

![Education level of parents by Intervention](image)

*Bases: Mother, PC –1419; Father, PC–940; Mother, Group–1898; Father, Group–634*

Participants with a degree level qualification were significantly more likely than participants with lower or no qualifications to complete either a Primary Care or Group intervention. In Group interventions, almost three quarters of participants with a degree had post-intervention data, in contrast to two-fifths of mothers with no qualifications (Figure 26).
The majority of participants who attended primary care interventions were not in paid employment (67.7% in Primary Care and 70.9% in Group). Participants in Primary Care interventions reported that the majority of their partners were in employment (63.8%). In contrast, in Group interventions, just 41.8% of partners were in employment. Furthermore, in Primary Care, half of participants (49%) lived in households where neither they nor their partner was in paid employment, whilst among Group participants this was 54.6%.

**ATTITUDES TOWARDS TRIPLE P AND IMPACT ON REFERRAL PRACTICES**

Practitioners’ understanding of Triple P was largely comprehensive: most of those interviewed were able to describe the programme in detail and had a good understanding of the different levels available. However we identified mixed views regarding to whom Triple P should be offered and whether or not practitioners felt it was their role to refer - these views linked closely to referral practices. Variation in terms of standard practice for offering Triple P to parents as well as different approaches to assessment of need depend on the Triple P intervention under consideration, and are described in detail in page 9-12 of the Iconic report (Appendix 6).
MODELLING OF POST-INTERVENTION DATA: WHICH PARTICIPANTS ARE MOST LIKELY TO COMPLETE?

Primary Care and Group level data were analysed using logistic regression models in order to explore which demographic factors had an independent effect on completing post-intervention data. Area level deprivation was not entered into the model for Primary Care due to the small numbers of participants for whom we have postcode data.

Having post-intervention data (and therefore having completed the intervention) for Primary Care was associated with:

- having had a more recent experience of Primary Care interventions (year of completion);
- not being in a Lone Parent or ‘other’ family type;
- being of a non-UK nationality;
- having a higher level of education.

The strongest of these predictors was having a non-UK origin: parents with a non-UK origin were more than twice as likely to have completed the intervention and post-intervention data. In addition, for each successive year of implementation of Triple P, participants were 1.5 times as likely to return their post-intervention data, which may be related to the increased expertise and encouragement of staff to improve completion of both the intervention and data measures. This model explained approximately 9% of the variation in completion rates.

Models were then fitted to explore which parents were most likely to have completed and have post-intervention data for Group interventions. Two models were fitted for Group: the first contained demographic variables including area deprivation, however, because the numbers of parents with postcode information was so small, a second model was fitted which excluded SIMD. In the first model, only area deprivation was a significant predictor of having post-intervention data. The odds of having post-intervention data were 1.23 for each quintile of greater affluence. The second model also only contained one significant factor: this time it was the employment status of the mother. Mothers who were unemployed had odds of 1.7 that they were less likely to have post-intervention data. Both models only explained approximately 2% of variation between completers and non-completers.
Almost a third of the parents consulted during the qualitative element of the evaluation had proactively sought assistance from a professional such as their Health Visitor, Social Worker or nursery/school staff. These parents chose to engage and, mainly sustained their engagement over the course of their support. Where parenting support was initially raised by a professional there were understandably greater challenges in terms of parent engagement, both initially and throughout the intervention. The main barrier was committing to the sessions and this issue is considered in more detail below in non-attendance and drop-out.

The majority of parents commented positively on the arrangements for Triple P Groups and Primary Care and it is our view that the arrangements are a positive enabler of parent engagement. For Triple P Group participants, a choice of venues and times (including evenings), and the availability of childcare were highlighted by parents as factors which helped their engagement. A handful of parents specifically stated that the availability of childcare at Triple P Groups was the critical factor in their engagement without which they said they would probably not have attended; the quality of the childcare was also positively commented on. Other parents commented on the proximity of the venues to their home. A very small number of parents who did not engage in Triple P Groups stated that none of the venues or times were suitable for them although they were few in number and also generally raised other issues.

Primary Care participants welcomed the availability of support in the home and the flexibility this brought in terms of timing and fitting sessions around nursery/school times or work, for example. Primary Care participants also highlighted flexibility in re-scheduling sessions they had missed which helped to sustain their engagement.

Parents identified factors influencing non-engagement. These included problems with the time and/or location of the Groups as well as a dislike of the group format – practitioners confirmed this latter point as a reason given for non-engagement.

The most significant reason for non-engagement raised by both parents and practitioners was a lack of commitment or genuine interest in parenting support. This was a factor in initial non-engagement and subsequent disengagement and was most prominent, a number of practitioners suggested, among parents referred by Social Work. A number of practitioners stated that they had spoken to many parents who said that they did not need help, they “do that already” (referring to applying positive parenting techniques) or their child’s behaviour was “just the way they are”. Practitioners also highlighted that some parents could not commit to the eight weeks required for Group Triple P because of other work or family – they felt this was “a big ask” for many parents - this is a different issue to a lack of interest. Practitioners also attributed some lack of engagement to referrals being made to hit targets rather than because of need or readiness to participate.

Many practitioners stated that engagement was affected by a view among parents that there was a stigma attached to engaging with Triple P where parents would be viewed by their peers as bad parents or more particularly where Triple P was seen by some parents as a programme for those...
involved with Social Work. Interestingly, this view was more common as a perception among practitioners than among non-engaged parents consulted during this study.

Most parents who did not engage with Group Triple P said they were not offered Primary Care as an alternative. Chapter 3 of the full qualitative report (Appendix 6) highlighted issues around practitioners’ awareness and knowledge about all forms of Triple P and the criteria for referring a parent to a specific intervention. Understandably, awareness was greater for those Triple P interventions in which practitioners were trained. Nevertheless there are a sufficient number of practitioners who have never referred parents to more than one type of Triple P, suggesting that there may be a general issue with understanding among practitioners of the different levels available and their referral criteria. Our discussions with practitioners suggested that there is a degree of uncertainty among a small proportion of practitioners about why parenting support is offered, who it is aimed at, whether it is universal and what the ultimate benefits of providing the parenting support will be for Glasgow.

There was a view among practitioners that word of mouth communication, specifically positive feedback from friends and family, is increasing along with awareness of Triple P among the public, which is helping to engage parents.

“It feels like word of mouth is increasing among parents. More of them have heard of it and more are asking for it”. (Health Practitioner)

“I’ve just joined a load of different parent forums and have posted the Triple P course on them. I hope that helps more people to be aware of the course, I would recommend it to anybody”. (Parent)

Parent and practitioner experiences with Triple P were explored in detail. The vast majority of parents who engaged with Triple P reported having a positive experience, citing factors such as the approachability of practitioners, and the balance of making information accessible without being condescending. Group participants enjoyed being able to interact with other parents, reporting that it left them feeling less isolated and well supported.

Some negative experiences were reported by parents. These included the behaviour or attitude of another parent in the Group as a nuisance although not sufficient to stop the consultee attending or benefiting from the Group. This tended to relate to the other parents talking about themselves or their situation too much, being disruptive, late or apparently under the influence of alcohol/drugs at Groups.

There was a feeling that the content of Group Triple P was not always most appropriate for an individual family’s needs, with reasons such as the age of the children and children with additional needs (such as ADHD) being cited.

A handful of parents said that they had hoped for more “hands on support”. This applied particularly to those who took part in Groups. They said that it was difficult to put lessons into practice once they got home and would like someone to show them what to do. There was also a call for more visual content, as it brings the information to life and keeps everyone’s interest.
A very broad range of practitioner experiences was gathered ranging from those who were extremely positive and deliver interventions frequently to those who deliver reluctantly or not at all. The type of intervention delivered, the parents and the fit with their role all play a part in practitioner experiences. These views are explored in detail on page 25-29 of the Iconic report (Appendix 6).
8. RESULTS: THE EXTENT THAT COMPLETION OF INTERVENTIONS INFLUENCE THE PERSISTENCE OF DIFFICULTIES

GENERAL COMMENTS
The low (<50%) completion rates of Primary Care and Group Triple P interventions precludes the use of statistical tests for the assessment of effectiveness of the interventions. In the sections that follow, simple descriptive data are presented which shed some light on the course of the problems Triple P interventions seek to address.

THE IMPACT OF PRIMARY CARE INTERVENTIONS
Parents who participated in a Primary Care intervention were asked to complete a limited number of measures at the start and end of the intervention in order to assess whether any changes had been experienced. The Parent Experience Survey (PES) was the main measure of any impact which the intervention might have had.

Table 7 shows the mean pre- and post-intervention questionnaire scores where these were available. The results were also analysed using a very conservative approach in which it was assumed that scores for those people who did not return any post-intervention data had not changed — “return to baseline” analysis. Using this approach differences between baseline and post-intervention means are much less. The ‘true’ value, if data were available for all cases at post-intervention, is likely to lie somewhere between the two unless families who failed to complete interventions developed new problems.

Table 7 Pre- and post-intervention mean scores for participants who started Primary Care interventions

<table>
<thead>
<tr>
<th>Scale</th>
<th>Completers Only</th>
<th>All respondents (Return to Baseline)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre mean</td>
<td>Post mean</td>
</tr>
<tr>
<td>PES – Number of difficulties</td>
<td>3.2</td>
<td>2.6</td>
</tr>
<tr>
<td>PES – Parenting experience</td>
<td>2.7</td>
<td>2.2</td>
</tr>
<tr>
<td>PES – co-parenting*</td>
<td>3.7</td>
<td>4.0</td>
</tr>
</tbody>
</table>

* A higher score on this scale represents a more positive view of co-parenting

Overall levels of difficulties, as measured on the PES had decreased from a mean of 3.2 to 2.6 for those who completed the intervention, and from 3.3 to 2.9 when non-completers were taken into account, assuming that they had not changed. This means that parents reported having fewer
difficulties with their child’s behaviour following the intervention. Parents were also more satisfied with their parenting experience (for example, finding parenting more rewarding/fulfilling and less stressful/depressing) following the intervention (a mean score of 2.7 pre-intervention, compared with 2.2 post-intervention for those who completed with the respective figures for all respondents being 2.7 and 2.5). Parent satisfaction with their relationship with their partner (where applicable) also showed an improvement, with the mean satisfaction score rising from 3.7 to 4.0 for completers and from 3.7 to 3.9 once non-completers were accounted for. As there is no comparison group, it is not clear whether these improvements would have taken place in the absence of Triple P interventions.

**THE IMPACT OF GROUP INTERVENTIONS**

A series of questionnaires was completed by parents/carers during the first and last sessions of the intervention, in order to give an idea of how things have changed for the parent over the course of the intervention. Alongside completing demographic data, parents were also asked to complete the Depression, Anxiety and Stress Scale (DASS), which asks about their own mental health, the Parenting Problems Checklist (PPC), which explores the number and intensity of different issues between parents, and the Parenting Scale (PS), which looks at the way in which a parent ‘parents’. Parents of children aged two years or older were asked to complete a Strengths and Difficulties Questionnaire (SDQ) which explores the social, emotional and behavioural difficulties experienced by the child concerned, whilst parents of under two’s were asked to complete the Richman Behavioural Checklist. In addition, parents who were living as a couple were asked to complete the Relationship Quality Index.  

Table 8 presents the pre- and post-intervention means and bases for the pre- and post- scores for parents who completed the Group interventions. Post-intervention data are not available for families who did not complete groups. Table 8 shows the mean pre- and post-intervention questionnaire scores where these were available. All scores improved to some extent. Again the results are also presented using the conservative “return to baseline” approach.

Table 8 Pre- and post-intervention mean scores for participants who completed Group interventions

<table>
<thead>
<tr>
<th>Scale</th>
<th>Completers only</th>
<th>All respondents (Return to Baseline)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre mean</td>
<td>Post Mean</td>
</tr>
<tr>
<td>DASS – Depression</td>
<td>10.2</td>
<td>5.8</td>
</tr>
<tr>
<td>DASS – Anxiety</td>
<td>7.2</td>
<td>4.3</td>
</tr>
<tr>
<td>DASS – Stress</td>
<td>12.7</td>
<td>8.0</td>
</tr>
<tr>
<td>SDQ – Emotional Symptoms</td>
<td>2.8</td>
<td>2.0</td>
</tr>
<tr>
<td>SDQ – Conduct Problems</td>
<td>4.1</td>
<td>2.8</td>
</tr>
<tr>
<td>SDQ – Hyperactivity/Inattention</td>
<td>6.2</td>
<td>5.0</td>
</tr>
<tr>
<td>SDQ – Peer Relationship Problems</td>
<td>2.8</td>
<td>2.2</td>
</tr>
<tr>
<td>SDQ – Pro-social behaviours (nb. Higher score = fewer problems)</td>
<td>6.8</td>
<td>7.5</td>
</tr>
<tr>
<td>SDQ – Total Difficulties</td>
<td>15.8</td>
<td>12.0</td>
</tr>
<tr>
<td>PPC – Number of problems</td>
<td>6.8</td>
<td>4.7</td>
</tr>
<tr>
<td>PPC – Intensity of problems</td>
<td>4.0</td>
<td>4.2</td>
</tr>
<tr>
<td>PS (original) – Laxness</td>
<td>3.2</td>
<td>2.3</td>
</tr>
<tr>
<td>PS (original) – Over-reactivity</td>
<td>3.2</td>
<td>2.3</td>
</tr>
<tr>
<td>PS (original) – Verbosity</td>
<td>4.1</td>
<td>3.3</td>
</tr>
<tr>
<td>PS (original) – Total score</td>
<td>3.4</td>
<td>2.6</td>
</tr>
<tr>
<td>PS (revised) – Laxness</td>
<td>3.4</td>
<td>2.3</td>
</tr>
<tr>
<td>PS (revised) – Over-reactivity</td>
<td>3.5</td>
<td>2.4</td>
</tr>
<tr>
<td>PS (revised) – Hostility</td>
<td>2.2</td>
<td>1.7</td>
</tr>
<tr>
<td>PS (revised) – Total score</td>
<td>3.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Richman Behaviour Checklist (under 2’s)</td>
<td>13.9</td>
<td>12.0</td>
</tr>
<tr>
<td>Relationship Quality Index (nb. Higher score = fewer problems)</td>
<td>27.2</td>
<td>28.0</td>
</tr>
</tbody>
</table>

Changes to Parenting

Looking firstly at changes to parenting behaviours, the Parenting Scale scores 30 items about parental responses to different situations, each scored on a 7 point scale, with low scores indicating good parenting and high scores indicating dysfunctional parenting. Two versions of the scale were used: a small number of early participants completed the original scale. This scale is broken down into three sub-scales: laxness (permissive, inconsistent discipline), over-reactivity (harsh, emotional and authoritarian discipline and irritability) and verbosity (parents talking too much or over-explaining in response to child behaviours). The revised scale was asked of the majority of parents. This comprises the same first two items as the original scale (laxness and over-reactivity), as well as
hostility (use of verbal or physical force). As numbers of participants who completed the original scale at both time points are very small, this section will focus on the revised scale. Means for the original scale can be viewed in Table 8.

The Total Scale score was provided at both pre- and post-intervention by 32.6% of clients who began an intervention. Factor scores are used to compare measures, which gives an average value across the scale. For those who completed an intervention, Total Factor scores improved between pre- and post-intervention measures, decreasing by one point, from 3.2 to 2.1, on a scale of 1-7. This is comparable to the difference between parents of clinic and non-clinic children in a normative sample: a mean of 3.1 for clinical cases vs. 2.6 for non-clinical (Arnold, O’Leary, Wolff, & Acker, 1993). Assuming that clients who did not complete the intervention did not change, the overall results for the Total Factor scores showed a small improvement from 3.3 to 2.9.

Improvements were also seen on the three subscales for those with pre- and post-intervention data. The largest falls were seen on the over-reactivity scale and laxness scale, with less of a change on the hostility scale, although the hostility mean started at a lower level (Figure 27).

**Figure 26 Pre- and post- Group intervention scores on the Revised Parenting Scale Total Score (for completers and non-completers)**

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Scale</td>
<td>3.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Laxness</td>
<td>3.5</td>
<td>3</td>
</tr>
<tr>
<td>Hostility</td>
<td>2.2</td>
<td>2</td>
</tr>
<tr>
<td>Over-reactivity</td>
<td>3.5</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*Bases – 1576 to 1634*


CHANGES IN PROBLEMS BETWEEN PARENTS

Parents were then asked about a range of child-related issues which affect couple parents e.g. Disagreement over household rules, Fighting in front of children, through the Parenting Problems Checklist (PPC). The Number of Problems score is the total number of issues which are said to be a problem. Where a parent has said an item is an issue, they are then asked about the extent to which this is an issue on a scale of 1-7. For all clients, the mean number of problems fell from 6.8 to 5.5 over the course of the intervention. For the 27.4% of those who completed the post intervention data, the mean number of problems fell from 6.8 to 4.7.

For those parents who cited any problems between parents in relation to dealing with their children, they were asked about the extent to which the particular problem had been an issue (from ‘not at all’ to ‘very much’). There was little change in the intensity of problems between the two time points, either for all participants or for those who completed.

Parents in couple families also completed the Relationship Quality Index, which explored the degree of satisfaction the participant felt in various areas of their relationship. A higher score on this scale indicated a greater degree of satisfaction with the relationship. There was no difference between pre- and post-intervention scores on this measure for all participants, whilst for completers there was a small improvement.

CHANGES TO PARENTS’ MENTAL HEALTH

The association between completing the Group intervention and parents’ own mental health was also assessed. Overall, scores decreased on all subscales, whilst for those participants who complete both pre- and post-intervention measures, considerable improvements could be seen on the Depression, Anxiety and Stress scales. On all three items, participants’ scores began well above the UK norm. Following the Group intervention, scores fell to similar levels to the population norm. Improvements were shown in terms of pre- and post-intervention depression scores, which decreased from 10.5 to 8.8 for all clients and from 10.2 to 5.8 for those who completed the post-intervention data, and stress scores, which dropped from 13.3 to 11.3 for all clients and from 12.7 to 8 for completers (Figure 28).
Changes to Children’s Social, Emotional and Behavioural Functioning

Parents completed the Strengths and Difficulties Questionnaire at the start and end of the Group intervention to rate their child’s social, emotional and behavioural difficulties. For those who completed the intervention and returned post-intervention data, improvements could be seen on the Total Difficulties scale and on all five subscales between pre- and post-intervention time points. For all clients, the mean Total Difficulties score decreased from 16.5 to 14.8, whilst for completers only, scores fell from 15.8 to 12.0 (on a scale of 0-40). This compares with a mean of 8.4 for 5 to 15 year old children in the UK (Green, McGinnity, Meltzer, Ford, & Goodman, 2005), 9.3 for 3 year olds in the UK (Goodman, 2013) and 5.6 for Glasgow City preschoolers. For those who had completed pre-and post-intervention measures, the biggest decrease in mean scores could be seen in the Conduct Problems domain (decreasing from 4.1 to 2.8, compared with 1.6 in the UK norms and 0.8 for Glasgow City preschoolers) and in the Hyperactivity/inattention domain (decreasing from 6.2 to 5.0, compared with 3.5 in the UK and 2.5 for Glasgow City preschoolers). In addition, the Pro-social skills sub-scale, which is a positively rated scale (a higher score meaning fewer difficulties) increased from 6.8 to 7.5. The UK mean for Pro-social Behaviours was 8.6, whilst the Glasgow City preschool mean was 7.6. It should be noted that data were missing for four fifths (80.7%) of those who started an intervention and differences were much reduced if one assumed that those who had not completed the post-intervention data had not changed.
As with the other data collected before and after Triple P interventions, it is not clear whether the improvements would have taken place in the absence of the intervention. It is usual to see spontaneous improvement in any clinical population as a result of this ‘regression to the mean’ effect. The meta-analysis of Triple-P trials (Wilson et al 2012) reported improvement in the pooled control groups corresponding to around 1.8 points in the SDQ Total Difficulties Scale: this would account for most of the effect on child behaviour reported here.

**Qualitative work on the impact of Triple P interventions**

**Parents**

Even before they began to fully implement Triple P strategies, parents reported that there were positive benefits to attending group sessions. Hearing stories from other parents about their children’s misbehaviour helped others to put their own child’s behaviour in perspective. Parents reported realising that behaviour they had worried about was normal, that many parents were in exactly the same situation, and that most parents struggled with very similar problems. Following participation, parents reported perceived improvements in parenting style, such as being able to react differently in stressful situations and apply learned strategies. They also reported feeling less stressed, depressed or anxious, improved relationships within the family, and better engagement with professional support services, such as those for families of children with ADHD.

Several parents said they had made new and good friends by attending the group discussions and some have stayed in touch after the sessions.

Very few parents had anything negative to say about the impact of Triple P. One suggestion was that parents learned nothing new because it was obvious “common sense” while another parent, who was training in child education, said she preferred to experiment with different strategies.

Parents said they had passed on tips and recommendations to friends and family and they surmised that these parents would also benefit. This was an observation also made by Primary Care practitioners.

Some practitioners had more mixed views, however, about the impact of Triple P on parents. They suggested that for some it was a quick intervention around a specific issue such as bedtime but would not necessarily lead to more fundamental changes in parenting.

**Children**

Parents reported dramatic changes in their children’s behaviour. A wide range of impacts were reported including:

- improved communication
- an understanding of rules, boundaries and consequences
- improved sleeping and eating patterns
- less arguing and fighting between siblings
• more quality time for the whole family
• positive feedback from professionals including teachers, nursery nurses, and social workers.

There was also a suggestion that there was an economic benefit, in that improved toilet training saved a considerable amount of money on nappies.

**PRACTITIONERS**

Practitioners mostly highlighted the impact on parents and children and found it more difficult to reflect on the impacts for themselves, despite being asked for their views. When pressed, practitioners mentioned improving their links with other agencies - it had helped their relationship with other professionals and they had a better understanding now of different roles. This was mainly Triple P Group practitioners who co-facilitated groups with other professionals. It also included a small number of Primary Care practitioners who had strengthened links to other professionals such as Social Work.

Practitioners also mentioned that they took satisfaction as a professional from seeing the positive impacts on parents and children described above. They referred to Triple P’s reputation as an ‘evidence-based programme’ and said they enjoyed delivering a programme which they knew had been shown to work.

“I get a lot out of it, very rewarding and you can see how it changes their behaviours in school”. (Education Practitioner)

On a personal note, practitioners reported that the knowledge gained from training in and delivering Triple P had helped them improve their own parenting skills.

However, practitioners also expressed negative views about the impact of having to provide Triple P evidence and data, as discussed in the previous chapter.

**STAKEHOLDERS**

Stakeholders provided a broader strategic perspective and additional examples around the impact of implementing the Glasgow City Parenting Support Framework and Triple P. The main impacts revolved around:

• Collective understanding that parenting is a key component of the support that all services need to offer to families and that each agency has a role in contributing to that programme
• The establishment of Triple P as the primary delivery mechanism for parenting support across a range of agencies in Glasgow
• The emergence of a body of staff, team leaders and service managers who are enthusiastic about and committed to the delivery of Triple P
• A significant number of parents and families that have may have benefitted from Triple P
• A shift in the way that services are delivered to families and a new approach to improving outcomes for children. This has fed into other strategic developments such as the focus on Nurture
• Examples of innovation, for example a successful approach to parent engagement at one nursery described as “Tea, Toast and a Talk”
• An ongoing process of reflection and learning, leading to improvements in the co-ordination of the programme
• The identification of further areas for development work including in social work and the third sector, and the need for additional capacity in the delivery of enhanced and specialist Triple P.
9. RESULTS: THE PREDICTORS OF RESOLUTION OF DIFFICULTIES BOTH AMONG PARTICIPANTS IN PARENTING SUPPORT INTERVENTIONS AND MORE BROADLY

Process factors, such as the organization running the intervention and year of intervention, as well as demographic factors, such as the level of education of the participant and the age of the child, were entered into statistical models to see which factors were associated with different outcomes on a range of measures.

For Primary Care interventions, the difference in the extent of difficulties with the child’s behaviour and the parent’s satisfaction with parenting, both from the Parent Experience Questionnaire, between pre- and post-intervention, were explored. Both models showed that having a higher score (i.e. greater difficulties) at the start of the intervention was associated with scores getting higher (worse). In addition, not having English as a main language in the home (which could be a proxy for being in an Ethnic minority group or having not been in the UK very long) was associated with worsening scores in both models. In contrast then, the resolution of difficulties and increasing satisfaction with parenting experiences in Primary Care was greatest among those who started with a lower score and who did have English as a main language in the home.

For Group Participants, a number of changes to scores were explored. Changes to the parent-reported number of difficulties experienced were first analysed. This model showed that a higher change score (indicating an increase in problems) between pre- and post-intervention was only associated with having a lower number of problems at baseline. This may be simply because if a parent reports a large number of problems pre-intervention, then the score is not able to get any higher. The difference between the total Parenting Scale scores was also analysed. This model showed that a higher change score (indicating worsening problems) was associated with having a lower pre-intervention score, having English as the main language spoken in the home, and being in a Group run by an organization other than Health or Education services. To dig a bit deeper into the organizational differences, mean change scores on the Parenting scale were examined. Education and Health-led groups had a mean change of -1.07 and -1.06, respectively. This compared with Glasgow Life who had a mean change score of -0.87. It should be noted however, that with the exception of Health and Glasgow Life, numbers are very small (Table 9).
Table 9 Mean change scores on the Parenting Scale total score by organisation leading intervention. More negative scores suggest greater effectiveness (p<0.01).

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Mean change score</th>
<th>N.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>-1.07</td>
<td>25</td>
</tr>
<tr>
<td>Health</td>
<td>-1.06</td>
<td>266</td>
</tr>
<tr>
<td>Third Sector</td>
<td>-0.92</td>
<td>18</td>
</tr>
<tr>
<td>Glasgow Life</td>
<td>-0.87</td>
<td>81</td>
</tr>
<tr>
<td>Prison</td>
<td>-0.82</td>
<td>17</td>
</tr>
</tbody>
</table>

Finally, in order to gauge what factors predict resolution of parent-reported social, emotional and behavioural problems in the child, change to the SDQ Total Difficulties was explored. This model showed that parents with a higher resolution of difficulties were those with a higher baseline score and those who did not have English as a main language. When the mean scores for English and non-English speakers in the home were explored, it emerged that the mean change score for those who primarily spoke English was -3.7, in contrast to non-English speakers, who had a mean change score of -5.5 (between group significance: p=0.03), however, numbers in this latter category were low (n.=23).
10. DISCUSSION

This evaluation considered a range of data to examine the process and outcome of implementing the Glasgow City Parenting Support Framework between 2009 and 2013. This included whole population data, Triple P intervention level data, and qualitative process data. Taken in combination, these data allow a consideration of what has worked well and what could be improved upon for future practice.

Levels of social, emotional and behavioural difficulties in Glasgow City were similar to UK normative data at 30 months, preschool and P3, though with some notable exceptions: Conduct Problems were found to be more prevalent at 30 months, compared with 2-3 year olds in the US, and levels of Hyperactivity/inattention problems were greater by the time children reached age 7-8 years old. However, when self-complete data were collected at age 10-11, children reported far higher levels of difficulties in all areas of social, emotional and behavioural problems in Glasgow City, compared with self-completed data from 11-15 year olds in the UK overall (Green et al., 2005). Whether this widening of the inequalities between Glasgow City and the rest of the UK is a true effect of living in Glasgow City, or whether it is simply due to the higher levels of disadvantage in Glasgow City, requires further investigation. Certainly, data from Levin suggest that excess mortality only emerges in adolescence (Levin, 2012). Another theory is that the differences in the early experiences of children in Glasgow, such as witnessing more violence and experiencing greater deprivation, may have an impact, but that this may be a ‘sleeper effect’ i.e. that the impact of these experiences may not be seen until adolescence or beyond (Rutter, 1985). There has been considerable debate about sleeper effects in child development in recent years, with some academics now disputing their existence (Clarke & Clarke, 1981). For others though there is a view that early adverse experiences may lie dormant for years before materializing as mental health issues, violence or delinquency (Noll, 2005; Loeber & Stouthamer-Loeber, 1986). If the latter view is correct, it could be that these early adversities play a role in the adult excess mortality on Glasgow, which can be seen in terms of the excess premature mortality through violence, drug and alcohol misuse and suicide, particularly in the male population (Walsh, Bendel, Jones, & Hanlon, 2010). A recent tentative finding suggested that children in Glasgow City may be more likely to have witnessed domestic violence than their counter-parts in other, demographically similar, cities (Taulbut & Walsh, 2013). The impact of witnessing domestic violence on children’s emotional development has been well-documented (Holtzworth-Munroe, Smutzler, & Sandin, 1997; Margolin & Gordis, 2000; Sternberg et al., 1993).
Analyses of preschool-aged children’s parent-reported SDQ scores from the Growing Up in Scotland Study, comparing scores in Greater Glasgow and Clyde compared with the rest of Scotland found what appeared to be a small association between living in the GGC area and SDQ scores, though only on the continuous SDQ Conduct Problems scale. Contrary to expectation, this appeared to be a negative effect, whereby continuous Conduct Problem scores in GGC are actually slightly better than those in the rest of Scotland, once demographic characteristics of the family and area are taken account of. Furthermore, when exploring the adjusted ‘likely difficulties’ and ‘no difficulties’ SDQ scores and all other continuous SDQ scores, GGC preschoolers did not differ from the those in the rest of Scotland, indicating no specific issues attributable to living in Glasgow (as compared with the rest of Scotland) at this age. It would appear, therefore, that the differences in the unadjusted proportions of children scoring in the likely difficulties range in GGC, particularly in terms of Conduct Problems, Hyperactivity/inattention and Peer Relationship Problems, are completely accounted for by the differences which can be seen in the demographic profiles of the two samples i.e. the differences in levels of deprivation, education levels of mothers and ethnicity explain all of the variance between the GGC and other areas (Marryat, Thompson, Minnis, & Wilson, 2014).

However, levels of difficulties were not uniform within Glasgow City. Substantial differences were found in the prevalence of social, emotional and behavioural difficulties between areas of Glasgow City. Indeed, even once the different levels of deprivation, Looked After children and gender mix, for example, were taken into account, some areas were still found to be doing better or worse than other areas. Of particular note were areas in the North East of the city, which are traditionally more deprived areas, but even once levels of deprivation were controlled for, these areas were still found to have higher levels of difficulties than would be anticipated. This compared to areas such as Govan, which have similar levels of deprivation, but did not have high levels of social, emotional and behavioural difficulties, once levels of deprivation were controlled for. Further work is currently underway in the evaluation team to attempt to establish why these differences may occur.

Longitudinal data were collected on a cohort of children between preschool and P3, which enabled us to explore what happened to individual levels of difficulties over time. Children who had scores which got worse over the first three years of school were more likely to have had a lower score at preschool, to be of a White-UK ethnicity, to have been Looked After by the time they were at preschool and to be in a smaller school. There was no effect of being in a particular school in Glasgow City, nor was there any effect of school denomination, numbers of exclusions or home area-level deprivation. Whilst there is a substantial body of evidence around the impact of having a
White UK ethnicity and of having been Looked After on social, emotional and behavioural development, the finding about smaller schools is more surprising. It could be that the larger schools in Glasgow City are those which parents are actively moving into areas and putting in placing requests to get their children into, so they may be perceived as being better quality than smaller schools by parents. It may also be that the parents who are actively seeking to get their children into more popular and bigger schools are different in their education levels or attitudes than other parents – areas which may also have an effect on social, emotional and behavioural functioning. Staff morale in smaller schools may be poorer, particularly if the school is not seen as being a popular choice for parents, or if the school’s continued status is at stake, which may again affect how children are viewed and scored. Furthermore, there was no significant variation by schools, meaning that no school was significantly more likely to either increase or decrease their children’s scores. It may be that this is because there is not that much difference between local authority schools overall and, as with parenting, most schools are doing a ‘good enough’ job at developing children’s social, emotional and behavioural functioning (Rutter, 1982). However, it could also be that this is because our numbers across schools are too small to pick up significant differences – once further cohorts have data between these two time points, it will be possible to evaluate this more comprehensively.

In terms of Triple P interventions, uptake has been relatively high across the city over the three years of the evaluation, with over 31,000 interventions being started in that time period, although most (around 26,000) of these were single session low-intensity interventions. When rates of uptake in the main more intensive interventions (Primary Care and Group Triple P) were explored across the years, it appears that numbers of parents/carers starting interventions has decreased, particularly in Primary Care, however, rates of completion of the interventions have increased. This may suggest that more clients who are ‘ready’ to undertake an intervention are being put forward for interventions by practitioners, as their experience grows in doing this. The qualitative data also suggest that in later years of the implementation of Triple P, parents who may be resistant to Triple P or who are not ready for Triple P interventions may be given some of the Triple P tools and learning to help them, often without the parents realising this. This may account for the fall in numbers, as this activity cannot be traditionally recorded.

Both the qualitative data and quantitative client satisfaction scores suggest that parents who complete interventions are highly satisfied with their experiences of Triple P. Where negative comments arose from parents, they tended to be around difficulties with the disruptive behaviour
of other parents within the groups, and practical issues such as not having enough time to discuss topics enough, and difficulties with venues, rather than negative views of the program itself. However, this needs to be taken in the context that the majority of parents do not complete interventions, it is not possible to get a comprehensive view of their views of the program.

Overall, parents/carers from more disadvantaged areas tended to be well represented in the various levels of Triple P. Level 2 seminars were delivered as part of the school induction program at entry to school for the first two evaluation years. At this level, data were available from education services on both attendees and non-attendees. Two-thirds of parents attended the seminar, though some parents were more likely to attend than others. In particular, parents of children from an ethnic minority and of children with Hyperactivity/inattention issues were less likely to attend. It is hypothesized that the former could be due to cultural or language barriers, whilst the latter may be related to the genetic associations in Hyperactivity/inattention, which may make parents less likely or able to engage with their child’s school.

Non-completion of both Group and Primary Care Triple P was high, with approximately half of clients not completing the interventions, respectively. Practitioners perceived two main reasons for this: having crises in the clients lives which naturally took precedence over Triple P, and parents finding that Triple P was not the ‘quick fix’ that they expected. Completing a Group intervention was associated with being in a Couple family, living in a more affluent area and being in a non-White UK family. Completion was also associated with having a lower level of difficulties on the SDQ at baseline. In contrast, there was no statistically significant difference between families who completed and did not complete Primary Care interventions in terms of their characteristics, which may suggest fewer barriers to particular groups taking part in this type of intervention.

Improvements could be seen across the board at post-intervention for parents who completed Primary Care and Group interventions (and the related measures). In particular, improvements were found for parents who completed the intervention in terms of their mental health, parenting behaviours (the exception being no improvement in laxness for parents who completed Group) and child social, emotional and behavioural problems – especially on the Conduct Problems and Hyperactivity/inattention scales. However, these data are available for fewer than half of the parents/carers who started the interventions, with data on some measures missing for 80% of clients. This causes problems in interpreting the findings as it is not possible to know what happened to the rest of these families.
Other studies have shown that parent reported mental health and parenting stress may improve over time, even where these parents are in the control group, and thus some of these improvements may have occurred of their own accord - eg (Malti, Ribeaud, & Eisner, 2011; Little et al., 2013; Hutchings et al., 2007). Findings from independent studies of Triple P interventions with control groups have demonstrated mixed findings: a recent randomized control trial in Birmingham compared results from Triple P Group interventions vs. a control group and found that SDQ scores, Eyberg Child Behaviour Inventory scores (ECBI) and Parenting Scale scores all improved, however, the scores from the control group improved as much as those from the parents who had attended the intervention (Little et al., 2012). Hartung and Hahlweg’s analysis of workplace Triple P found similar results, with the exception of occupational self-efficacy rising in the intervention group, compared with the control group which remained relatively steady at post-intervention (Hartung & Hahlweg, 2010): there are however some questions over conflicting interests among the authorship of this study (see Eisner’s commentary at http://www.biomedcentral.com/1741-7015/10/130/comments). Furthermore, a RCT of PATHS and Triple P programs used together, again found no significant positive effects two years later (Malti et al., 2011). In contrast, Gallart and Matthey did find significant differences, in a small trial, between intervention and control groups at follow-up on the DASS and ECBI, but not on the parenting scale (Gallart & Matthey, 2005). Four further recent independent studies of Triple P have now been reported, each showing no difference in outcome between intervention and control groups (McConnell, Breitkreuz, & Savage, 2012; Schappin et al., 2013; Spijkers, Jansen, & Reijneveld, 2013; Kleefman, Jansen, Stewart, & Reijeneveld, 2014). Six out of the seven independent trials of Triple P reported in the past ten years have therefore failed to show any important effect of the intervention compared with the control condition.

Our analysis of trends in whole-population preschool SDQ scores did not demonstrate any evidence of improvement in preschool child mental health over the period of the evaluation.
11. CONCLUSIONS

It appears that Glasgow City may display some differences in levels of Conduct Problems during early childhood and in Hyperactivity/inattention in middle childhood. By the time children finish primary school, there appears to be a substantial inequality in self-reported social, emotional and behavioural difficulties between Glasgow City and the rest of the UK. Although this appears to be primarily due to differences in demographic characteristics of the city in early childhood, further work needs to be done to explore if this remains the case in later childhood.

Triple P Primary Care and Group interventions have now been fully implemented in Glasgow City, with other interventions, such as discussion groups and online Triple P, still in the process of consolidation. The qualitative data suggest that Triple P is acceptable to parents and practitioners in Glasgow City. Where negative comments about the program arose from practitioners, this was largely related to the way the Triple P was implemented in the early days. If it is considered desirable to continue implementation of Triple P on a whole-population level in Glasgow, work should be done with practitioners to promote understanding of the way in which practitioners can use Triple P and other programs in their work.

Primary Care and Group Triple P appear to be successful in attracting parents/carers from areas of higher deprivation to start the intervention. Whilst no differences were seen in the characteristics of people completing the Primary Care Triple P intervention, Group Triple P data indicate that parents from more deprived areas, and with children with higher levels of problems, were less likely to complete.

Both the quantitative and qualitative data clearly show that parents who completed interventions were highly satisfied with those interventions, whilst negative comments in the qualitative data referred to difficulties with other parents’ behaviour in the group and with practical issues such as the venue. Analysis of pre- and post-intervention data showed improvements in almost all areas, though this was substantially weaker when non-completers (who were assumed not to have improved) were added into the analysis. Completion rates were frequently low and no other post-intervention data are available for parents who did not participate/complete the intervention. These results must therefore be treated with caution, as the great majority of independent studies of Triple P interventions have shown that control groups tend to also show improvements of similar magnitude across time to those reported here (McConnell et al., 2012; Spijkers et al., 2013; Little et al., 2013; Malti et al., 2011; Schappin et al., 2013; Wilson et al., 2012).
The lack of impact of Triple P on the social and emotional wellbeing of the whole population of children at primary school entry over the evaluation period contrasts with claims of whole population impact in Triple-P sponsored studies (Sanders et al., 2008; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Given the substantial level of Triple P activity in Glasgow it is unlikely that the lack of effect is attributable to inadequate ‘reach’. While it is conceivable that ‘sleeper effects’ might be present and positive impacts may emerge in the future, the authors of this evaluation consider that the recent substantial body of independent evidence that Triple P lacks effectiveness supports the view that this parenting programme has not produced a population-level impact in Glasgow.

While the Triple P programme itself may have been ineffective, there is good reason to believe that the parenting support infrastructure in Glasgow has matured substantially. There is now a large cohort of practitioners versed in the principles of behaviour management, and there is strong evidence that professional skills in engaging with families who could benefit from parenting support have developed to a remarkable extent. The near-universal acceptance of the benefits of monitoring the social and emotional wellbeing of young children within Glasgow is another reason for optimism: whole-population data of this sort can be used to identify neighbourhoods, institutions and projects which are ‘getting it right’ for children. This in turn could allow Glasgow to identify approaches which will improve the wellbeing of the whole population in the future (Hertzman & Williams, 2009).
Reference List


Hahlweg, K., Heinrichs, N., Kuschel, A., Bertram, H., & Naumann, S. (2010). Research Long-term outcome of a randomized controlled universal prevention trial through a positive parenting program: is it worth the effort?


APPENDICES

APPENDIX 1 – GLASGOW CITY PARENTING SUPPORT FRAMEWORK

Outcomes:

1. An improvement in the well-being of our children with a particular focus on reducing inequalities.
2. Parents who are better able to provide protection for their children.
3. Parents who are better able to provide consistent boundaries, secure attachment and enhanced emotional well being in their children.
4. Parents who are better able to provide healthy and active lifestyles for their children.
5. Parents who are better able to provide a learning environment for their children and to support their children’s wider learning environment e.g. at nursery and school.
6. Parents who are better able to involve children and young people in their communities and decisions that affect them.
7. Children who are ready to learn and who are less at risk of serious behavioural difficulties and subsequent anti social or violent behaviour.

Initial Services Focus:

- Midwifery services
- Primary Care Teams
- Child and Family Health Teams
- Parent and Children Together (PACT) teams
- Multidisciplinary Pre School Assessment Teams
- Oral Health Action Teams,
- Health Improvement teams
- Educational establishments and early years services
- Voluntary sector services
**Integrated Staged Intervention Model**

**Stage 4:** Multi-Agency Involvement (IAF)

**Stage 3:** Resources external to establishment but within Education

**Stage 2:** Within establishment

**Stage 1:** In class / early years' group resources

**Tier 1:** Universal service provision, e.g. early years establishments / schools; General Practice; Nursing.

**Tier 2:** Health and Social Work Children's Teams (e.g. Speech and Language Therapy, Occupational Therapy, Nursing, Child protection; Family Support. Additional targeted intervention available to all schools and learning communities.

**Tier 3:** Pan / Cross Community provision, e.g. Learning Centres; Nurture classes; Psychiatry Services; Paediatric Services; Youth Justice Teams; Psychological Services.

**Tier 4:** Regional and City Wide Multi-agency Specialist Provision, e.g. Inpatient services;

**NOTE:** Universal provision is also relevant across all Tiers and Stages, e.g. a child may require a Tier 4 service or Stage 4 interventions, but also continue to access universal services such as schooling or G.P. services.
**Triple P Levels**

1. **Universal.** This level provides parents with access to information about parenting through a coordinated media and promotional campaign using print and electronic media. This level of intervention aims to increase community awareness of parenting resources, to encourage parents to participate in programmes, and to create a sense of optimism by depicting solutions to common behavioural and developmental concerns.

2. **Selected.** This intervention involves brief, individual or seminar-based consultation with parents and caregivers. Selected interventions provide topic specific guidance to parents of children with mild behaviour difficulties, with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies.

3. **Primary.** This is a 4-session intervention targeting children with mild to moderate behaviour difficulties and includes active skills training for parents.

4. **Standard and group.** These interventions are more intensive than lower level interventions. These interventions may be run with individual parents, groups of parents or simply by guiding parents who are working from a Triple P self-help parenting book. Standard and group interventions take between 8 to 10- sessions and are for parents of children with more severe behaviour difficulties.

5. **Enhanced.** Often practitioners work with parents and caregivers experiencing relationship conflict, parental depression or high levels of stress. These parents often benefit from a more intensive family intervention programme. The enhanced level is usually delivered to parents after they have undertaken a standard intervention in an individual consultation.
APPENDIX 2 – CONTEXT

Aim of Triple P

To improve outcomes for children through co-ordinated support for parents. Specifically, the intended outcomes\(^7\) are:

- An improvement in the well-being of children with a particular focus on reducing inequalities
- Children who are ready to learn and with a reduced risk of serious behavioural difficulties and subsequent anti-social or violent behaviour
- Parents who are better able to provide their children with:
  - protection
  - consistent boundaries, secure attachment and enhanced emotional well being
  - healthy and active lifestyles
  - a learning environment
  - support with engaging in the wider learning environment.

Features of the Triple P programme

The framework is delivered by an integrated, multi-agency, coordinated approach across a variety of levels\(^8\):

<table>
<thead>
<tr>
<th>Level 1: Universal Triple P</th>
<th>Media and information strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2: Selected Triple P</td>
<td>Information and support</td>
</tr>
<tr>
<td>Level 3: Primary Care Triple P</td>
<td>Early detection and brief behaviour counselling</td>
</tr>
<tr>
<td>Level 4: Standard, Group and Self Directed Triple P</td>
<td>Teaching skills on a broad range of child behaviour in home and community settings</td>
</tr>
<tr>
<td>Level 5: Enhanced Triple P</td>
<td>Individually tailored for families who experience continued difficulties after completing Standard or Group Triple P</td>
</tr>
<tr>
<td>Level 5: Specialist Triple P</td>
<td>For targeted groups, includes:</td>
</tr>
<tr>
<td></td>
<td>○ Stepping Stone (disability)</td>
</tr>
<tr>
<td></td>
<td>○ Pathways (parents in the child protection system)</td>
</tr>
<tr>
<td></td>
<td>○ Workplace (working parents)</td>
</tr>
</tbody>
</table>

\(^7\) http://www.gla.ac.uk/media/media_231800_en.pdf

\(^8\) http://library.nhsggc.org.uk/mediaAssets/CHP%20South%20East%20Glasgow/Parenting%20Jan10.pdf
Challenges

Report by South East Glasgow CHCP on parenting notes that:

“This is an ambitious programme...and requires significant organisation and co-ordination to meet the identified requirements within the identified timescales”.

The University of Glasgow’s Year 1 evaluation highlights gaps in the evidence base for Triple P, particularly relating to:

- barriers to the effective delivery of the programme to the most materially deprived families
- the effective engagement of fathers
- the long term efficacy of the programme

Feedback gathered from Children and Family teams identified a range of challenges associated with resources, training needs, practice, information sharing, capacity, engagement and ownership, as follows:

<table>
<thead>
<tr>
<th>Resources</th>
<th>Too much information in Triple P packs. Practitioners require additional materials, for example DVDs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training needs</td>
<td>Some staff still require training or training at higher levels. Wrong staff trained. Cynicism about the accreditation process.</td>
</tr>
<tr>
<td>Practice</td>
<td>In some cases family needs are too complex for Triple P. Staff not motivated to return data.</td>
</tr>
<tr>
<td>Information sharing</td>
<td>No consistent paperwork to track Triple P interventions. Staff require clarity on referral protocols.</td>
</tr>
<tr>
<td>Capacity</td>
<td>Paper work is time consuming. Interventions by Health Visitors take too long. Only 20 minutes allowed per intervention, which in practice takes 45-60 minutes.</td>
</tr>
<tr>
<td>Engagement</td>
<td>Language barriers for ESOL learners can present delivery problems. Referrals made too late. Screening tools a barrier to engagement with some parents.</td>
</tr>
<tr>
<td>Ownership</td>
<td>Education services not as engaged as health. Confused boundaries between health and social work. Gap in coordination/leadership of Triple P.</td>
</tr>
</tbody>
</table>

9 See: 5.5: http://library.nhsggc.org.uk/mediaAssets/CHP%20South%20East%20Glasgow/Parenting%20Jan10.pdf


11 http://www.gla.ac.uk/media/media_287744_en.pdf
Dudleston Harkin’s qualitative research with 18 Health Visitors (2010) identified:

- Concern about the proportion of parents who fail to complete the programme.
- Caution that the Framework is only in its very early stages and that it has to be considered a long-term approach.
- Stigma surrounding accessing parental support and the need for a “generational” change in attitude.
- The need for one to one work with vulnerable parents with some Health Visitors suggesting that the group format or interventions requiring significant commitment and motivation are potentially unsuitable for vulnerable parents.
- Challenges in meeting the needs of ethnic minority parents, with several Health Visitors suggesting that Triple P groups were effectively unavailable for this group.
- The extent of staff training varied greatly, with consequences in relation to delivering the new contacts and providing a co-ordinated approach to parenting.
- The perceived lack of evidence to indicate the efficacy of Triple P. In particular, Health Visitors frequently cited the lack of evidence to indicate the effectiveness of Triple P with vulnerable families.
- The importance of gaining and responding to feedback from delivery staff.
- Questions raised about resourcing Triple P and the requirement for Health Visitors to conduct at least 3 groups a year given their caseloads.
- A participant questioned the extent to which conducting Triple P groups was appropriate for a Health Visitor as opposed to a social worker.

Dudleston Harkins’ qualitative research with parents (2010) identified:

- A family’s personal circumstances can change quite significantly in a short period of time, and as such the need for families to be continually assessed was emphasised.
- Issues with the tools used, with parents finding the Adult Wellbeing Scale intrusive and overly personal. Some felt the Language Screen caused anxiety in relation to children appearing not to reach important milestones.
- Suggestions that the health visiting service should initiate more contact with parents in order to make the family feel important and to continue the relationship between parent and Health Visitor.

Solutions from Dudleston Harkins’ report:

- Health Visitors maintained the need for greater advertising of Triple P to raise awareness, normalise the programmes and reduce the stigma associated with parental support.
- Health Visitors suggested that often parents who took part in and completed the Triple P programme were not those in most need. Other options required to meet the needs of vulnerable families including intensive one-to-one work.

SYSTEMATIC REVIEWS


Findings: Mothers of children aged two and over who volunteer for the programme report that the
short term interventions work better than no interventions. No evidence that Triple P works in the long-term or across a wider population. Report suggests that effective targeting of families with severe problems would be more effective than current ‘public health’ approach.

**Relevance:** Suggests there is little evidence to support Triple P benefits over wide population and in the long-term and no evidence that Triple P is any better than any other active intervention. Suggests that the evidence base normally cited is flawed because of conflicts of interest, high risk of bias, and poor reporting.


**Findings:** Challenges findings of Wilson et al (above) on the basis of ‘restrictive and narrow evaluation framework’.

**Relevance:** This strongly challenges the findings of the earlier paper and it could be argued the findings of the two effectively cancel each other out. Wilson et al challenge the bias of much of the Triple P research because of conflict of interest in that some researchers may be involved in promoting Triple P. Sanders et al states that one of Wilson’s co-authors is involved in the development of a ‘rival’ parenting programme. However both papers are interesting as background reading and useful in that they identify some flaws in other Triple P evaluations of impact not processes.


**Findings:** Some evidence that group-based parenting programmes improve emotional and behavioural difficulties. But insufficient evidence as to whether they can prevent it.

**Relevance:** Programmes only include children aged under five years. No useful information about processes.


**Findings:** Group-based parenting interventions are effective and cost-effective in improving behavioural problems in the short-term. Interventions also improve parents’ mental health and parenting skills.

**Relevance:** Only reviews short-term impact. No useful information about processes.


**Findings:** Learning new knowledge and skills plus the support and acceptance of their parent peers in the groups resulted in improved parenting.
**Relevance**: Suggests that group work is crucial component, but there is no comparison with other one-to-one programmes. Most relevant to Triple P levels 4 and 5.

**TRAINING REVIEWS**


**Findings**: Flexibility in designing the interventions to meet each client family’s needs improves participant retention and likelihood of programme completion. Those who complete the training are more likely to deliver the programme.

**Relevance**: The high levels of Triple P are intended to be designed to each family’s needs. Informs questions to practitioners and participants about perceived flexibility.

**ADDITIONAL RESEARCH**


**Findings**: 
Relevance: Practitioners consultation guide should include questions about their views on training and level of confidence in delivering Triple P.
## Appendix 3 — Research Objectives

<table>
<thead>
<tr>
<th>Parent</th>
<th>Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To gauge perceptions of the need for parenting support</td>
<td>• To gauge perceptions of parenting support services available</td>
</tr>
<tr>
<td>• To explore perceptions of parenting support services available</td>
<td>• To explore how the need for parenting support services are assessed and how they are offered</td>
</tr>
<tr>
<td>• To explore participation in other parenting support services (targeted and universal)</td>
<td>• To explore experiences of the implementation of Triple P</td>
</tr>
<tr>
<td>• To assess perceptions of the suitability of Triple P</td>
<td>• To explore acceptability of the training provided for Triple P</td>
</tr>
<tr>
<td>• To assess awareness of the different levels of Triple P available</td>
<td>• To explore levels of support/discussion provided to parents before Triple P intervention offered</td>
</tr>
<tr>
<td>• To explore levels of support/discussion provided before Triple P intervention offered</td>
<td>• To assess understanding of the different levels of Triple P available and how they are offered</td>
</tr>
<tr>
<td>• To explore the appropriateness of the Triple P intervention offered</td>
<td>• To explore experiences in the delivery of Triple P interventions</td>
</tr>
<tr>
<td>• To explore reasons for participating / not participating in Triple P</td>
<td>• To explore perceived enablers and barriers in the delivery of Triple P</td>
</tr>
<tr>
<td>• To explore perceived enablers and barriers to engaging with Triple P</td>
<td>• To explore reasons for drop-out in Triple P interventions</td>
</tr>
<tr>
<td>• To investigate the understanding of reasons for, and barriers/enablers to, completing evaluation questionnaires</td>
<td>• To investigate the understanding of reasons for, and barriers/enablers to, data collection</td>
</tr>
<tr>
<td>• To explore experiences of participating in Triple P interventions</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 4 – WORKSHOP SUMMARY

TRAINING
Changing early negative practitioner perceptions / refresher training and myth busting
- Use the term parenting updates rather than Triple P refresher.
- Promote as ongoing updates on a suite of parenting tools which includes Triple P to help ensure skills from other parenting approaches are not lost.
- Sessions need to be carefully designed to demonstrate respect for professional judgement – especially in terms of assessment of parental readiness whether that is for Triple P or other support.

Raising awareness among practitioners and extending the reach
- Sessions need to be targeted on basis of multi-agency approach which must be key part of delivery method.
- Identify and target participants as they are needed across agencies.

Establishing a small peripatetic team of practitioners
- Role of suggested peripatetic team needs to be carefully defined.
- Concerns that a specialist team of deliverers would undermine or de-skill other practitioners.
- Concerns about whether this fits with skills mix model.
- Would need careful consideration of how to retain parenting support as part of mainstream provision.
- Not universal support for dedicated delivery team.

PRE-DELIVERY
Practitioners aware of the full range of levels of intervention to ensure promotion of a universal programme
- Still living with the legacy of historic difficulties – evident in lower than anticipated referrals to Triple P Group.
- Also, still adjusting to the replacement of local parenting co-ordinators.
- Do staff have sufficient knowledge of Triple variants and the criteria for Group and Primary Care? Need to provide universal information on Triple P to practitioners.
- Are kinship carers being targeted and trained in parenting? They can be a difficult group to work with.
- There is a need for a long term communications strategy - we have to help staff to communicate about Triple P better.
- Opportunities to raise awareness include the 30 month check-up and the P1 seminars.
- Test of change underway in the South.
- Social Work options include designated time for relevant staff or a dedicated team and Triple P needs to complement Family Focused Therapy (FFT). Recognise it is an add-on – there is a need for change, replicate FFT and engage third sector partners.
- April Montgomery is well known in Education – can this be replicated elsewhere?
- Do we need to improve support in health? We selected/opted to route delivery in the community – is this still the right model?
Develop a flow chart for practitioners showing how the interventions relate to parental support needs – needs to clarify universal and targeted approaches. A model and Aide Memoire would be useful.

Need to incorporate awareness training across sectors.

Mentoring could work as we need to support staff better, and this needs to be face-to-face. Can we replicate good practice such as breastfeeding mentors?

Develop a mentoring team to support newly trained practitioners.

Future marketing approach

Utilise parenting portal which is being developed.

Look to replicate Glasgow’s Your Support Your Way (information source for older people).

Leaflets under development - cover parenting, GIRFEC and make locality specific. Could they use local staff?

More generally, local staff can be an asset in marketing parenting support.

Will marketing be Board-wide, Glasgow City or localised – who decides?

Should marketing be about general parenting support with reference to Triple P where relevant?

How can we make tip sheets more universally available while respecting licensing agreement?

Would incentives work to encourage participation? Could be vouchers for Glasgow Life or cinemas. Mellow bumps provides prizes at the end.

Consider the use of social media such as Facebook, Twitter and YouTube to encourage universal reach and attract families. Recognise however, corporate difficulties with such methods.

Also consider other innovative methods such as advertising on the back of receipts and banners at supermarkets.

Triple P on-line – how do we use this and trial it?

PARENT ENGAGEMENT

How to better involve the third sector and extend reach

Excellent relationships exist with third sector organisations.

Need to recognise the contribution of all potential players across sectors

While some targeted training of third sector staff would be useful, an awareness raising programme with the third sector organisations would be more useful especially in the context of supporting parental ‘readiness’.

Awareness raising programme can draw on previous research to map the sector and on recent events with Social Care Ideas Factory

Need to consider practical issues including existing third sector funding arrangements which tend to be linked to the specific delivery.

Utilise Circle of Support which is an asset-based approach drawing on various support inputs in the community.

Consider co-delivery between the third sector and health.

Link to Early Years Collaborative, NPM roll out/30 month check up.

The third sector can contribute to myth busting.

How to better assess/understand/develop parents’ level of readiness to participate in Triple P
• Link with One Glasgow Joint Support Team’s planning - make readiness a direct question and consider how the third sector can help engagement building.
• Build on Psychology of Parenting training and the positive parent engagement achieved, also build on existing relationship between the third sector and health.
• Develop a decision tree on the delivery of support around readiness.
• Be aware that an increase in parental numbers could lead to more issues with ‘engagement’ as well as creating capacity issues for staff.

DELIVERY

Clarity on issue of flexibility of delivery and how to get the message to practitioners
• Need to be clear on what information will be provided on flexibility to address myths and negativity among practitioners.
• Also need to address practitioner perception that providing parenting intervention is optional.
• Engaging with and using positive members of staff to help change practice and opinions.
• Early Years Collaborative can be a facilitator of change.
• Develop a pathway to clarify Triple P flexibility as soon as possible.
  More effective communication with practitioners about the ability to use the full range of evidence based parenting programme
• The updated Parenting Support Framework addresses this issue.
• Central Parenting Team to gather update to date information on which practitioners trained in other tools in the next 2 to 3 months.
• Where relevant, need to provide training in other parenting tools – staff already trained in such tools can help facilitate their use.
### APPENDIX 5 ADDITIONAL TABLES

#### Table 10 Regression Results for Seminar Attendance

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1 - B (S.E)</th>
<th>Model 2 - B (S.E)</th>
<th>Model 3 - B (S.E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked After Status</td>
<td>-0.651 (.24)</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>Gender</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>-0.820 (.06)</td>
<td>-</td>
<td>-0.49 (.08)</td>
</tr>
<tr>
<td>Deprivation Quintile</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>Emotional Difficulties</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>-</td>
<td>-0.29 (.14)</td>
<td>-0.39 (.15)</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Peer problems</td>
<td>-</td>
<td>-0.35 (.16)</td>
<td>NS</td>
</tr>
<tr>
<td>Total Difficulties</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Pro-social problems</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Base</td>
<td>4767</td>
<td>2885</td>
<td>2792</td>
</tr>
<tr>
<td>% variance explained (Rsq)</td>
<td>2.8%</td>
<td>0.5%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

**B = Beta. This tells us how much change the would be if there were to be a one unit change in the predictor variable e.g. the difference between having hyperactivity problems and not, is responsible for a decrease in the likelihood of attending a seminar by .29 (almost a third). SE = Standard Error. This essentially tells us the accuracy of the beta value – the closer to 0, the more accurate/less variation there is.**

#### Table 11 Regression Results for intervention completion

<table>
<thead>
<tr>
<th>Variable</th>
<th>Primary Care - B (S.E)</th>
<th>Group 1 (with SIMD) - B (S.E)</th>
<th>Group 2 (without SIMD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of intervention (2009)</td>
<td>-0.42 (0.08)**</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Ethnic origin (UK)</td>
<td>-0.70 (0.16)**</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Family Type (couple family)</td>
<td>0.27 (0.10)*</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Mother education (No qualifications)</td>
<td>0.11 (0.04)*</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Area Deprivation (1-Most deprived)</td>
<td>NS</td>
<td>0.21 (0.11)*</td>
<td>-</td>
</tr>
<tr>
<td>Mother employment (employed)</td>
<td>NS</td>
<td>NS</td>
<td>-0.53 (0.15)**</td>
</tr>
<tr>
<td>Base</td>
<td>1229</td>
<td>277</td>
<td>910</td>
</tr>
<tr>
<td>% variance explained (Rsq)</td>
<td>9%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**B = Beta. This tells us how much change the would be if there were to be a one unit change in the predictor variable e.g. the difference between having hyperactivity problems and not, is responsible for a decrease in the likelihood of attending a seminar by .29 (almost a third). SE = Standard Error. This essentially tells us the accuracy of the beta value – the closer to 0, the more accurate/less variation there is.**
### Table 12 Regression Results for change results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Primary Care – level of difficulties B (S.E)</th>
<th>Primary Care – Parenting satisfaction change</th>
<th>Group PPC number of problems - B (S.E)</th>
<th>Group SDQ Total Difficulties</th>
<th>Group PS - Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-intervention score (continuous)</td>
<td>1.04 (0.34)**</td>
<td>0.15 (0.05)**</td>
<td>-0.58 (0.11)**</td>
<td>-1.71 (0.69)*</td>
<td>-0.51 (0.07)**</td>
</tr>
<tr>
<td>Main language (English)</td>
<td>1.82 (0.69)*</td>
<td>0.26 (0.10)*</td>
<td></td>
<td></td>
<td>0.53 (0.21)*</td>
</tr>
<tr>
<td>Ethnic origin (UK)</td>
<td></td>
<td></td>
<td>-0.31 (0.04)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation delivering intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.09 (0.03)*</td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td>1980</td>
<td>1980</td>
<td>277</td>
<td>277</td>
<td>277</td>
</tr>
<tr>
<td><strong>% variance explained (Rsq)</strong></td>
<td>8%</td>
<td>8%</td>
<td>30%</td>
<td>7%</td>
<td>27%</td>
</tr>
</tbody>
</table>

14 B = Beta. This tells us how much change there would be if there were to be a one unit change in the predictor variable e.g. the difference between having hyperactivity problems and not, is responsible for a decrease in the likelihood of attending a seminar by .29 (almost a third).

SE = Standard Error. This essentially tells us the accuracy of the beta value – the closer to 0, the more accurate/less variation there is.
Qualitative Evaluation of the Glasgow City Parenting Support Framework

Final Report

University of Glasgow

May 2014
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<td>Impact</td>
<td>34</td>
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<td>Conclusions and recommendations</td>
<td>38</td>
</tr>
</tbody>
</table>
Summary

Introduction

The University of Glasgow is evaluating the Glasgow City Parenting Support Framework on behalf of NHS Greater Glasgow and Clyde, Glasgow City Council, and their partners. As part of the overall evaluation, Iconic was commissioned to undertake a qualitative evaluation to investigate the views and experience of stakeholders, practitioners and parents of the implementation of the Framework.

Published in 2009, the Framework identifies parenting support as a powerful and cost-effective intervention which can make a vital contribution to improving outcomes for children, and support a reduction in educational, social and health inequalities. There was an initial focus on the 0 to 7 age range delivered by services specified in the Framework. The evidence-based Positive Parenting Program (Triple P) was identified as the main parenting support intervention although it was not seen as the exclusive intervention. The Parenting Core Group has overseen implementation of the Framework.

The study objectives focus on Triple P and this is reflected in the evaluation and this report. Qualitative methods consisting of depth interviews and discussion groups engaged 20 stakeholders, 56 trained practitioners and 74 parents across Glasgow with a concentration in the Early Year Collaborative areas. Practitioners included those who had delivered Triple P as well as those who had not; parents included those who had engaged with the programme as well as those who had not. Over 20 stakeholders attended a workshop in May 2014 to discuss the findings and plan future actions.

Training

A total of 820 practitioners have been trained in at least one Triple P intervention between November 2009 and the beginning of March 2014.

Stakeholders and practitioners commended the quality of training and the trainers who were described as supportive, friendly and knowledgeable. Training was intensive but valuable and most trainees enjoyed the mix of professions and welcomed the peer support provided. Attendance at the training sessions did not have a significant impact on existing workloads.

Practitioners’ views on training - as well as their views on subsequent delivery - were partly informed by the timing of the training and the means by which trainees were identified at that time. The early trainees included some who were nominated by their managers and reluctantly attended training – they had mixed experiences and less positive views than later trainees who volunteered for the training after discussions with their manager. These later trainees felt that this led to a supportive environment for the training and subsequent delivery. There was some interest in additional training among practitioners.
A Continuing Professional Development programme has been delivered to staff at the One Glasgow Early Years establishments to raise awareness of the programme.

Pre-delivery

A number of parents were aware of Triple P before it was offered and had seen flyers or posters, or had heard about the programme at P1 induction seminars or by word of mouth.

Parents described having a positive response to the programme when it was first raised, using terms such as “helpful”, “a good idea”, and “enthusiastic”. This was a particularly strong theme with those first offered Primary Care which may be linked to the delivery format and the existing relationship with the professional offering such support.

Parents’ experience was that the referral process was mostly quick and efficient. Support and information provision during the process was adequate for most parents although some would have liked more information about the content of the programme.

Practitioners highlighted some referral issues including limited capacity to deliver Primary Care which restricted the number of referrals made to this level but in some cases led to referrals to Group. Other practitioners only referred parents to the Triple P level in which they themselves were trained. There was also mixed messages about referral criteria for the different levels of intervention which could lead to inappropriate referrals.

Some stakeholders and practitioners had negative views on the Triple P marketing highlighting that it was not clear or engaging.

Parental engagement

Generally engagement among parents was good, especially among those who self-referred who had proactively sought support. Parents identified a number of factors which acted as enablers to their engagement including: a good choice of venues and times, the availability (and quality) of childcare, the availability of Primary Care support in the home environment, and the enthusiasm and support of practitioners.

The group format appealed to most parents who participated in Triple P Groups. They particularly enjoyed knowing there were other parents in their situation who could empathise with them and support them. However, some parents reported that the group format was off putting and was a factor in their non-attendance or disengagement.

Parental engagement was reportedly challenging at the referral stage when parents were disinterested in the support offered and during delivery when their commitment was tested. For some parents their ability to attend eight weeks of Group or four weeks of Primary Care was “a big ask”. For other parents commitment related more to their willingness or desire to attend and work at applying their learning. Both Initial disinterest and limited commitment was felt to be most significant among parents
with multiple and complex needs, including some of those referred by Social Work, as these parents can face personal crises or realise that the support was “not a quick fix”. This raised the issue of readiness which was a much debated point during the evaluation.

16 Although practitioners found readiness a difficult term to define precisely they highlighted that parents who disengaged because they were not ready to commit represented an inefficient use of resources. This can be manifest as wasted resources processing referrals, as well as wasted resources and frustration from delivering interventions that the parents do not complete. It was also suggested that there could be a negative impact on parents who may be ready to engage at a later stage, but whose experience of premature involvement in Triple P prevents them from doing so.

Delivery

17 Overall, parents and practitioners had positive views on the content, format and resources (DVDs, Tip Sheets, and Workbooks) available within the Triple P programme and this applied equally to Group and Primary Care interventions. Parents also had positive views on the practitioners describing them as approachable, friendly and knowledgeable.

18 Primary Care practitioners tended to be those in contact with participants and they reported that it was a good fit with existing role. They did report however that it can take some weeks to deliver depending on the circumstances. A wider range of professionals are involved in Group facilitation and their views were mostly positive although this was influenced by their training experience, the availability of preparation time, their experience of delivering, and the information provided on participants.

19 Stakeholders noted variable delivery within some professions and settings. They specifically identified variation among health visitors and in nurseries. Social Works’ limited involvement was also noted although the reasons for this were not widely understood.

20 There were starkly contrasting practitioner views on Triple P flexibility. Some practitioners felt that the programme was inflexible citing problems such as the intensity of the content, the prescriptive nature of delivery, and a need for literacy skills. However, other practitioners described how they overcame these issues to successfully engage a wide range of parents.

21 Some health practitioners felt a focus on the use of Triple P, reinforced by targets, limited their ability to use their professional judgement in supporting parents.

22 The requirement to submit monthly returns detailing Triple P delivery was generally accepted by practitioners who appreciated why the information was required. However, there was a small but vocal minority who opposed this process.

23 Practitioners highlighted that the current monitoring process led to an under-reporting of activity. Some activity which goes unreported was described as “Triple P
by stealth” where practitioners apply Triple P principles or deliver elements of the programme but this valuable activity is not reported to the Central Parenting Team.

Impact
24 Positive impacts on parents were identified, by parents and practitioners, in terms of their parenting knowledge and skills, health and wellbeing, improvements in family relationships, and in new or improved interaction with professionals. A small number of practitioners questioned the sustainability of these impacts on parents in the long term.

25 Practitioners highlighted improved professional skills and enhanced links with other professionals.

26 Stakeholders discussed a range of strategic impacts including building a collective understanding that parenting is a key element of the support provided to families, the establishment of Triple P as the primary intervention with a core of committed and enthusiastic practitioners, and developing a process of ongoing reflection and refinement.

Conclusions and recommendations
27 The views and experiences of stakeholders, practitioners, and parents were mostly positive and demonstrate that the Framework has been a significant influence on parenting support in Glasgow. A comprehensive training programme has led to extensive delivery by a wide range of staff across agencies in both the public and third sectors and these practitioners have engaged numerous parents. The feedback suggests that Triple P is both feasible and acceptable to stakeholders, practitioners and parents in Glasgow as the main parenting support intervention.

28 Based on the findings of this evaluation the following recommendations are made for consideration by stakeholders:

- Parenting support updates are rolled-out to practitioners containing a module where negative views are confronted head-on and challenged
- Practitioners who are most interested in delivering Triple P should be the focus of future training
- Consideration be given to establishing a small peripatetic team of specialist Triple P practitioners who concentrate on delivery, alongside the existing model
- Awareness raising sessions - along similar lines to the CPD sessions developed for the One Glasgow Early Years establishments - should be delivered to a targeted audience of professionals working with families
- Awareness raising is undertaken among practitioners with responsibility for referrals, to ensure that Triple P is promoted as a universal programme and that practitioners are fully aware of the different types/Levels of intervention available for different kinds of families
- As a general rule, parents should be provided with more information about Triple P during initial discussions about referral, with detailed information provided to those who request it
- The supply of Triple P resources should be improved
Future marketing should be targeted and focused around clear, simple and engaging messages, emphasising that Triple P is a universal service with potential benefits for any parent in Glasgow

- With further support and encouragement the third sector has the potential to reach and engage a wide variety of parents including disadvantaged groups
- Wherever possible practitioners are given protected time to prepare for Triple P Group delivery
- Group facilitators should be provided with appropriate information on the participants
- Guidance on ‘readiness’ should be developed and distributed to all practitioners who could potentially refer parents to Triple P to provide clarity on this issue
- Fresh information on flexibility is conveyed to all practitioners
- Communicate to practitioners why monthly returns are required and what use they are put to
- Consideration is given to revising the monthly returns to take account of valuable delivery which many practitioners suggested ‘goes under the radar’
- The University of Glasgow’s evaluation findings are widely shared to allow for continuous reflection on and responses to the additional evidence base
- An overall review of communications with practitioners is considered.
1 INTRODUCTION

1.1 The University of Glasgow Institute of Health and Wellbeing is evaluating the Glasgow City Parenting Support Framework on behalf of NHS Greater Glasgow and Clyde, Glasgow City Council, and their partners. As part of the overall evaluation, Iconic was commissioned in November 2013 to undertake a qualitative evaluation to investigate the views and experience of stakeholders, practitioners and parents\(^1\) of the implementation of the Framework.

**Background**

1.2 Glasgow’s Parenting Support Framework was published in June 2009 with the vision to:

‘achieve better outcomes for all children and their families and to ensure that those who most need support, benefit appropriately from parenting support services’.

1.3 The stated rationale for the Framework is that parenting support is a powerful and cost-effective intervention that can make a vital contribution to improving outcomes for children and can support a reduction in educational, social and health inequalities. The Framework aims to improve outcomes for children through co-ordinated support for parents; specific outcomes are shown in Appendix 1.

1.4 The Framework’s initial focus was on the 0-7 age range including the antenatal period, delivered primarily by the services listed in Appendix 1. It includes an Integrated Staged Intervention Model with four levels or tiers of parenting support from universal to specialist services (see Appendix 1).

1.5 The evidence-based Positive Parenting Program – more commonly known as ‘Triple P’ – is identified in the Framework as the main parenting support intervention. The Framework also identifies the Solihull Approach as a significant component and states that ‘other parenting support approaches, namely Webster Stratton and Mellow Parenting, will be used if more appropriate or more acceptable to individual families or when staff are already trained and experienced in their use’.

1.6 Within the Framework, Triple P is described as:

‘a multi-level, parenting and family support strategy. Triple P aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. Parents have differing needs and desires regarding the type, intensity and style of assistance they may require. Triple P addresses these differing needs through its levels’.

\(^1\)The term ‘parent’ in this report follows the terminology used in the Glasgow City Parenting Support Framework in which ‘parent’ refers to the main caregivers of a child, for example birth parents, grandparents, kinship carers, adoptive parents and foster carers. ‘Practitioner’ refers to staff from the public and third sector organisations across Glasgow trained in Triple P, including those who delivered the programme as well as those who did not. ‘Stakeholder’ refers to the senior representatives of the public and third sector organisations involved in the development and implementation of the Framework.
1.7 The Triple P Levels are: Universal, Selected, Primary, Standard and Group, and Enhanced (see Appendix 1). More detailed information on Glasgow’s Triple P programme is available online.

1.8 Implementation of the Framework is overseen by a multi-agency group – the Parenting Core Group – and has coincided with the adoption of the One Glasgow Approach by Glasgow Community Planning Partnership (GCPP). The Approach is described by GCPP as:

‘a Total Place approach to budget planning and financial challenges based on pooling resources, focusing on specific shared priorities, eliminating duplication, and creating efficiencies’.

1.9 Triple P training and delivery has been implemented through a substantial programme in Glasgow encompassing practitioners from a number of universal services that engage with families, particularly practitioners from NHS Greater Glasgow and Clyde, as well as staff from Glasgow City Council, and third sector organisations including Glasgow Life. A Central Parenting Team monitors practice, supports Triple P roll out across agencies, co-ordinates staff training and manages referral processes.

1.10 Further detail about the delivery model in Glasgow and information about the background to the study is provided in the contextual review attached as Appendix 2.

Study aims and methodology

1.11 The purpose of the study is to investigate the views and experience of stakeholders, practitioners and parents of the implementation of the Framework with specific reference to the research objectives shown in Appendix 3. The objectives concentrate on the implementation of Triple P which dictate the focus of the research and this report.

1.12 Qualitative research methods are used in this study. These serve to identify contextual issues and the views and experiences of those who took part in the research. The themes and issues represented in this report are not to be interpreted as statistically significant.

1.13 Evaluation and research activities were conducted over the six-month period between November 2013 and April 2014. At the outset of the study it was agreed that the fieldwork should concentrate on the three Early Years Collaborative Test Sites in the North West, North East and South sectors of Glasgow. Key elements of the methodology are summarised below. The evaluation has been overseen by a Steering Group comprising representatives from the University of Glasgow and NHS Greater Glasgow and Clyde.

Stage One: Preparation

1.14 In the inception phase the evaluation team attended briefing meetings, reviewed contextual information from Glasgow and the implementation of Triple P elsewhere, and developed a suite of research tools for use with stakeholders, practitioners and parents.
1.15 We conducted depth interviews with 20 key stakeholders from the organisations involved in developing and implementing the Parenting Support Framework. This included senior representatives from NHS Greater Glasgow and Clyde and Glasgow City Council as well as members of the Central Parenting Team.

**Stage Two: Qualitative research with parents and practitioners**

1.16 The Central Parenting Team provided contact details for a sample of parents referred to Triple P as well as staff trained in the delivery of Triple P interventions. Stratified sampling of parents from North West, North East and South Glasgow identified: 150 parents who had engaged in Triple P Groups, 150 parents who had not engaged in Groups, 29 parents who had completed Primary Care, and 23 who had disengaged from Primary Care. Stratified sampling of trained practitioners identified 140 individuals in total across the three areas, covering a cross-section of organisations and delivery experience which ranged from frequent deliverers to non-deliverers of Group and Primary Care Triple P.

1.17 Prior to contact from the research team, consent was achieved by a letter sent by the Central Parenting Team to parents in the sample informing them about the study and giving them the opportunity to opt out. Each parent was offered a £10 gift voucher for a high street store of their choice to reimburse them for their time participating in the research. In total our researchers consulted 74 parents - 64 completed interviews by phone or in person and 10 took part in focus groups. Approximately eight out of ten of those who participated had engaged in the Triple P programme to some degree while the remaining parents had been offered support but did not engage with the programme.

1.18 We also undertook 56 interviews with practitioners trained in Triple P, by phone or in person (individual or paired interviews) - whichever method suited them. The majority of the practitioners consulted were health professionals (35) although our researchers also consulted practitioners from education (8), the voluntary sector (7), and Social Work/Parent and Children Together Team (6). Most of the practitioners who took part in interviews regularly deliver Triple P as approximately one fifth of those interviewed infrequently or never deliver interventions.

**Stage Three: Analysis and report writing**

1.19 All qualitative evidence gathered in the study has been systematically reviewed, assessed and analysed by the research team with specific reference to the research objectives. The findings presented in this report are evidence-based and focus on four key themes: training, pre-engagement, engagement and delivery, and impact.

1.20 A stakeholder workshop was held in May 2014 to reflect on the findings and discuss next steps. The workshop was attended by over 20 stakeholders and a summary of the breakout discussion sessions is shown in Appendix 4. Further dissemination activities are likely to include the publication of an academic paper in an open access peer-reviewed journal.
Report Structure

1.21 The remainder of this report is structured as follows:

- Chapter 2 covers training
- Chapter 3 reviews pre-engagement activity
- Chapter 4 sets out findings on engagement and delivery
- Chapter 5 assesses impact
- Chapter 6 contains our conclusions and recommendations.
2 Training

2.1 This chapter assesses stakeholders’ and practitioners’ views and experiences of the training programme delivered as part of the Glasgow City Parenting Support Framework. Triple P has been the focus of the training. A brief summary of the programme is presented to provide context for the views and experiences expressed. The chapter then focuses on the implementation of the training programme, content, impact on workload, future training, and Continuing Professional Development.

Training delivered

2.2 Information provided by the Central Parenting Team shows that a total of 820 practitioners have been trained in at least one Triple P intervention between November 2009 and the beginning of March 2014. Some practitioners have trained in more than one intervention and a total of 1,047 training places have therefore been used during this period.

2.3 Following the training sessions, the final step to becoming a Triple P practitioner is an accreditation process. By March 2014, 903 of the 1,047 training places have led to accreditation (86%) although this figure could rise further as recent trainees complete the accreditation process. The majority of the practitioners trained are health visitors and other health professionals although many practitioners from education, social work, and a number of third sector organisations have also been trained. The majority of training has been in Primary Care interventions.

Implementation of Triple P training

2.4 Consultees reported that a collaborative approach between managers and staff has generally been applied in the last two years or so to identify Triple P trainees. In this approach professionals enrol in training when they and their manager view Triple P as being beneficial to their job and something they want to use. This approach helps to ensure that trainees and managers are fully prepared and able to accommodate the impact of training on their existing workload. Stakeholders were overwhelmingly supportive of this approach to training. Staff who volunteered for Triple P training in this way were generally positive both about training and subsequent delivery.

2.5 Contrasting views were gathered from some consultees involved in training in the early years of the Framework. At that time staff tended to be nominated for Triple P training by their line manager based on their position and expected role in the delivery of the programme. While many professionals were happy to attend and have positive views, a minority were not and this led to some negative experiences and views which were gathered during this evaluation. It is important to highlight that most of these views relate to historic training processes but nonetheless are important because of the legacy it has left among some stakeholders and practitioners. There remains residual resentment of the original process which appears to colour perceptions of training and delivery of Triple P among a minority of consultees.
2.6 Negative views on the original training implementation process were gathered from managers who had to nominate reluctant staff, practitioners who reluctantly attended training and, in some cases, also delivered reluctantly, and several stakeholders - the strongest views emanating from health and social work consultees. They felt that the early trainee selection was influenced by a rigid structure of who was to be trained and pressure to fill training places rather than on making the best use of resources. There was also some criticism of communications between managers and staff, and between organisations, regarding the rationale behind the introduction of Triple P and reasons for training selection. There was a view that Triple P was being imposed without due consultation or acknowledgement of practitioners’ existing experience, skills, or workloads.

“Trained some of the wrong people, trained some of those people who did not want to be trained. You have to have volunteers rather than conscripts and we had a lot of conscripts at the beginning, conscripts have been unhappy in a lot of cases and that’s where a lot of bad press comes from”.

(Stakeholder)

2.7 More recent experiences tended to be more positively recounted by managers, practitioners and stakeholders who described a process of negotiation rather than instruction which led to ‘happier trainees and deliverers’. Generally Triple P is now presented and recognised as something which enhances and contributes to, or underpins, existing roles. One practitioner’s comments capture the value of the way the implementation of training has evolved:

“You have to believe in it to deliver it well, therefore not everyone should have to deliver it. Anyone who wants to deliver should be encouraged to do so”.

(Health Practitioner)

Views on training

2.8 Overall a large majority of trainees were positive about the actual content and delivery of the Triple P training. The quality of the training and the trainers was highlighted; trainers were said to be supportive, friendly and knowledgeable. Professionals who had been most recently trained were generally the most positive about the training.

2.9 There was widespread recognition that the content and training materials were very good and participants said they took a lot from it. Trainees suggested that there was a lot of information to absorb in a concentrated period of time, however most enjoyed the intensity of the training, thought it was what they expected of a training programme, or made attending worthwhile. The quality of the venues and facilities were also noted.

2.10 Trainees welcomed the opportunity to train alongside a mixture of colleagues from different agencies as they learned from others and gained insight into other professional roles. There was a view that training alongside different agencies had
positive long-term benefits in terms of encouraging future multi-agency working. Peer support was also identified as a positive aspect of the training as trainees helped each other.

2.11 Accreditation of Triple P practitioners was also highlighted as a positive element of the programme. This was viewed as an asset because it quality assures the training, unlike another programme experienced. Another view was that accreditation was welcome, but did not necessarily result in quality assured practice as some delivery was described as “poor”. A handful of practitioners raised concerns about the lack of existing quality assurance processes in the delivery of Triple P.

2.12 There were some negative comments on the training programme summarised below although we emphasise that they came from a minority of trainees and should be viewed in the context of overwhelmingly positive feedback on the training content and delivery. The negative comments related to:

- The intensity of the training as some trainees would have preferred more time, although they acknowledged that they could not afford to take more time away from their normal workload
- A gap between the theory and then being able to deliver Triple P in practice which included the practical skills and confidence to facilitate groups. Some trainees tackled this by arranging to shadow experienced colleagues
- Views that the training content was not relevant to the most disadvantaged and vulnerable Glasgow families, being seen as too middle class and too Australian
- A suggestion that the role playing aspect made some trainees feel uncomfortable although there was a recognition of the need and value of such content
- Multi-agency training did not recognise the different needs of different roles
- A perception that the training would have been costly with Australian trainers and the choice of venues and catering
- A view that time and money had been wasted training professionals who did not want to be there or deliver Triple P
- Limited advice on how to incorporate what they viewed as additional work into existing workloads.

2.13 There were no discernible patterns in practitioners’ views and experiences relating to the different levels of Triple P training completed.

Impact of training on workload

2.14 Trainees appeared to attend the Triple P training without it having a detrimental effect on their workload and the support of colleagues and managers was acknowledged. Although some trainees said they had delayed or re-arranged meetings or particular aspects of their work or had asked colleagues to take on certain tasks, they did not raise this as a major problem. A number of trainees mentioned how supportive their line manager and colleagues had been.

2.15 A small number of practitioners reported that there had been an adverse impact on their workload which they had to make up when they returned to their job. These
trainees tended to be health professionals who were reluctant to attend the training. It is our impression that training is now more targeted and involves greater discussion prior to enrolment which is beneficial in terms of both individual and service capacity.

**Future training**

2.16 A number of practitioners - particularly those most enthusiastic about Triple P - were interested in being trained in additional levels of the programme. There were no specific trends in terms of future training needs that stood out with those trained in Group interested in Primary Care and vice versa. There were some concerns about capacity and finding the time to do additional training but they were minor concerns.

2.17 Stakeholders highlighted forthcoming training in Triple P discussion groups for a range of staff and Level 4 and 5 for Social Work staff involved with families with children on the Child Protection register, children and families where there are kinship care arrangements, and children under statutory supervision. Both these training programmes have the potential to widen the reach of Triple P in Glasgow.

2.18 Isolated examples of practitioners dissatisfied with future training arrangements were encountered. One practitioner who had requested a refresher course reported that they were told the priority was to train new people, and another, who said they had been waiting for training for over a year, expressed frustration that they could not deliver without it.

**Continuing Professional Development**

2.19 We are aware that a Continuing Professional Development programme has been developed by the Central Parenting Team and Glasgow City Council Education Services for delivery in the One Glasgow Early Years establishments (48 nurseries striving to be Family Learning Centres) to raise awareness of Triple P. It is not Triple P training but an awareness raising session for staff covering: what Triple P is, what the vision for the City is, and what their role in signposting parents to Triple P could be. This short session – lasting approximately an hour – is intended to raise awareness of Triple P among staff in the nurseries so they are more knowledgeable about Triple P, and how it can support parents. Some of those involved in delivery reported that the sessions had been positively received.

2.20 Given some of the later comments on awareness and reach in this report, it is our impression that a similar awareness raising programme may be beneficial in other settings. For example, with other professionals such as Social Work, allied health professions, early years primary school, and the many different elements of the third sector that come into contact with families, including minority communities.
3 **Pre-Delivery**

3.1 This section explores the pre-delivery phase of Triple P covering attitudes towards Triple P and the impact on the referral practices, self-referral, awareness of parenting programmes, marketing, information provision, first impressions, and support for parents.

**Attitudes towards Triple P and impact on referral practices**

3.2 Practitioners’ understanding of Triple P was largely comprehensive whereby most of those interviewed were able to describe the programme in detail and had a good understanding of the different levels available. However we identified mixed views regarding to whom Triple P should be offered and whether or not practitioners felt it was their role to refer - these views linked closely to referral practices.

3.3 Practitioners do not universally believe that the programme is for all parents. The reason for this view included practitioners who suggested that it is not suitable for families with multiple and complex needs, others who feel it is only for parents facing significant parenting challenges, and others who suggested it was only suitable for very motivated and confident parents.

3.4 One nursery school head teacher reportedly turned down the opportunity to implement Triple P when a trained practitioner joined the staff because parents “didn’t need that kind of support”. The nursery is in a relatively affluent area of Glasgow and the head felt the programme was not applicable to the nursery’s parents but in so doing did not recognise that Triple P is intended to support parents regardless of their income or social circumstances. The stakeholder who reported this experience felt that a more strategic approach was required to communicate to heads and service managers the aims of parenting support and the referral pathways, which would share the vision and build commitment across the City.

3.5 Variation in terms of standard practice for offering Triple P to parents as well as different approaches to assessment of need depend on the Triple P intervention under consideration, and are described below.

**Tip Sheets**

3.6 Many practitioners described a pro-active approach to the distribution of Tip Sheets and offer them to parents as a matter of routine. They are usually offered by health professionals on home visits for new babies or at the 30-month universal child health surveillance (CHS) contact. It was suggested that they serve several purposes:

- to equip parents with tools and techniques for dealing with challenges
- as an introduction to broach the topic of parenting and facilitate discussion around this theme
- to let parents know that support is available should issues arise in future.
3.7 Practitioners who do not routinely offer Tip Sheets provided a variety of reasons for not doing so. The most common explanation was a perception that Tip Sheets are a scarce resource and therefore only to be handed in a reactive sense i.e. if they identify parents who are already clearly struggling. A handful said that while they intend to offer Triple P Tip Sheets to all parents who may find them useful, they sometimes forget to bring them. Another view was that it is not always appropriate to hand out Tip Sheets, due to concerns about bombarding parents with too much information or issuing sheets at a time when they are not ready to take the messages on board.

3.8 There was a view that the recent introduction of targets has led to an increase in offering Tip Sheets though not all feel that this is a positive development. A view expressed by some Health Visitors suggested that targets may be introducing distortions to practice, for example by encouraging staff to offer the sheets without thought about whether or not the parent is likely to engage in the messages or if the subject of parenting support is being raised at an appropriate time. For example, one said:

“I hand them out but sometimes it goes against my instinct because it’s not based on an assessment of need – which is what our practice should be – but because we have to hit a target”.

(Health Practitioner)

3.9 Practitioners described waiting for new supplies of Tip Sheets including one who waited “months”. Frustration was expressed at practitioners not being permitted to photocopy Tip Sheets, and it was suggested that the Solihull Approach is more flexible and user-friendly in this regard (i.e., it is possible to photocopy resources).

3.10 Practitioners highlighted that changed delivery structures for their work have influenced the number of opportunities for identifying a need for Triple P. The introduction of the 30 month CHS contact was pointed to as a good point at which they can raise the issue of parenting and identify parents who may be struggling. It was suggested that they get less opportunity to observe parents’ interaction with children because immunisations are now conducted by lower grade staff; however many of the staff who have recently been handed responsibility for immunisation are also in the process of being Triple P trained so should be picking up these referrals.

Primary Care

3.11 During interviews four themes about referral to Primary Care emerged:

- views about whether or not Primary Care is effective – several practitioners suggested that Group has a greater impact on parents and is therefore their preferred offering
- some of those trained in Primary Care have not offered it to parents because they lack the confidence to deliver it
- whether or not they have the capacity to deliver it themselves or within their team – the majority said they would offer it to parents more frequently if there was more time available to deliver it
• assessments as to the likelihood of parents engaging over the full course of four
sessions – approximately half said that four sessions was too much of a
commitment for their parent and this was taken into consideration at the
referral stage.

Groups

3.12 There are variations in practitioners’ views on the appropriateness of whether or not
to offer Triple P Groups to parents. Many of those who refer parents to Groups
suggested that they do so on the basis that it is a particularly effective form of Triple P
delivery due to the detailed nature of the intervention, the opportunity to give
parents an understanding that they are not alone, and the normalisation of their
child’s behaviour.

3.13 Several staff have a standard practice of referring parents to Groups mainly on the
basis that they do not have the capacity to deliver Primary Care. Such referrals are
therefore not particularly linked to an assessment of whether or not this is the most
appropriate mode of delivery.

3.14 A view was expressed that Primary Care Triple P is better than Group for parents with
intensive support needs because it is delivered in a one-to-one format. Others gave
examples of situations where Group referrals may not be appropriate, for example in
cases where a parent has no contact with their child.

3.15 Practitioners commented on referral screening processes and expressed
disappointment that, in some cases, their referrals to Groups are rejected. For
example a health professional explained that a few referrals had been made on the
grounds that parents were socially isolated yet was told that referral to Group had
been declined. There was a perception that it was damaging to decline any referrals to
Group, because it would hinder trust between parent and practitioner, due to the
encouragement and support required to get parents to agree to the referral in the first
place. The process was further questioned by another practitioner who commented
that “it’s an affront that our clinical assessment can be overturned by someone who
does not have contact with the family”. However we note that the Central Parenting
Team report that it is standard practice to discuss any referral rejections with the
practitioner in question and explain the rationale for doing so.

3.16 One view suggested an apparent shift in referral practices, highlighting that in the
early years of rollout there was a perception that practitioners were “supposed” to
refer parents straight to Group. The understanding now, however, is that the process
is to deliver Primary Care first, and then refer onto the Group if there are additional
needs that cannot be met within the Primary Care sessions.

3.17 Practitioners said they would welcome the opportunity to refer parents to Level 5
where there were specific and significant issues. It was reported that the absence of
this Level of intervention so far had contributed to inappropriate referrals to both
Primary Care and Group, for example particularly families with multiple and complex
needs or those who have limited contact with their children. Practitioners suggested
that it would be beneficial to offer specific groups for these parents outwith the mainstream offering. Although Stepping Stone Triple P has been delivered in Glasgow, awareness of it appeared low as demonstrated by the following example. One parent, whose child has severe learning difficulties was highly critical of an initial referral to Triple P Group where the parent felt the tools and techniques were inappropriate to their situation. The Group discussions had left her feeling isolated but a subsequent referral to Stepping Stones had been a much more positive experience. This parent felt their experience suggested the Health Visitor had limited awareness of the relevant support available and confirmed the general view that there is under-provision of support for families with specialist needs in Glasgow.

Discussion Groups

3.18 The limited numbers of practitioners with experience of Discussion Groups commented on the value of this format and most suggested they are a better mode of delivery than either Primary Care or Group, and therefore increasingly refer parents to these interventions. Their explanations included:

- a perception that Discussion Groups are easier for parents to engage with because they are themed on single issues
- one-off groups are less of a time commitment for parents
- they offer the valuable group experience so parents see that they are not the only one struggling with behavioural issues.

3.19 The practitioners that deliver Discussion Groups said they frequently find that parents sign up for the rest of the course after the first session.

Self-referral

3.20 It was noteworthy that almost a third of the parents interviewed described a process of self-referral. In these cases parents had either:

- specifically heard about Triple P and approached someone - typically their School, Health Visitor or the Central Parenting Team - to find out how to get a referral (roughly two thirds of those who self-referred); or
- were not aware of Triple P but contacted a professional to flag up that they were looking for help to manage their child, which led to their referral to the programme (approximately a third of those who self-referred).

Awareness of parenting programmes

3.21 Approximately half of parents consulted said they were aware of Triple P before they were referred to the programme. The most common sources of information on Triple P were seeing flyers at places such as GPs or nurseries, closely followed by having heard about it at school P1 induction seminars. Approximately 1 in 10 of the parents interviewed had been told about it by friends, a handful had seen posters in their local library and only two parents mentioned the television advertising campaign.

3.22 Those who had not heard of Triple P before their referral were asked where they would have gone for parenting support if they had not come across Triple P. Most
suggested that their first instinct would be to approach their GP or Health Visitor, while others said they would look online for information or ask their Social Worker.

3.23 The handful of parents of teenage children who took part in interviews said they knew about Triple P but had the impression it was only for those with babies or young children. These parents suggested it is not widely known that Triple P is available for those with older children.

3.24 Almost every parent who participated in an interview said that families in Glasgow need support and most suggested that Triple P should be available for all and be “normalised”. Those with older children, or more than one child, often expressed regret that they had not known about Triple P sooner.

“I wish I’d come to this when my child was a baby – I feel like I’m trying to rewrite history now and maybe I’ve already done some damage, it’s hard to change habits. If I’d known this stuff from the outset things would be much easier”.

(Parent)

3.25 Parents’ awareness of other support programmes was extremely limited: only two of the parents interviewed were able to name other programmes in Glasgow.

Marketing

3.26 As shown above, the Triple P marketing campaign had some effect in reaching parents via flyers, posters and the P1 seminars while awareness of the TV campaign was very limited. Parents made very few comments on the content of the marketing however stakeholders and practitioners were quite critical. The main issue was the confusing messages the advertising portrayed which the stakeholders and practitioners felt did not explain simply enough what parenting support was available and who it was aimed at. It was reported that STV’s marketing research had shown a good level of reach for the advertisements insofar as it showed people consulted recalled seeing it. Stakeholders identified limitations in funding and support from Triple P International as contributing factors.

“The advertising is garbage. It doesn't help, it hinders us to be honest. There is no way it is pitched at parents I work with. It is pitched at the wrong level. It doesn’t make sense to me and if I don’t understand it then parents won’t at all”.

(Health Practitioner)

3.27 Practitioners and stakeholders expressing negative views about this issue did not distinguish between historic and more recent marketing activity. The advertising material has been modified since the start of the programme however, the critical comments related to the overall approach to marketing which may in some cases be a legacy of the earlier marketing activity.

Pre-delivery information provision
3.28 There was a view from parents that the information provided before taking part in Triple P was satisfactory and their comments on this theme typically related to receiving information on practical matters such as having sufficient detail about where and when the Groups were taking part, and a brief summary that Triple P was a programme to help parenting.

3.29 A further group of parents said they would have welcomed more information about what was actually involved in the Groups and Primary Care such as what issues it covered, how it would be delivered, and that it required them to work with their children applying the techniques over a period of time. If this was provided, it may help minimise some of the unreasonable expectations that practitioners reported encountering during delivery around parents expecting Triple P to be a quick fix, in our opinion. There was a view among practitioners, however, that providing more detailed information requested by some parents could be counterproductive and could put other parents off from attending. The solution may be to ask parents more regularly if they have enough information in advance and to have material available for those who want it.

3.30 One parent cited that limited information was part of her reason for not engaging with Triple P – she was unable to find the Group within the venue she had been told to go to and felt scared and vulnerable. This parent suggested that the information included in the referral letter, which showed that most groups take place during working days and are located in poorer areas of the city, gave her the impression that Triple P is not for middle class or working parents.

First impressions

3.31 Most of the parents who were offered Triple P described having a positive response to the programme when it was first suggested, using terms such as “helpful”, “a good idea”, and “enthusiastic”. This was a particularly strong theme in interviews with those first offered Primary Care and parents linked this to the delivery format (that it would take place in their home) and the trusted relationship with the professional offering support (usually their Health Visitor). A small number of parents connected their positive response to a feeling of desperation, suggesting that they were simply relieved that some sort of help was available.

3.32 The programme was said to have been presented to parents in a non-threatening way - themes on first impressions included: a helpful programme for all parents; a way to understand and manage children’s behaviour; a positive way of dealing with issues; a chance to meet other parents; and a means of learning tips and tools. Despite this framing, some parents acknowledged that they were initially concerned that the offer signalled they were either a bad parent or someone who was not coping. Only after starting the programme did they feel reassured and relaxed about taking part.

“I’ll be honest with you, at first when someone says: “there’s this thing you might be interested in, it’s about positive parenting” you can get a wee feeling of oh gosh, am I not doing the right things? Am I being recommended it because I’m rubbish at this”?

“I felt like the Health Visitor was saying I was not a good parent, not a good mother”.

14
However comments from stakeholders and practitioners revealed a slightly different picture. There was a suggestion from staff that their colleagues had been heard to make negative comments about Triple P to parents with responses like “that’s not for you” or “you don’t need that” if they asked about it. They suggested that this dismissive attitude acts as a barrier to parent engagement and fuels a perception that the programme is not a universal service and is only for “problem” families.

Support for parents

Significant amounts of pre-engagement support for parents were not identified, but almost all stakeholders and numerous practitioners suggested that such activity would be likely to increase the numbers who take part in Triple P. Examples of the types of support advocated included telephone contact, texts or a face to face meeting with the person delivering their Group. Practitioners said these steps would motivate, reassure and remind parents about the Triple P on offer.

A handful of examples of pre-engagement activity were identified by parents and practitioners:

- one parent said that their Health Visitor had shown them a DVD prior to attending their group, to let them know about the types of issues covered
- a practitioner who frequently delivers Groups said they usually phone parents before the Group begins to introduce them, provide an opportunity for the parents to ask questions, explain how to get to the venue and describe what the Group entails. This practitioner said: “I really do this to encourage and reassure parents – it also helps me prepare”.

Parents said their initial contact with the Central Parenting Team had been helpful and reassuring, noting that they valued being given a choice about the location and times of groups as well as the crèches offered. The limited number of parents who mentioned phone contact with the Team had mixed views. One view was that the person they had spoken with was reassuring and had made them feel that Triple P was likely to be a good experience. Another view was that contact with the Central Parenting Team had not been helpful and felt that Triple P sounded “very formal”.

The majority of parents said their referral to Triple P was relatively quick and straightforward. Only a minority of parents had any negative views about the length of wait for their referral and these were usually parents who took part in Triple P more
than two years ago. They described waits of “months” and a very small number of parents gave this as the reason for not engaging with the offer, once it was made, because the behavioural issues they had sought help with had been resolved by that time.
4 Delivery and Parent Engagement

4.1 This section covers parent engagement, delivery experience, resources, monitoring and support. Background information on delivery is included below to provide context for the discussions that follow.

Triple P delivery

4.2 The Year 1 Report by the University of Glasgow highlighted that 12,818 interventions had been delivered between November 2009 and December 2011. This figure includes parents who received more than one intervention. Over two thirds of the Triple P interventions which make up the figure (70%) were comprised of the P1 induction seminar.

4.3 The table below summarises the total number of interventions delivered directly to parents by practitioners, outwith the P1 seminar. It shows that almost half of the interventions were single interventions, mainly distributing the Tip Sheet; it also shows that similar numbers of Primary Care and Group interventions had been delivered at that time.

Table 4.1: Delivery of Triple P interventions by level

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number of parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single intervention (e.g. Tip Sheet)</td>
<td>1,804 (48%)</td>
</tr>
<tr>
<td>Level 3 (Primary Triple P)</td>
<td>935 (25%)</td>
</tr>
<tr>
<td>Group intervention</td>
<td>995 (27%)</td>
</tr>
<tr>
<td>Total number</td>
<td>3,734</td>
</tr>
</tbody>
</table>

Parent engagement

4.4 As highlighted in Chapter 2, almost a third of the parents consulted during this evaluation had proactively sought assistance from a professional such as their Health Visitor, Social Worker or nursery/school staff. These parents chose to engage and, mainly sustained their engagement over the course of their support. Where parenting support was initially raised by a professional there were understandably greater challenges in terms of parent engagement, both initially and throughout the intervention. The main barrier was committing to the sessions and this issue is considered in more detail below in non-attendance and drop-out.

4.5 The majority of parents commented positively on the arrangements for Triple P Groups and Primary Care and it is our view that the arrangements are a positive enabler of parent engagement. For Triple P Group participants, a choice of venues and times (including evenings), and the availability of childcare were highlighted by parents as factors which helped their engagement. A handful of parents specifically stated that the availability of childcare at Triple P Groups was the critical factor in their engagement without which they said they would probably not have attended; the quality of the childcare was also positively commented on. Other parents commented
on the proximity of the venues to their home. A very small number of parents who did not engage in Triple P Groups stated that none of the venues or times were suitable for them although they were few in number and also generally raised other issues.

4.6 Primary Care participants welcomed the availability of support in the home and the flexibility this brought in terms of timing and fitting sessions around nursery/school times or work, for example. Primary Care participants also highlighted flexibility in re-scheduling sessions they had missed which helped to sustain their engagement.

4.7 Parents identified factors influencing non-engagement. These included problems with the time and/or location of the Groups as well as a dislike of the group format – practitioners confirmed this latter point as a reason given for non-engagement.

4.8 The most significant reason for non-engagement raised by both parents and practitioners was a lack of commitment or genuine interest in parenting support. This was a factor in initial non-engagement and subsequent disengagement and was most prominent, a number of practitioners suggested, among parents referred by Social Work. A number of practitioners stated that they had spoken to many parents who said that they did not need help, they “do that already” (referring to applying positive parenting techniques) or their child’s behaviour was “just the way they are”. Practitioners also highlighted that some parents could not commit to the eight weeks required for Group Triple P because of other work or family – they felt this was “a big ask” for many parents - this is a different issue to a lack of interest. Practitioners also attributed some lack of engagement to referrals being made to hit targets rather than because of need or readiness to participate.

4.9 Many practitioners stated that engagement was affected by a view among parents that there was a stigma attached to engaging with Triple P where parents would be viewed by their peers as bad parents or more particularly where Triple P was seen by some parents as a programme for those involved with Social Work. Interestingly, this view was more common as a perception among practitioners than among non-engaged parents consulted during this study.

4.10 Most parents who did not engage with Groups said they were not offered Primary Care as an alternative. Chapter 3 highlighted issues around practitioners’ awareness and knowledge about all forms of Triple P and the criteria for referring a parent to a specific intervention. Understandably, awareness was greater for those Triple P interventions in which practitioners were trained. But there are a sufficient number of practitioners who have never referred parents to more than one type of Triple P to suggest that there may be an issue with a broad understanding among practitioners of the different levels available and the referral criteria for those. Our discussions with practitioners suggested that there is a degree of uncertainty among a small proportion of practitioners about why parenting support is offered, who it is aimed at, whether it is universal and what the ultimate benefits of providing the parenting support will be in Glasgow.
4.11 There was a view among practitioners that word of mouth, specifically positive feedback from friends and family, is increasing, as is awareness of Triple P among the public, which is helping to engage parents.

“It feels like word of mouth is increasing among parents. More of them have heard of it and more are asking for it”.

(Health Practitioner)

“I’ve just joined a load of different parent forums and have posted the Triple P course on them. I hope that helps more people to be aware of the course, I would recommend it to anybody”.

(Parent)

Parent experiences

4.12 The vast majority of parents who engaged with Triple P had a positive experience.

4.13 Parents highlighted the way interventions have been delivered as contributing greatly to their positive experience and this applies to both Group and Primary Care. Group facilitators were overwhelmingly seen as approachable, friendly, and knowledgeable; similar adjectives were used for staff delivering Primary Care with knowledge and flexibility the most appreciated qualities. In both Group and Primary Care settings, a number of parents commented on how the professional had made the information accessible using simple – but not patronising – language that they understood and could relate to. Many of these parents said they really appreciated this as it made them feel the support was ‘for people like them’ or ‘normal, everyday Glasgow people’. Parents reported that they were able to ask questions and the professionals were very helpful in answering them.

4.14 The content of the Group and Primary Care sessions was overwhelmingly viewed positively by parents. Parents talked about learning a lot from the Triple P sessions particularly on how to deal with their child’s behaviour and specific situations. Some parents said they had struggled with absorbing that quantity of information.

“There’s always some kind of induction when you get a new job, no matter what it is, but there’s nothing with parenting. It’s good to learn”.

(Parent)

4.15 Group participants said that they particularly enjoyed the interaction with other parents. Hearing about other family situations made them feel they were not alone in facing such situations. Peer support was also said to be a positive aspect of the Groups. Parents commented on how friendly the group was, how supportive the other parents were and how ‘normal’ they were. This feedback demonstrates that there is a significant proportion of parents for whom Group Triple P is appropriate. It was also felt to be useful to be in a group of parents with children of mixed ages because they got information about issues that might occur in the future. Equally, the positive
feedback on the flexibility of Primary Care demonstrates that this is the appropriate delivery mechanism for other parents who may be wary of Group settings, unable to attend an eight week Group programme, or facing different parenting issues.

4.16 Some negative experiences were reported by parents. These included the behaviour or attitude of another parent in the Group as a nuisance although not sufficient to stop the consultee attending or benefiting from the Group. This tended to relate to the other parents talking about themselves or their situation too much, being disruptive, late or apparently under the influence of alcohol/drugs at Groups. This behaviour was observed in one or two individuals at the Groups our researchers attended to facilitate focus groups. It was also reported by parents at the Groups that there was insufficient time to discuss issues with the rest of the group, although other parents were not keen on allowing more time for this.

4.17 There was a feeling that the content of Group Triple P was less relevant for children who were at the older end of the 0-12 age range and more relevant to parents with “tantruming toddlers” - one such parent later enrolled on Group Teen and felt it was much more appropriate. Similarly, (as briefly highlighted in Chapter 3) parents felt the content could include more help for parents with children with additional needs such as attention deficit hyperactivity disorder (ADHD) or learning difficulties – this could however be an indication of some inappropriate referral or insufficient information being provided about a particular family. Other negative experiences related to isolated incidents such as rooms being too cold, or claustrophobic, or difficulty finding the entrance to a venue.

4.18 There was a suggestion that there may be cultural barriers for some parents from minority ethnic groups as parents recounted personal experiences and views. However, the evaluation included only a handful of black and minority ethnic parents and further targeted research would be required to examine these views more fully.

4.19 A handful of parents said that they had hoped for more “hands on support”. This applied particularly to those who took part in Groups. They said that it was difficult to put lessons into practice once they got home and would like someone to show them what to do. There was also a call for more visual content, as it brings the information to life and keeps everyone’s interest.

4.20 The overwhelming majority of parents who had experienced Triple P thought it was good that Glasgow offered parenting support services. They felt there was need for such support and believed many other parents would benefit.

4.21 Only a few parents knew that Triple P was offered at different levels, and that was only those who had personally experienced more than one kind of intervention.

Practitioner experiences

4.22 Consultation with practitioners broadly reflected the level of Triple P delivery by staff from the different delivery agencies, so views and experiences presented below are therefore mostly those of health professionals. Although views from health practitioners tended to be more mixed than the other professionals this partly reflects
the extensive experience that comes from their greater numbers as well as the additional focus on delivery in the sector that comes from the Health Board’s strategic and operational lead. The breadth of delivery achieved by the practitioners consulted from all sectors is commendable with a positive “can do” attitude evident among many.

4.23 A very broad range of practitioner experiences were gathered ranging from those who were extremely positive and deliver interventions frequently to those who deliver reluctantly or not at all. The type of intervention delivered, the parents and the fit with their role all play a part in practitioner experiences.

Primary Care

4.24 Practitioners who deliver Primary Care Triple P on a regular basis were professionals for whom parenting support is a key part of their job – the fit with their core work is therefore strong. Many of these professionals work in health although we also consulted those in education, the voluntary sector and social work (in the form of Parents and Children Together (PACT) teams). Practitioners experience has been broadly positive and they highlighted impacts for themselves, the parents and the children (see Chapter 5). As the Primary Care parents tend to be on the case load of the professionals there were no significant problems in terms of administration. The main difficulty was maintaining parents’ engagement so that all sessions could be delivered (see non-attendance and drop-out below). Practitioners reported that the delivery of Primary Care Triple P rarely took four weeks and could take far longer because of parents’ variable commitment and engagement. Practitioners generally felt the Triple P tools were appropriate and would benefit parents who were prepared to commit to applying the lessons.

Groups

4.25 A wider group of professionals have been involved in the delivery of Group Triple P including groups organised by the Central Parenting Team and those organised by nurseries or voluntary sector providers. The views on Group delivery appear to be linked with professionals’ initial desire to be trained and subsequent desire to deliver rather than to any specific profession, role or location. For those practitioners who were happy to be trained, delivery of Group Triple P has generally been positive. However, where practitioners felt compelled to attend training their experience of delivering of Groups has generally been less positive and some have opted out when given the opportunity. It was suggested by some practitioners that those who felt compelled to deliver could have done so less than enthusiastically which may have affected the quality of the Groups. However, no concerns about delivery were reported by parents.

“I said from the outset that teachers with a class would struggle to deliver it. There’s just no time!”

(Education Practitioner)
4.26 The amount of time practitioners had to prepare for and reflect on Groups and complete paperwork varied. For some health professionals this lack of time was their biggest complaint and affected some of their overall views of Triple P. One practitioner cited this as an example of why they had only ever delivered one group stating that it took a full day to prepare for the Group. Practitioners who were afforded time for preparation, reflection and administration very much appreciated it and felt it benefited their delivery.

4.27 Group facilitators reported that the information they receive on participants was limited and this could lead to issues in delivery, although they stressed these were minor issues. Practitioners generally wanted as much information as possible on the family, covering issues such as involvement of Social Work, whether the children were resident with the parent, caring responsibilities including kinship care, and history of substance misuse and mental health. In theory this information should be provided by the source of the referral – and if necessary followed up by the Central Parenting Team - in reality, some practitioners reported, the information was sometimes limited and meant they were delivering “blind”. A handful of practitioners pointed out that it was not always possible for the professional making the referral to know the parents’ background, although the Central Parenting Team should be trying to fill any gaps.

4.28 Stakeholders noted the variable implementation of Group and Primary Care Triple P by practitioners from the same profession. In some cases professionals were embracing Triple P and embedding delivery at every opportunity, whereas others in the same profession were far less enthusiastic deliverers or non-deliverers. The most quoted example was in Health Visiting where stakeholders felt implementation could vary significantly between practitioners, teams, or settings although no particular pattern was highlighted by stakeholders or evident to us from our consultations. Another example comes from stakeholders who were concerned about the variable implementation of Triple P in nurseries. They noted that some nurseries had successfully implemented both Groups and Primary Care, others had implemented either Group or Primary Care, whereas some had implemented neither. Consultation with practitioners from nurseries confirmed a range of delivery experiences.

4.29 Stakeholders and practitioners also commented on Social Work’s limited role in delivery to date with some questioning why the programme had not been more fully embraced by Social Work. Our overall view is that some of these views were misinformed as Social Work’s stance was not fully understood by these consultees. There was also a view that some of the referrals from Social Work were inappropriate as the parents were not ready to engage with Triple P. Evidence suggests that these views have some foundation and we recommend that awareness is raised with all referral agencies, including Social Work, about the criteria for Triple P referral.

Seminars

4.30 Only a handful of practitioners consulted during the study had delivered Triple P seminars. They felt there were too many slides in the presentation and that historically most parents had not engaged well because of this and the fact the seminar was included as part of the P1 induction process. Recent changes to make the
sessions optional and cut down the number of slides were welcomed by these practitioners.

4.31 It was highlighted in Chapter 3 however, that the seminars had acted as an indirect referral route with many of those who already had awareness of Triple P mentioning that they heard of it at the school induction seminar.

**Programme flexibility**

4.32 Negative views were expressed where practitioners felt that they were forced to use Triple P (Group and Primary Care) and they could not use their own judgement. It tended to be these practitioners who suggested that Triple P was not appropriate for some of their parents - citing issues such as substance misuse, mental health problems, and literacy difficulties - and was not flexible. However, the practitioners who were most positive about the Triple P experience were those that were flexible and made Triple P work for their families. Many of these practitioners talked about “tweaking delivery” or “making it appropriate” for parents and this mainly involved using easily understood language, helping parents with literacy issues, taking delivery at a pace the parent could cope with, or delivering sessions in whatever order seemed most appropriate to individual families.

“We talk about the fidelity of the programme – we maintain the fidelity but apply it flexibly to suit the groups”.

(Third Sector Practitioner)

“They should allow health professionals to choose elements of the programme, for example, not to use the Booklet if they can’t read, pick and choose bits from the Tip Sheets or bits from the Workbook. Triple P is too restrictive. As a health professional if you try to use your professional judgement you get it in the neck, you’re told to use Triple P. As the primary tool for all parents it’s a dismal failure”.

(Health Practitioner)

4.33 The positive feedback from parents on the use of simple language and flexibility shows that this helped their engagement.

“Straight talking”.

“The two ladies were very down to earth, they gave their own stories about being parents and told you it was ok if the kids did certain things”.

“It felt very relevant”.

(Parents)

4.34 The flexibility of Triple P delivery – or inflexibility depending on the point of view – was a much debated point during the evaluation. One of the most important points was made by the Central Parenting Team who stated that the programme is designed to
be flexible and delivery can be tailored to meet parent’s individual needs. However, our consultation shows that some practitioners are not aware of this and view it as a very rigid programme where flexibility is frowned upon. We recommend that information on flexibility is conveyed to all practitioners.

**Non-attendance and drop-out**

4.35 Figures from the Year 1 Report\(^2\) highlight that less than half of parents completed an intervention they started with completion rates varying from 19\% for Primary Care Teen to 47\% for Group. The reasons for non-attendance at some sessions or non-completion (drop-out) were examined with practitioners and parents.

4.36 Two main reasons were identified by practitioners. Firstly, were issues or crises occurring in the parents’ lives which took precedence over Triple P such as personal problems, substance misuse relapse, or debt/benefit problems; parents cited other reasons such as bereavement or the breakdown of a relationship for dropping out of an intervention. There was a suggestion from some practitioners that these issues were more prominent among parents referred by a professional particularly Social Work or where Social Work was involved with the family. This was a factor in non-attendance and drop-out.

4.37 Secondly, practitioners suggested that Triple P was not ‘the quick fix’ that some parents thought it would be and they dropped out two or three weeks into the programme. Some of these parents – it was suggested by practitioners – were not prepared to work at applying the Triple P methods or wanted someone else to do the hard work. Another point raised by practitioners was that some parents dropped out of the Groups after they had received the Workbook as they felt they then did not need to attend any more sessions.

> “Sometimes parents think it is a magic bullet, no matter how much information you give them they still expect someone else to sort it out for them. They get put off by how much is expected of them”.

(Health Practitioner)

> “Some parents think it’s going to be easy, although this is less prominent now as referrers are explaining it better”.

(Third Sector Practitioner)

4.38 Some practitioners – usually those working with families with significant issues – gave examples of parents having unrealistic expectations as to what Triple P involved and this contributed to non-engagement. For example, Health Visitors reported that some parents had thought Triple P involved the practitioner helping parents with bedtime routines.

\(^2\) ‘Parenting Support Framework Evaluation’ (University of Glasgow, 2013)
4.39 Practitioners suggested that some parents did not give the real reason for not attending and would use ‘excuses’ such as illness or medical appointments. These practitioners suggested that they could predict with a reasonable degree of certainty which parents would drop out of Triple P Groups. There were parents consulted during the research who did identify reasons such as illness and medical appointments for missing some sessions. Other reasons included missing a week of Group Triple P because a new TV was being delivered.

4.40 One nursery had introduced a novel way of cutting down on non-attendance and drop-out at Triple P Groups they delivered exclusively for parents of children at the nursery: additional funding had been secured to provide incentives to parents who attended Group sessions in the form of trips out with the children. One of the Group facilitators reported that this had worked well with trips to places of interest such as museums and libraries as well as a trip to a local supermarket where the parents were observed putting into practice the Triple P lessons they’d covered. The nursery had previously organised Groups which had been poorly attended.

4.41 Good examples of linking Triple P delivery with other services were apparent. For example, Glasgow Life has integrated Triple P closely with other offerings such as Bounce n Rhyme, Toddlers Tales and Future Families, with practitioners speaking to parents about Triple P at these groups and other events whenever they are in contact with parents. Another example was the strong links that Rosemount Lifelong Learning – a community-based organisation in the Royston area - has established with Addaction – another third sector organisation delivering substance misuse support services across Scotland - which results in their delivering Triple P Group to Addaction’s clients in this part of Glasgow, as well as Groups and Primary Care to Rosemount’s own service users.

Readiness

4.42 The above discussion on non-attendance and drop-out raises one of the most debated issues covered during this evaluation – “readiness”. This phrase arose in the majority of stakeholder and practitioner interviews and refers to the point at which a parent is willing to seek or accept parenting support and importantly able to sustain that support. Practitioners and stakeholders frequently referred to families not being ready for support and therefore not engaging at the time of referral or starting an intervention but subsequently disengaging. Readiness is an important issue because referral of parents who are not ready can lead to wasted resources processing their referral, as well as wasted resources and frustration from delivering interventions that the parent does not complete. It can also impact on parents who may have been ready to engage at a later stage, but whose negative experience of premature involvement in Triple P prevents them from doing so.
4.43 There was a perception from some health practitioners that the pressure to meet targets led to inappropriate referrals of parents who were not ready. There was also a practitioner view that because Glasgow had invested heavily in Triple P “we are stuck with it” and “we have to do it now because the Health Board has to justify the cost”.

4.44 Some parents had agreed to parenting support for the wrong reasons and they were not ready to fully engage. The following practitioner quotes illustrate these views.

“It is wrong to “push” parents into groups through over encouragement, it would be better to do some ground work with them so they are ready”.

“For primary care and some groups, parents have to be ready as they engage but they are not actually willing to do what is needed. Some parents see it as a tick box exercise”.

“It can be offered by a health professional when the parents is not always ready, it’s not appropriate. It’s not a magic wand. Some parents say yes to get health professionals out the door”.

(Health Practitioners)

4.45 Our discussions with practitioners suggested that they found “readiness” difficult to define as demonstrated by the following views. We recommend that guidance is developed to help with this.

“I only offer it if parents are ready, it’s pointless otherwise. If they ring me crying then I know they are ready”.

“If some parents aren’t ready they can be referred time and again. It is the Health Visitors job to establish the readiness - are parents asking for the interventions and are they eager to change? This is frequently discussed at team meetings. The CPT say they are screening but that doesn’t look like the reality - it needs better information on the referrals as so many issues effect readiness”.

(Health Practitioners)

Resources

4.46 The majority of practitioners and parents held positive views on the resources – the DVDs, Tip Sheets and Workbooks.

**DVD**

4.47 The majority of parents and practitioners felt the DVD was of benefit to the programme although there were mixed views. Most parents enjoyed viewing the DVD and felt it helpful. Some said it was very useful to see situations they could relate to, one describing it as a “light bulb” moment and another saying it was “upsetting” (but helpful) as they recognised themselves doing the same thing as viewed on the DVD. There were some comments on the setting and age of the content but the negative views were a minority.
“The DVD made a lot sense, it was true to life seeing the mother stressing and the partner disagreeing with her. It was very beneficial to actually see situations”.

“Absolutely laughable but you could see yourself on the screen, and once you see it you realise what you are doing and what you should be doing”.

(Parents)

4.48 Practitioners who supported the use of the DVDs welcomed the break in delivery style it allowed and while they acknowledged that the content was dated and the Australian setting was, literally, a long way from the everyday lives of the Glasgow participants they felt a) the important messages were there and b) the setting/age actually helped engage the Group as it “breaks the ice” and promotes discussion. The newer DVD for the Triple P discussions was viewed positively by the small number of practitioners who had used it. A handful of practitioners also stated that it was helpful that the content was based elsewhere. For example, one said it would be a “distraction” if it were set in Glasgow because parents are territorial and would make judgements about the programme based on where in the City the DVD was filmed, what the house of the actor looked like, their accent etc. and suggested this might be detrimental to engagement.

4.49 A minority but vocal group of practitioners felt the DVD was not relevant to the Glasgow setting being too Australian, dated and middle class (citing the language used and the availability of a spare room for time out, for example). For example, one practitioner commented that “not many of my parents have swimming pools in their back garden”. These practitioners felt the delivery of the messages was undermined by the setting/age – with one stating they chose not to use it during the delivery of Primary Care sessions for this reason - and they would prefer a Glasgow or Scottish version.

Tip Sheets

4.50 As highlighted in Chapter 3, Tip Sheets were mainly welcomed by practitioners as a means of engaging parents who could not or would not commit to longer engagement. There were many positive comments on the content with a few practitioners wishing there were more sheets covering a broader range of topics; one practitioner had taken matters into their own hands and had prepared their own sheets that they used when these issues arose.

4.51 Negative comments related to the delay in receiving additional copies of the sheets and a very small number of practitioners who would prefer to be able to hand out the Tip Sheets without the need for the accompanying session. We did consult a small number of practitioners who hand out the sheets without the accompanying formal session. However, other practitioners were opposed to such an approach with one highlighting their sense of professional pride and ownership of Triple P which recognised the need to deliver the intervention and not just hand out the Tip Sheet. There were no negative comments from parents on the Tip Sheets.
“The Tip Sheets were really amazing. I am keeping them safe and using them for my youngest”.

(Parent)

4.52 Many of the practitioners who frequently work with families with significant issues reported that offering a Tip Sheet to these parents can take as much time as delivering Primary Care to those with less complex needs. For example, it may take four meetings to cover one sheet and ensure that parents with low levels of literacy or learning disabilities understand key messages. These staff expressed frustration that the time-intensive nature of this work is not recognised when targets are set or reported on.

Workbooks

4.53 The vast majority of parents had positive views on the Workbooks. They liked having a source of information they could refer to in-between sessions, and subsequently after the programme had finished. Parents said they refer back to the book many months later and have shared it with partners, ex-partners and grandparents to try to encourage consistency in the application of Triple P messages. Parents also mentioned that they had shared the Workbook with their friends and family for them to use with their children. On the other hand a small number of parents said they had struggled to get grandparents and partners to apply the techniques, while others chose not to share the information with others fearing they would be judged as bad parents because of the stigma attached to Triple P.

4.54 Literacy was raised by a minority of practitioners as one of their major concerns about the accessibility of the programme and parent engagement. Those who held this view felt the programme was difficult for parents with limited literacy skills with the most passionate proponent of this view suggesting that the programme was designed to fail parents because of the literacy expectations. Such practitioners felt the programme was not flexible enough to accommodate such parents, or they were not allowed to be flexible in their delivery to enable these parents to benefit. However, the opposite view was stated by an equally passionate set of practitioners who were delivering in a way that engaged parents with literacy issues – they did so by explaining parts of the Workbook to parents, or going through the Workbook with the parent, and telling the parents not to worry about the Workbook if they felt they did not want to use it. Accessibility for parents with literacy issues was one of the most debated parts of our discussions with practitioners.

“Some parents see the Workbook and are put off. It is literacy concerns but also some are afraid of Social Work knowing their business”.

(Education Practitioner)

“The Books are really good, they’re helpful and can be adjusted”.

(Health Practitioner)
4.55 Adding Workbooks in languages other than English was raised by a handful of practitioners who felt it would be helpful. One parent who was born outwith Scotland said they would have welcomed the Workbook in their first language although they did try to get as much out of the existing Workbook as they could.

4.56 A common concern raised by a number of practitioners was the difficulty in getting more copies of the resources. This occurred when they ran out of Tip Sheets or when they had let a parent borrow their DVD, even though they know they are advised not to do so.

**Improving reach**

4.57 By far the most quoted means of improving reach was raising awareness of Triple P and doing so in a way which presented it as a universal programme that was not just for parents with multiple and complex needs, Social Work referrals or “bad parents”, but was a useful tool for everyday Glasgow parents.

4.58 Ways of raising awareness included health professionals introducing parenting support to parents whenever there were opportunities such as at immunisations, health checks, or appointments, as well as health and other professionals being more proactive and reaching out to groups such as mothers and toddler groups, addiction support groups, and other interest groups such as through organisations working with Glasgow’s BME community. Some of the most enthusiastic practitioners called for the normalisation process to go further with the introduction of Triple P at the ante-natal stage – making it part of the whole process of being a parent and not something that is used at crisis points. One Health Visitor for example suggested that a description of Triple P and a link to the website should be included in the Red Book given to parents for each new baby.

4.59 Practitioners also called for advertising that is clear and simple so parents understand it – this followed the comments highlighted in Chapter 3 about the negative perceptions of Triple P marketing. Part of the awareness raising process, parents suggested, should include advertising how to self-refer and messages that Triple P is confidential and welcoming. One stakeholder also suggested that internal marketing among the workforce would be helpful:

“I’d say a PR exercise is needed to restate the commitment and purpose of the investment – what we are trying to do and why”.

(Stakeholder)

4.60 Stakeholders and practitioners suggested that additional reach could be achieved through extending the delivery by third sector agencies that bring extra capacity for delivery, skills and access to working with particular groups and a different dynamic to working with parents. It was also suggested that this is a potential mechanism for increasing the resources available for Triple P.

“The third sector has been phenomenally successful in terms of bringing additional funding to deliver Triple P and they are very open and keen to work with us”.
“Third sector organisations can help to address some of the gaps in terms of more tailored support for the groups that we’re having trouble reaching like single dads and ethnic minorities”.

(Stakeholders)

4.61 A further idea came from practitioners and stakeholders who suggested that more could be done to develop the programme if additional resources were made available. For example it was suggested that a Triple P practitioner team or “unit” with the sole purpose of Triple P delivery could be deployed to help to develop and embed Triple P within new settings. There was support for this proposal at the Workshop discussions although there were also some reservations (see Appendix 4).

4.62 A further suggestion was that embedding Triple P within the Family Nurse Partnership role would also extend delivery and awareness among hard to reach families.

Monitoring

Assessment Booklets

4.63 There were opposing views among both parents and practitioners on the Assessment Booklets. Parents who were positive about the Booklets highlighted the opportunity to look back at the responses they made at the start and practitioners felt the Booklets provided an opening to discuss parents’ aims at the start and progress at the end - these practitioners recognised the Booklets as an aid to delivery.

4.64 However, there were also negative views expressed by practitioners about the Booklets, citing problems getting parents to fill them in (including literacy barriers) and returning them. Some of these practitioners felt quite strongly that the information was required to fill an administrative need at the Central Parenting Team on evidencing numbers engaged, rather than a genuine need for information on impact. Their views appear to affect their overall views on Triple P. To overcome this perception, the Central Parenting Team may wish to demonstrate how the information is used and more importantly what impact it has evidenced in Glasgow to date.

Monthly Returns

4.65 The majority of practitioners consulted reported that they collated and submitted their monthly returns to the Central Parenting Team; those who did not submit the forms were non-deliverers or infrequent deliverers. There was generally an appreciation of why the information was required and a general acceptance that the level of information submitted on the forms was proportionate. Stakeholders stated that monitoring is important in embedding delivery and maintaining a high profile for Triple P.

4.66 There was however a minority of practitioners strongly opposed to the submission of the monthly forms, although most did reluctantly submit the information. For these practitioners the monitoring return was a “tick box exercise”, which they believed
reflected a focus on delivering numbers to meet Triple P targets not needs-driven interventions chosen by a professional using their own judgement. They felt they were being made to provide evidence that they were doing their jobs, which undermined their self-confidence and trust. The time required to complete these forms on a monthly basis was also highlighted by many of those who were negative about the returns.

4.67 A significant number of practitioners felt pressure to meet targets, although there was a view that the pressure was less now than it had been. The pressure was also more greatly felt among health professionals than other professionals. In Chapter 3 we highlighted examples of practitioners handing out Tip Sheets to parents they have contact with not because of need but to meet targets. There were negative perceptions about the impact of targets, linked by some to a belief that they are not trusted to do their jobs without being checked up on. One practitioner who was also trained in the Solihull Approach felt they could not apply Solihull as they “were too busy delivering Triple P”.

"I'm in a caring profession, not a business - this drive to meet targets goes against the work we do to try and support and provide relevant, targeted help”.

(Health Practitioner)

4.68 The above experiences show that some practitioners felt under pressure to deliver Triple P and did not feel able to use their professional judgement and/or use other parenting support interventions. This experience contrasts with the Framework which stated that Solihull was intended as a significant component of delivery and that other parenting support approaches such as Webster Stratton and Mellow Parenting were to be used if they were deemed more appropriate or more acceptable to families or where staff were already trained and experienced in their use. We found very limited use of other interventions among the practitioners we spoke with.

4.69 Positive views about targets and the referral process centred on embedding Triple P into practice, the value of normalising the offer of Triple P and the importance of raising awareness and “planting the seed” so that parents know support is available.

Under-reporting

4.70 A minority of practitioners was concerned that the monitoring process under-records the level of parenting support being delivered in Glasgow and they identified different ways this can happen. The first and most obvious way is where returns are not made and therefore delivery is not recorded. Secondly, some Primary Care practitioners struggle to get their parents to complete the Assessment Booklet (as highlighted above) which means the intervention is not fully recorded. Thirdly, some Primary Care practitioners felt the Assessment Booklet does not capture all of the support provided to a family where there is more than one child present in the household because the Booklet focuses on the progress made with one child’s issues. Fourthly, some of the parenting support is not recorded as although the Triple P ethos of positive parenting
may have been used, they have done so in a less formal way that doesn’t use the official material and is not therefore recorded as an intervention.

4.71 On the last of the above points, some practitioners talked about “Triple P by stealth”. These practitioners reported that extensive partial delivery of Primary Care Triple P is taking place but is not recorded. This kind of delivery includes modelling positive approaches to engaging with children, sharing tips and techniques, and talking about Triple P methods without alerting parents to the fact that they are using Triple P.

“I use it to advise families, but I can’t do it formally. I have too much else on”.

(Social Work Practitioner)

“I suppose we need to change the mindset of the Central Parenting Team, so that they recognise the value of these proactive interventions that we are delivering”.

(Health Practitioner)

“Because of the client group we have I think it’s a shame that these interventions we perform using tip sheets, where we maybe need to spend a lot of time going over the same issues, don’t seem to be as valued or counted as a level 3 intervention - because we are being proactive in our use of them”.

(Social Work Practitioner)

Support for practitioners

4.72 Some health staff expressed a view that they receive less support since the local parenting coordinators moved to the Central Team and reduced from five members of staff to two. While the Central Parenting Team reports that it was always the intention to embed peer support within health teams, there was a strong view among some staff that they get less support than before. Views around the impact of this reduction in support included suggestions that local motivation and delivery have decreased as a result. For example, staff said they valued regular phone calls, being supported by a coordinator from the same professional background and previously had frequent opportunities to discuss the delivery of Triple P. Some suggested that a previous informal approach made it easier to discuss challenges or problems and also encouraged them to make efforts to free up capacity so that more delivery was possible.

4.73 A limited number of practitioners had attended the Peer Support Network and they reported that it was poorly attended in their experience. They also reported that the sessions were of limited use where questions raised by practitioners were not adequately answered or where the topics covered needed to be more practical and helpful in addressing specific situations. Several practitioners described informal peer support within their teams and suggested this was sufficient. This was seen to be particularly important in the early stages of Triple P delivery immediately after the training.
4.74 Most practitioners reported receiving the newsletter although many of the practitioners said they did not read it or did so only occasionally. Feedback among those who read it was mixed with most suggesting it could be improved with more relevant content.

4.75 Practitioners said they would value information about whether or not parents engage in Triple P after they have referred them to the programme. Examples of how this information would make a difference included:

- the opportunity for further engagement with and support to the parent on the grounds of discussing their learning
- a means for follow up work to identify the impact of Triple P on the family
- to be aware that those who have not engaged might have unmet support needs
- to learn more about why parents do not take up the offer and gather feedback which may be used to improve engagement with the Triple P programme.

4.76 However, there was also a view that practitioners may not like to know if referred parents had not engaged in Triple P, suggesting it might lead to an onus on practitioners to “encourage” parents to give it a try. This related to not having the capacity for any additional work.
5 IMPACT

5.1 This chapter highlights the impact to date of the Glasgow City Parenting Support Framework on practitioners, parents and their children. The wider impacts of the Framework and Triple P’s implementation raised by stakeholders are also summarised.

Parents

5.2 The overwhelming majority of those parents who had participated in Triple P found the experience to be strongly positive. This applied to parents who participated in Primary Care and Group Triple P.

5.3 Even before they began to fully implement Triple P strategies, parents reported that there were positive benefits to attending group sessions. Hearing stories from other parents about their children’s misbehaviour helped others to put their own child’s behaviour in perspective. Parents reported realising that behaviour they had worried about was normal, that many parents were in exactly the same situation, and that most parents struggled with very similar problems.

5.4 The most significant impacts were, unsurprisingly, evident in terms of parenting. Firstly, the vast majority of parents reported improved knowledge and skills on parenting issues and knowing how to react to specific situations and what techniques to apply, including naughty steps, quiet time, time out, behaviour charts, and lots of praise. Secondly, they reported improved or new confidence in handling situations and putting into practice their new skills and knowledge. Many parents said having the Tip Sheets and Workbooks gave them extra confidence because they knew they could refer to them if behaviour deteriorated.

5.5 Parents also reported other benefits. Firstly, improved mental health and wellbeing including feeling less stressed, depressed, or anxious that came from their improved ability to cope with their children’s behaviour. Secondly, parents reported improved relationships within the family and outside of the family such as at school or nursery, or with friends and neighbours. Parents reported that improving the behaviour of one ‘difficult’ child impacted positively on the wider family and on adult relationships with each other. Thirdly, parents reported that engagement with professionals which included referral to Triple P had also led to other support being provided for their children as for example they had a diagnosis for ADHD, been referred to speech and language therapy, or come into contact with support agencies such as Geeza Break.

5.6 As a result parents reported that their Triple P experience had made them feel they were simply a nicer or better person. Several cited a reduction in the amount of shouting in the household as something which had made them feel much better about themselves.
"I wasn’t always shouting”.
"I was sick of the sound of me shouting”.
"All we ever did was shout”.
"Instead of shouting at your children, you’re told about being positive, and being consistent"
"I feel much better myself now that I'm not constantly on their backs".
"I'm not getting as frustrated now and I'm keeping calm".
"I feel a lot more confident now, he still tries to push the boundaries but it's all about being consistent and not giving in".

(Parents)

5.7 Several parents said they had made new and good friends by attending the group discussions and some have stayed in touch after the sessions.

5.8 Very few parents had anything negative to say about the impact of Triple P. One suggestion was that parents learned nothing new because it was obvious “common sense” while another parent, who was training in child education, said she preferred to experiment with different strategies.

5.9 Parents said they had passed on tips and recommendations to friends and family and they surmised that these parents would also benefit.

5.10 Primary Care practitioners - who had an ongoing relationship with the parents - reported that they had witnessed these impacts on parents. They reported that parents were using the tools and strategies provided and that positive changes were evident that benefitted the whole family.

"Children like it. Families like it. You can see it working”.
(Health Practitioner)

“Confident parents means confident children which makes everyone's job easier”.
(Education Practitioner)

“I feel it's a great tool and it works for parents, it makes a difference for families”.
(Social Work Practitioner)

5.11 Some practitioners had more mixed views about the impact of Triple P on parents. They suggested that for some it was a quick intervention around a specific issue such as bedtime but would not necessarily lead to more fundamental changes in parenting. One practitioner described Triple P as “more work without more impact” and another
as “no better than common sense but more expensive”. These views relate to the
degree to which some parents are ready for and engage in Triple P as discussed in the
previous chapter; they also relate to the negativity some practitioners expressed
towards issues such as training, inflexibility and pressure to deliver which were
discussed in the previous chapter.

“When I first started delivery I did it a lot and was giving myself a pat on the back for
implementing this new programme. Then I noticed it was having little or no effect on
the families I work with. It's seen as a solution for high tariff families - I see an
increasing number of social workers thinking it will solve things, but in my experience it
doesn't work because it requires sustained and intense effort from parents who aren't
ready or willing for that kind of approach”.

(Health Practitioner)

Children

5.12 Parents reported dramatic changes in their children’s behaviour. A wide range of
impacts were reported including

- improved communication
- an understanding of rules, boundaries and consequences
- improved sleeping and eating patterns
- less arguing and fighting between siblings
- more quality time for the whole family
- positive feedback from professionals including teachers, nursery nurses, and
  social workers.

5.13 There was also a suggestion that there was an economic benefit, in that improved
toilet training saved a considerable amount of money on nappies.

Practitioners

5.14 Practitioners mostly highlighted the impact on parents and children and found it more
difficult to reflect on the impacts for themselves, despite being asked for their views.
When pressed, practitioners mentioned improving their links with other agencies - it
had helped their relationship with other professionals and they had a better
understanding now of different roles. This was mainly Triple P Group practitioners
who co-facilitated groups with other professionals. It also included a small number of
Primary Care practitioners who had strengthened links to other professionals such as
Social Work.

5.15 Practitioners also mentioned that they took satisfaction as a professional from seeing
the positive impacts on parents and children described above. They referred to Triple
P’s reputation as an ‘evidence-based programme’ and said they enjoyed delivering a
programme which they knew had been shown to work.
“I get a lot out of it, very rewarding and you can see how it changes their behaviours in school”.

(Education Practitioner)

5.16 On a personal note, practitioners reported that the knowledge gained from training in and delivering Triple P had helped them improve their own parenting skills.

5.17 However, practitioners also expressed negative views about the impact of having to provide Triple P evidence and data, as discussed in the previous chapter.

Stakeholders

5.18 Stakeholders provided a broader strategic perspective and additional examples around the impact of implementing the Glasgow City Parenting Support Framework and Triple P. The main impacts revolved around:

- Collective understanding that parenting is a key component of the support that all services need to offer to families and that each agency has a role in contributing to that programme
- The establishment of Triple P as the primary delivery mechanism for parenting support across a range of agencies in Glasgow
- The emergence of a body of staff, team leaders and service managers who are enthusiastic about and committed to the delivery of Triple P
- A significant number of parents and families that have benefitted from Triple P
- A shift in the way that services are delivered to families and a new approach to improving outcomes for children. This has fed into other strategic developments such as the focus on Nurture
- Examples of innovation, for example a successful approach to parent engagement at one nursery described as “Tea, Toast and a Talk”
- An ongoing process of reflection and learning, leading to improvements in the co-ordination of the programme
- The identification of further areas for development work including in social work and the third sector, and the need for additional capacity in the delivery of enhanced and specialist Triple P.
6 CONCLUSIONS AND RECOMMENDATIONS

6.1 This final chapter sets out the overall conclusions and recommendations from this qualitative evaluation of the implementation of the Glasgow City Parenting Support Framework. The conclusions cover the key themes of this report – training, pre-delivery, delivery and parent engagement, and impact.

6.2 Overall, the views and experiences of stakeholders, practitioners, and parents were mostly positive and demonstrate that the Framework has been a significant influence on parenting support in the City, not least in the establishment of Triple P as the main parenting support intervention in Glasgow. A comprehensive training programme has led to extensive delivery by a wide range of staff across agencies in both the public and third sectors and these practitioners have engaged numerous parents in a variety of Triple P sessions. The feedback suggests that Triple P is both feasible and acceptable to stakeholders, practitioners and parents in Glasgow as the main parenting support intervention.

Training

6.3 Chapter 2 reports that practitioners’ views on Triple P training were broadly split between recent trainees who volunteered for the training and were generally positive about it, and those who were originally nominated for the training and had more mixed experiences. Although training practices have changed, the experience of a minority of those who trained in the past continues to colour their present perception of Triple P and as a result they may not have embraced the programme in a positive manner. We recognise that this is a difficult issue to tackle, but we recommend that parenting support updates are rolled-out to practitioners containing a module where negative views are confronted head-on and challenged. This issue should of course be seen in the broader context of the overwhelmingly positive views expressed by the majority about the quality of the training content and the trainers.

6.4 Practitioners who are most interested in delivering Triple P should be the focus of future training, including those from professions within health and elsewhere who have not been the focus of training to date; clearly this will require support from senior figures within those services. The forthcoming training for Social Workers in Triple P Levels 4 and 5 is welcomed as it should help address issues around commitment and readiness of Group and Primary Care participants, some of the gaps in delivery for parents of children with specific needs, and occasional views on disruptive Group participants, highlighted in Chapter 4.

6.5 Consideration should be given to establishing a small peripatetic team of specialist Triple P practitioners who concentrate on delivery, alongside the existing model. Additional capacity, the opportunity to build up skills, and the freeing up of other professionals’ time are the main benefits envisaged from such an approach. One potential drawback is financial although further investigation would be required, taking all factors into consideration, to assess whether this would be cost effective.
There was support for the establishment of such a team among the Workshop participants although this was not universal and discussions highlighted a number of caveats including carefully defining the team’s role.

6.6 **Awareness raising sessions** - along similar lines to the CPD sessions developed for the One Glasgow Early Years establishments – should be delivered to a targeted audience of professionals working with families. One potentially significant impact of such activity is extending the reach of the programme. The evidence suggests that while anecdotally more parents are aware of Triple P, there is a need to promote it more widely and more accurately among parents and practitioners.

**Pre-delivery**

6.7 Chapter 3 highlighted that the pre-delivery stage was generally viewed positively by parents and practitioners. First impressions among parents were mostly positive, and pre-delivery information and support were adequate for most parents. The negative views expressed by a minority of parents and practitioners have informed the following recommendations.

6.8 **Awareness raising among practitioners with responsibility for referrals, to ensure that Triple P is promoted as a universal programme and that practitioners are fully aware of the different types/Levels of intervention available for different kinds of families.** Alongside targeted awareness raising sessions support material such as simple flowcharts or an interactive online tool, and an aide memoire, should also be developed. An awareness-raising programme along these lines could reduce the opportunities for inappropriate referrals and address the experience of some parents who felt they were not offered appropriate options on the type of interventions available, as highlighted in Chapter 4. The information relayed to practitioners also addresses the issue of flexibility in the delivery of Triple P which was identified during this evaluation.

6.9 **As a general rule, parents should be provided with more information about Triple P during initial discussions about referral, with detailed information provided to those who request it.** Pre-delivery needs should also be discussed with parents as a means of checking readiness and potential commitment to the programme which have been raised as issues in this report.

6.10 **The supply of Triple P resources should be improved** if at all possible as this was a cause of frustration for some practitioners. Although a relatively minor issue it could improve the perception of the programme and have a significant knock-on effect.

6.11 Practitioner feedback on marketing was mostly negative, while relatively few parents had any recollection of it. Therefore, **future marketing should be targeted and focused around clear, simple and engaging messages, emphasising that Triple P is a universal service with potential benefits for any parent in Glasgow.** Incorporating feedback from Glasgow parents who have already benefitted from Triple P has, we understand, been incorporated into recent advertising and should continue to be a
feature of future marketing. Workshop participants also suggested making use of social media, the parenting portal, and local practitioners to spread the message.

**Delivery and parent engagement**

6.12 Chapter 4 recorded widespread delivery among practitioners from many organisations who were generally positive about the experience. Delivery within Health, particularly Health Visitor teams, has been particularly extensive. We also noted examples of good practice among practitioners in some nursery, third sector and library settings. Generally, delivery within Education, Social Work and the third sector has been less widespread but the plans to expand and refocus delivery in these sectors would, in our view, be a welcome addition to the reach of parenting support in Glasgow. In particular we believe the third sector has been underutilised to date and with further support and encouragement has the potential to reach and engage a wide variety of parents including disadvantaged groups such as Glasgow’s BME community, parents with substance misuse issues, disabled parents, lone parents, and families where children have additional support needs. Workshop participants highlighted that targeted training and widespread awareness raising in the third sector could play an important part in supporting parental readiness and thereby increasing engagement; they also highlighted that consideration was important of existing third sector funding arrangements and the impact it may have on the sector’s future involvement in implementing the Parenting Support Framework.

6.13 The Triple P content and resources were viewed positively by the vast majority of practitioners and parents. This applied to both Primary Care and Group and in most cases the interventions were appropriate to the needs of the parents. We recommend that wherever possible practitioners are given protected time to prepare for Triple P Group delivery including contacting participants which could improve attendance, although we acknowledge this may be difficult to implement, particularly in the current climate of public sector cuts. In addition, Group facilitators should be provided with appropriate information on the participants in advance as the feedback has been that more detail would be welcomed.

6.14 Chapter 4 highlighted that the main issue around non-engagement, raised by both parents and practitioners, was a lack of commitment or genuine interest in parenting support and the concept of ‘readiness’ was specifically discussed. Therefore, guidance on ‘readiness’ should be developed and distributed to all practitioners who could potentially refer parents to Triple P to provide clarity on this issue. Workshop participants discussed practical steps to consider parental readiness and suggested this could include making readiness a specific question on the One Glasgow Joint Support Team assessment.

6.15 The flexibility of Triple P delivery was also highlighted in Chapter 4 as a significant issue among practitioners. Some practitioners’ main complaint about Triple P was that it was inflexible. However others commented on how they “tweaked” delivery to fit specific circumstances and these practitioners appeared to be among the most positive and effective of those we consulted. Although the Central Parenting Team has emphasised to practitioners that the programme is designed to be flexible our
consultation shows that some practitioners are not aware of this. We therefore recommend that fresh information on flexibility is conveyed to all practitioners, although this needs to be carefully developed to ensure it is accurate and unambiguous, as highlighted by Workshop participants.

6.16 Although the monthly returns were not an issue for the majority of practitioners, where it was a concern it tended to be a significant one which affected their overall views of the programme. The main issues were: the time to complete the forms, a belief that it conveyed a lack of trust, pressure to meet Triple P delivery targets, and the feeling the returns were a tick box exercise. It may therefore be useful to communicate to practitioners why the monthly returns are required and what use they are put to.

6.17 Another monitoring issue widely mentioned was the under-reporting of delivery activity with practitioners reporting a significant amount of delivery going unreported, or under-reported. We propose that consideration is given to revising the monthly returns to take account of this valuable delivery which many practitioners suggested ‘goes under the radar’.

6.18 Implementation of the Framework has been dominated by Triple P. This strong focus on Triple P is generally viewed positively. Triple P is seen as a successful programme which can be embedded into or can underpin almost all aspect of working with families. The Framework promotes the use of Triple P alongside other parenting tools when appropriate and there is no requirement that Triple P must be used exclusively. However, some practitioners suggest that this is not the reality of implementing the Framework and feel that they have to use Triple P even in those situations where another tool might be more suitable. This can lead to a more general resentment about other aspects of the programme, such as the need to monitor. We understand that the updated Framework addresses this issue and it is hoped this leads to practitioners feeling more able to apply their professional judgement regarding the most appropriate evidence-based parenting intervention.

Impact

6.19 Chapter 5 highlighted the impact to date of the Parenting Support Framework on parents, their children, practitioners and wider impacts identified by stakeholders. Parents’ knowledge, skills, and confidence to address their children’s behaviour were frequently described as a significant impact which in turn led to improvements in their children’s behaviour. Other positive impacts on parents’ health and wellbeing, particularly their mental wellbeing, were also noted. For their part practitioners highlighted acquiring new skills, making new contacts and a feeling of professional pride. Stakeholders identified key impacts including a collective understanding that parenting is a major component of the support that all services need to offer to families and that each agency has a role in contributing to that programme, as well as the establishment of Triple P as the primary delivery mechanism for parenting support across a range of agencies in Glasgow.
6.20 Views about longer-term impacts on families were less certain and stakeholders expressed an interest in learning about the lasting effects of the programme in the years to come. We commend the monitoring and evaluation activity currently being undertaken by the University of Glasgow and recommend that any findings are widely shared to allow for continuous reflection on and responses to the additional evidence base.

6.21 Some of the issues with the minority of discontented Triple P practitioners result from outdated information and a poor understanding of the broader delivery context. Underpinning that is a concern that decisions being made at a higher level are not based on a real understanding of their work. An overarching review of communications with practitioners would be a useful exercise.

6.22 Overall, this qualitative evaluation has reported on the positive views and experiences of stakeholders, practitioners and parents involved in the implementation of the Glasgow City Parenting Support Framework.