



AN EVALUATION OF 'PARENTS UNDER PRESSURE'

A PARENTING PROGRAMME FOR MOTHERS AND FATHERS WHO MISUSE SUBSTANCES

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Impact and Evidence series

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

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EXECUTIVE SUMMARY

Background

Not all parents who misuse drugs or alcohol present a danger to their children; nevertheless, parental substance misuse can place babies and children at increased risk of maltreatment. Almost half of the families who were part of a serious case review between 2011 and 2014 misused alcohol or substances (Sidebotham et al, 2016). Substance misuse is often only one of a number of difficulties faced by these families, and these multiple adversities present a cumulative risk to children. The NSPCC is particularly concerned about risks to babies and young children given their greater vulnerability to maltreatment (Cuthbert et al, 2011) and as the scale of parental substance misuse has become clearer. Around 93,500 babies under the age of one in the UK are living with a parent who is classified as a ‘problematic’ drinker (Manning, 2011).

Parents Under Pressure (PuP)

Parents Under Pressure (PuP) is a home-visiting service that aims to provide parenting support to parents who are in treatment¹ for drug or alcohol misuse. This is with the aim of improving the quality of the parent–child relationship and reducing the risk of child maltreatment. The programme is underpinned by an ecological model that aims to address the complex and multiple problems inherent within these families and offers a structured yet non-sequential process of therapy. Mindfulness is a key aspect of the programme and the proposed mechanism of change, helping parents to recognise and regulate their emotions and be fully present throughout daily interactions with their child. Previous evaluations of PuP in Australia with the parents of children aged 2–8 years, and in the UK with pregnant mothers, found it to have a positive impact on parental wellbeing, parenting attitudes, child abuse potential, and outcomes for the child.

The NSPCC has delivered PuP since 2011 across eleven sites in England and Scotland. The service was initially delivered to families with parental substance misuse with children aged under two, but this was later extended to children aged under five. It was planned that the PuP programme would be delivered over a 20–24-week period.

1 Treatment is defined as attendance at specialist drug and alcohol treatment programmes with a named drug/alcohol worker. Those who only access self-help programmes like Alcoholics Anonymous or Narcotics Anonymous, or drop in facilities at drug clinics or needle syringe exchange programmes, are not considered to be in receipt of treatment.

Evaluation of PuP

There are two evaluations of the NSPCC's implementation of PuP, both of which received full ethical approval from the NSPCC's Research Ethics Committee. Seven of the eleven NSPCC sites participated in the randomised controlled trial (RCT) that was commissioned from the University of Warwick (Barlow et al, 2018). This RCT explored the impact of PuP on child abuse potential, parental emotional regulation, parental psychological functioning, parenting stress, and infant/toddler socio-emotional adjustment. Outcomes were explored at the end of PuP and at six-month follow-up alongside a process evaluation and cost-effectiveness analysis. The RCT is reported on elsewhere and can be found here: <http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C7030>.

Alongside the RCT, an analysis has been undertaken of the practice measures used by practitioners during the PuP programme using a larger sample of parents (n=166) across all eleven NSPCC sites. The measures are all self-reported by parents/carers and explored the parent's wellbeing, mindful parenting and social support, along with their perception of their child's social and emotional adjustment. The measures were conducted at three time-points; at the beginning of PuP; half-way through; and at the end of the programme. This evaluation aims to complement the RCT by focusing on understanding more fully the pattern of change that occurs during the programme and factors affecting change among the parents receiving PuP.

The analysis in this paper aims to answer the following six questions:

1. What is the demographic profile and the needs of the parents and children who access PuP?
2. Are there any differences between the parents (and their children) that start, but do not complete, PuP compared with those who complete the programme?
3. Is there evidence of change for the parents and children who complete the programme? How does change occur over time?
4. What factors are associated with the change experienced by parents and children during PuP?
5. Does the safeguarding status of children change during PuP and are there any predictors of change?
6. What do we know about the fathers enrolled in PuP?

Findings

Of the 223 parents who were eligible to take part in this evaluation between February 2012 and March 2017, 74 per cent (n=166) consented for their measures data to be used in this evaluation. This is the largest evaluation of PuP to date. Of the 166 parents taking part in this evaluation, 40 were also included in the RCT (24 per cent of this evaluation sample).

There were few differences between the parents who did and did not provide evaluation consent. However, our evaluation findings are likely to be more representative of mothers than fathers and of parents with more than one child than those with just one child. The findings are also likely to be skewed towards parents who were involved with the PuP programme for longer, and possibly towards the parents of children with greater social-emotional and behavioural problems.

Profile of the parents accessing PuP

The parents accessing this programme had experienced multiple adversities alongside their substance misuse, including domestic violence, financial difficulties, relationship difficulties, criminal activity and mental ill-health. The majority (84 per cent) were receiving input from children's services, highlighting the varying levels of risk posed to the children in these families. Nevertheless, the measures data collected during the PuP assessment showed that around two thirds of parents self-reported normal or low levels of symptoms of depression, anxiety and/or stress. The majority also reported good support from at least one significant person in their lives, few daily parenting challenges and safe levels of alcohol consumption. Given the level of adversities experienced by these parents, we would have expected their self-reported emotional wellbeing to be lower and their experience of daily parenting challenges, and potentially their alcohol consumption, to be higher. This discrepancy may be related to a tendency for parents to under-report problems in the early stages of involvement with the programme. This issue was also raised by practitioners in the interviews carried out for the NSPCC-commissioned RCT (Barlow et al, 2018).

Programme completion

The PuP programme was generally effective in retaining parents, with two thirds of parents completing either the full version of the programme or the amount of work (dose) that was deemed appropriate during assessment. This is similar to other versions of the programme delivered in Australia and the UK. However, the programme was delivered for an average 8–10 weeks longer than the 20–24 weeks recommended by the programme developers. This is

likely to be due, in part, to the way in which programme duration was calculated based on NSPCC recording systems. The average number of sessions received by those who completed PuP was 20. Parents with lower family support and those who had other children who had been removed from their care at the time of assessment were the most likely to complete the programme. These parents may have been more invested in the programme as they may have had more to gain from it. However, there is also the possibility that some parents felt they had little choice but to engage given they had previously had their children removed from their care.

Change for parents during PuP

We identified significant positive change in parental emotional wellbeing, levels of mindful parenting, family, friend and total support, and parents' experiences of daily parenting challenges during the programme. Specifically, there were 41 parents who started PuP with a moderate to extremely severe level of emotional symptoms (depression, anxiety and/or stress) and 78 per cent of these parents improved to normal or low levels by the end of PuP. This is in line with the findings from the previous evaluations of PuP and the NSPCC-commissioned RCT of PuP (Barlow et al, 2018), which also found significant change in parents' levels of depression at six-month follow-up. While the RCT did not measure change in mindfulness, interviews with parents who received PuP suggested that parents engaged well with this aspect of the programme. The only areas assessed in the current evaluation that did not significantly change during PuP were practical and emotional parenting support.

The most significant change for parents appeared to occur within the first half of the programme, and these changes tended to be sustained or slightly improved on in the second half. Coupled with the findings from the NSPCC-commissioned RCT of PuP (Barlow et al, 2018), these findings suggest that parents make significant improvements between assessment and half-way through the programme, sustaining this change until six-months after PuP completion.

Change for children during PuP

We included one child-focused measure in this evaluation, which explored parents' perceptions of their child's (aged 1–3 years) social-emotional and behavioural problems and competencies. This limits what we can say about the children of the parents accessing PuP, as measures were only completed and analysed for 17 children. We identified significant positive change in parents' reports of their child's social-emotional competencies from the start to the end of the programme, highlighting the potential for change. However, there were no significant changes in social-emotional and behavioural

problems. The NSPCC-commissioned RCT of PuP did not identify significant change in either of these areas at the end of PuP or at six-months follow-up (Barlow et al, 2018). It is likely that we would need to assess children after a longer period of time for the changes in parents and parent-child interaction to become embedded and have an impact on the child's functioning.

The analysis of change in safeguarding status highlighted an overall trend for reduced risk of child maltreatment for the families taking part in PuP. The number of children on a child protection plan reduced by a third by the end of PuP (from 47 to 29) and the number of children who were *not* involved with children's services almost doubled (from 15 to 25). A third of parents experienced reduced children's services surveillance in line with the findings from the NSPCC-commissioned RCT (Barlow et al, 2018), which identified a reduction in child abuse potential in 31 per cent of the PuP sample. However, one in seven parents experienced increased children's services surveillance and the number of children who were removed from their parent's care rose from two to seven. The level of intervention parents received from NSPCC practitioners throughout the PuP programme may have helped professionals gain a more informed assessment of the family's needs. As such, increased children's services surveillance and the placement of the child outside of the family will have been designed to reduce the risk for the child. The safeguarding status of around half of the cases did not change by the end of the programme.

Which parents make the most significant changes during PuP?

Our findings suggest that around one third of the parents who access PuP will show significant improvements in their emotional wellbeing along with a reduced risk of maltreating their children (as evidenced by a reduction in children's services intervention). A quarter of the parents appear to make significant improvements in their levels of mindful parenting. These findings are in line with the previous evaluations of PuP, which have also demonstrated change for around a third of parents (Barlow et al, 2018; Dawe & Harnett, 2007; Harnett et al, 2018). Our evaluation explored which parents were most likely to benefit from PuP and found that the parents with clinically significant levels of depression, anxiety and/or stress appear to have benefited the most regarding their emotional wellbeing.

What do we know about the fathers who access PuP?

Our small case study of 10 fathers taking part in this evaluation (representing 42 per cent of all fathers who accessed PuP) suggests that they are very similar in their characteristics and needs to the mothers who accessed PuP. However, they may present with a greater experience of additional adversities on top of their substance misuse,

such as greater levels of domestic violence, criminal convictions, and recent experiences of trauma. More needs to be done to engage fathers in future evaluations of the PuP programme as we know relatively little about their needs and the progress they make. Due to the small sample of fathers included in this analysis, these findings are limited and should not be generalised to all fathers receiving PuP.

Further developments of the measures used in the PuP programme and future evaluations

The high evaluation consent rate (74 per cent) and the reasonable level of measure completion at all three time-points (55 per cent of the evaluation sample completed measures at T3) suggests that the PuP measures and associated evaluation were acceptable to parents and practitioners. Nevertheless, we would recommend a review of the measures used as some were under-developed and had not been 'normed' using a wider population sample. Given the high number of adverse life events and trauma experienced by these parents, it may be useful to connect with the ACE (adverse childhood experiences) agenda and consider use of the ACE assessment tool and measures of trauma. Future evaluations may also wish to consider incorporating reports from additional respondents in order to gain a more accurate assessment of the primary caregiver and child's functioning. Measures of defensiveness or socially desirable reporting could also be included to assess the reliability of the parents' reports. Including a measure of parent-child interaction or child abuse potential would also be useful to help understand the potential impact of the programme on the children, as would a longer follow-up period to assess change for children.

Limitations of the evaluation

This evaluation did not include a control group of parents who did not receive PuP and we are therefore unable to confidently attribute our findings to the PuP programme. However, the NSPCC-commissioned RCT of PuP does include a control group and also includes a number of the same parents and measures included in this evaluation. As the RCT also reports a number of significant positive changes for the parents receiving PuP (Barlow et al, 2018), we can more confidently attribute the change seen in our evaluation to this programme.

Around a quarter (26 per cent) of the parents who participated in PuP did not consent for their measures to be used in the evaluation, which may have led to biased findings. However, we found few differences between the parents who did and did not consent to the evaluation. The reliability of the data collected through parents' self-report of their functioning in areas like their emotional wellbeing,

mindful parenting and alcohol consumption is also questionable, and future information gathering would benefit from drawing upon additional informants. Finally, we had missing data on a number of the demographic variables and therefore the prevalence of certain characteristics reported in this evaluation are likely to be higher.

Conclusion

This is the largest evaluation of the Parents Under Pressure programme and demonstrates the potential for families who are facing multiple adversities (alongside substance misuse) to make positive changes with support. Parents accessing this service had better emotional health and greater levels of mindful parenting at the end of PuP, and a third of parents were deemed to pose less of a risk to their children. Within the context of the NSPCC-commissioned RCT (Barlow et al, 2018), these findings suggest that PuP is an effective programme for improving outcomes for parents, which are likely to improve the quality of the parent-child relationship and reduce the risk of child maltreatment.

The programme appears to be acceptable to parents as demonstrated through the high parental retention rate. Those parents who seemingly have the most to gain from the programme are the most likely to stick with it and make greater significant changes. Commissioners may therefore consider prioritising the programme for parents with low familial support, those who have previously lost the care of some of their children, and those with moderate to extremely severe levels of self-reported depression, anxiety and stress. The most clinically significant levels of change appear to take place during the first half of the programme and are sustained throughout the latter half. Longitudinal analysis is necessary to explore whether these programme effects are maintained after programme completion, but the RCT findings (Barlow et al, 2018) suggest that this is likely until at least six-months post-intervention. Further research would be needed to see if the programme effects were sustained for longer.

AN EVALUATION OF 'PARENTS UNDER PRESSURE'

Background

Not all parents who misuse substances present a danger to their children, but parental drug and alcohol abuse is frequently a risk factor in child protection cases. For example, for 39 per cent of children on a child protection plan in 2016 in Scotland there were concerns regarding parental substance misuse (Bentley et al, 2017)². Analysis of 293 serious case reviews between 2011–2014 revealed that almost half of these families misused alcohol or substances (Sidebotham et al, 2016). Indeed, substance abuse and alcohol misuse were common among the parents of the 31 babies, aged 0–19 months, who died suddenly and unexpectedly. Other issues like domestic abuse, frequent house moves, and the general chaotic lives of the parents were also prevalent within these cases. This echoes the findings from other research that reports the common co-occurrence of parental substance misuse, domestic violence and mental health difficulties (Brandon et al, 2009). These multiple adversities present a cumulative risk to children (Sidebotham et al, 2016).

The scale of parental drug and alcohol addiction has been a hidden problem, but the scale of need is becoming increasingly clear. For infants, for example, analysis of the Psychiatric Morbidity Survey (Manning, 2011) suggests:

- Around 79,000 babies aged under one year in England are living with a parent who is classified as a 'problematic' drinker. This is equivalent to 93,500 babies across the UK.
- Around 26,000 babies aged under one year in England are living with a parent who would be classified as a 'dependant' drinker. This is equivalent to 31,000 babies across the UK.
- Around 43,000 babies aged under one year are living with a parent who has used an illegal drug in the past year. This is equivalent to 51,000 babies across the UK.

2 Parental substance misuse can be listed as a specific additional concern for placing children on the child protection register or a child protection plan in Scotland, where only the main concern (relating to the type of child abuse and neglect) is recorded in England, Wales and Northern Ireland.

- Around 16,500 babies aged under one year are living with a parent who has used Class A drugs in the past year. This is equivalent to 19,500 babies across the UK.

These numbers are concerning given the vulnerability of such young children to maltreatment, as discussed by Cuthbert et al (2011) in their *All Babies Count* report. They note, for example, that:

- almost half of all serious case reviews in England (45 per cent) involve a child aged under one;
- approximately 10 per cent of all children subject to a child protection plan are aged under one;
- and most strikingly, children aged under one face around eight times the risk of child homicide compared with other age groups.

In April 2016, the NSPCC launched a new strategy with the aim of making five million children safer over five years. One of the five goals for this strategy is to prevent child abuse in families facing adversity, including substance misuse, and the Parents Under Pressure programme has been implemented to help achieve this. Learning about the best ways to protect children and prevent abuse and neglect is at the heart of what we do at the NSPCC. Through a rigorous cycle of developing, delivering and testing our services, we learn what works. We then share our knowledge to support policymakers, commissioners and those working directly with children and families. Parents Under Pressure has gone through this cycle of development and evaluation within the NSPCC with a view to sharing our learning and helping partner organisations to take on this service to improve outcomes for children.

Parents Under Pressure (PuP) Programme

Parents Under Pressure is a home-visiting service that aims to provide parenting support to parents who are in treatment³ for drug or alcohol misuse. The service was developed in Australia (www.pupprogram.net.au/) and was originally designed for ‘multi-problem high-risk families’ who have children aged 2–8 years.

The programme recognises that parents using substances typically experience problems across multiple domains of family life and functioning, including child behaviour problems, mental health difficulties, and social isolation. It is therefore underpinned by an ecological model that aims to address the complex and multiple problems inherent within these families, within the context of a coherent treatment model. This includes parent and child wellbeing, parent–child interaction and attachment, family relationships, and the broader social environment including the availability of social support. The programme follows a manualised approach to intervention, yet the order and dose in which the content of the modules are delivered to the families is tailored to meet individual need. As such, it offers a structured, non-sequential process of therapy.

The PuP model is delivered over 20 weeks and aims to help parents develop their parenting skills and build positive and secure relationships with their children. The programme focuses on the things the parents do well in order to build their confidence (ie a ‘strengths-based’ approach). Professionals work with parents to help them: understand their child’s development; tune in and respond to their child’s emotions and needs; and improve the way they interact with their child. The programme contains 12 modules, starting with assessment and checking out priorities and goal setting. Working with the PuP practitioner during assessment, parents identify the additional modules from the following list that would be helpful for them to focus on:

- view of self as parent
- managing emotions when under pressure
- health-check your child
- connecting with your child: mindful play

³ Treatment is defined as attendance at specialist drug and alcohol treatment programmes with a named drug/alcohol worker. However, the criteria was relaxed slightly so that those who were on an opiate substitute script and seeing a GP were classed as ‘in treatment’. Those who only access self-help programmes like Alcoholics Anonymous or Narcotics Anonymous, or drop in facilities at drug clinics or needle syringe exchange programmes, are not considered to be in receipt of treatment.

- mindful child management
- managing substance use problems
- extending support networks
- life skills
- relationships.

A final session is spent reflecting on the parents' achievements over the course of the programme. Each session lasts 1–2 hours and additional case management work may occur outside of the treatment sessions if required by the family, focusing on issues like housing.

A variety of methods are used to deliver the programme, including video feedback, completion of 'Parent Workbook' exercises, and mindfulness exercises. Mindfulness is a key aspect of the programme and the proposed mechanism of change, helping parents to recognise and regulate their emotions and be fully present throughout daily interactions with their child.

While the service was originally designed for parents of children aged 2–8 years, the NSPCC initially limited the referral criteria to the parents of children under the age of two years because of the increased risk of harm for younger children, as discussed above. While there is evidence of the effectiveness of PuP with families with children aged 2–8 years (see proceeding section), the NSPCC wished to address the evidence gap for this programme with the younger children.

The NSPCC started delivering the service in 2011 and it was rolled out across 11 sites. It proved more challenging to generate referrals for the service than anticipated, however, as new referral pathways needed to be developed outside of children's services (for example, with drug and alcohol teams) and to identify possible referrals within these and gain a family's consent to the programme. As such, the eligibility criteria were extended in May 2014 to families with children up to the age of five to maximise programme uptake. Some of the sites were participating in the [NSPCC-commissioned RCT](#) of PuP and the upper age limit for entry into the RCT was 2.5 years (Barlow et al, 2018). Hence, for those teams, children up to the age of 2.5 were randomised between usual services or usual services plus PuP, but all referrals of children aged between 2.5 and up to five could be accepted for PuP in the usual way. Children up to the age of five were included in the service evaluation.

In addition to the child's age, the other eligibility criteria for the service was that the primary carer should:

- have a problem with substance or alcohol abuse
- be accessing substance misuse treatment
- not be in a relationship where there is active and ongoing domestic abuse
- have a named social worker for their child if there are recognised social care issues
- be able to understand spoken English.

Where the parent was pregnant and did not have other children who were under the age of five, they could be enrolled on the PuP programme with a view to it starting when their baby was born. If the parent was not currently caring for their child, they could start PuP as long as they were having weekly contact and there were plans for reunification.

NSPCC practitioners who delivered PuP were qualified social workers who received training over two days on the theoretical basis of the programme, with a one-day follow-up training session and ongoing clinical supervision. Practitioners became accredited in delivering PuP when they had completed three PuP cases under the supervision of the programme developers and had written a case study.

Previous evaluations of PuP

Previous evaluations of the PuP programme in Australia have demonstrated positive outcomes for participating parents. A randomised control trial (RCT) involving 22 methadone-maintained parents (of children aged 2–8 years) receiving PuP found that these parents showed statistically significant improvements across multiple domains of family functioning (Dawe & Harnett, 2007). This included a reduction in rigid parenting attitudes, child abuse potential, and child behaviour problems, and these improvements were significantly greater than for the control group of parents who received standard care. There were similar findings in a case study of 10 families accessing PuP in Australia, eight of whom benefited from the PuP programme in a clinically meaningful way (Harnett & Dawe, 2008). In addition to the above outcomes, parental emotional wellbeing, parent–child interaction, parental social support and parenting daily challenges were also found to improve. The Australian version of PuP, delivered over 10–12 weeks, has also been shown to have a good parental retention rate (Dawe & Harnett, 2007), which is promising given the difficulties of engaging families with multiple risk factors, including substance misuse, in treatment services.

More recently, a UK evaluation of PuP for pregnant women (Harnett et al, 2018) found it to be effective when applied to 31 mothers who received the programme from 18 weeks' gestation until their infant was 12 months old. When their infant was two months old, the mothers receiving PuP had significantly reduced levels of depression, anxiety and stress, and significantly improved social support. Their drinking patterns, however, did not change. For 42 per cent of parents receiving PuP, there were also improvements in the safeguarding status of the child, with looser restrictions placed on the parent by the end of the programme.

Finally, an economic evaluation of the PuP programme in Australia has demonstrated the programme's financial and social benefits. Dalziel et al (2015) concluded that for every 100 families receiving the PuP programme, 20 would be diverted out of the child protection system as PuP reduced their risk of child maltreatment. They suggest this could translate to a net saving of £1.7 million for every 100 families treated through PuP on the basis that there would be 20 fewer cases of child maltreatment.

Despite these positive findings, previous evaluations of PuP show that it does not effect change for all parents. For example, Dawe & Harnett (2007) found that 36 per cent of families deemed "high risk" for child abuse and neglect at the outset of the study remained "high risk" by the end. Additionally, Harnett et al (2018) found that 26 per cent of the pregnant mothers receiving PuP had legal care proceedings instigated immediately post-birth compared with none of the mothers receiving routine care. However, this is interpreted by the authors as a positive finding, suggesting that in these cases the outcomes of the assessment and work carried out through PuP helped social workers make better and timelier decisions about the placement of these babies, thus preventing further harm and disruption to their placements. In future evaluations of PuP, it is important to explore which parents the service may work for and why.

NSPCC evaluation of PuP

To assess the implementation and impact of the PuP programme within a UK context, the NSPCC has commissioned an RCT of the service (carried out by a team of researchers at the University of Warwick) and have conducted their own service evaluation.

The RCT has been designed to evaluate the impact of the programme on child abuse potential, parent–child interaction and parental wellbeing (Barlow et al, 2013; 2018). Parents are assessed on entry to the study and then randomised into the services-as-usual group or PuP plus services-as-usual group. Parents are reassessed by the research team at two further points: six months later – which would correspond roughly with the end of the PuP treatment programme – and a further six months afterwards to explore the sustainability of any changes. It also explores user experience of PuP along with the cost-effectiveness of the programme. The RCT focuses only on parents with children under the age of 2.5 years and was carried out across seven of the 11 NSPCC service delivery sites. It ran concurrently with the NSPCC service evaluation and has been reported on separately. The RCT report can be found here: <http://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C7030>

The NSPCC service evaluation has been designed to complement the RCT, drawing upon a larger sample of parents across all the NSPCC delivery sites. By focusing on the characteristics and needs of service users with a larger sample, it helps to strengthen the generalisability of the RCT findings. It is also able to look in more detail at service delivery, focusing on factors like programme attrition. Two of the outcome measures used in the RCT are included in this evaluation (measure of parental emotional wellbeing and parents' perceptions of their child's social-emotional functioning) and 40 of the parents who took part in the RCT also took part in the service evaluation (24 per cent of the total evaluation sample). However, this study also explored a number of different outcomes for parents compared with the RCT and looked in more detail at change in mindful parenting, which underpins the PuP programme. We were also able to explore the process of change experienced by parents during PuP as we had a half-way assessment and could explore whether any factors predicted change. Finally, the NSPCC evaluation involved more fathers than in the RCT intervention group and previous evaluations of PuP, facilitating a case study exploration of the fathers participating in PuP. It is important to note that while we looked at areas of change for parents, the lack of a control group of parents who did not receive the service means we cannot comment on programme impact as we do not know if any change would have occurred irrespective of PuP.

Through the NSPCC service evaluation, we sought to answer six key research questions:

1. What is the demographic profile and the needs of the parents and children who access PuP?
2. Are there any differences between the parents (and their children) that start, but do not complete, PuP compared with those who complete the programme?
3. Is there evidence of change for the parents and children who complete the programme? How does change occur over time?
4. What factors are associated with the change experienced by parents and children during PuP?
5. Does the safeguarding status of children change during PuP and are there any predictors of change?
6. What do we know about the fathers enrolled in PuP?

Methods

Eligibility criteria for the evaluation

For parents to be eligible for the PuP service evaluation, families had to meet the eligibility criteria listed above. Two other criteria had to be met for inclusion in the evaluation:

- the parents had to give evaluation consent (see next section), and
- the practitioner working with the family had to be accredited in delivering PuP.

Evaluation process

Practitioners explained the NSPCC evaluation of PuP to all parents agreeing to undertake assessment for the programme and invited them to take part. If a parent said yes, this was recorded, and the NSPCC evidence team were notified so they could include information collected from that parent in the evaluation. Consent to the evaluation was gained separately to consent for receiving the programme and parents were assured that their participation in the evaluation would not influence the service they received.

All primary carers, regardless of whether they were taking part in the evaluation, were asked to complete a series of questionnaires and standardised measures during the first few assessment sessions (called Time 1 measures, or T1). These measures were used primarily to inform practice, allowing the practitioner to gain baseline information on the child and parent's wellbeing, along with the parent's alcohol use, significant life events within the past year, daily parenting struggles, and current and desired levels of social support. Parents repeated these measures mid-way through the programme to assess progress (Time 2 measures; T2), and at the end of the programme as an indicator of progress over the course of the programme (Time 3 measures; T3). Practitioners then entered the measures data into a service database held by the programme developers for scoring and interpretation. These measures were selected by the programme developers to help practitioners gain a better understanding of parents' needs during assessment and to explore progress made throughout the programme. If the parent consented to taking part in the evaluation, the information collected through these measures was downloaded from the PuP database each month and sent to the NSPCC Evidence Team to be included in the evaluation.

This evaluation was given full ethical approval from the NSPCC's Research and Ethics Committee.

Measures used

Eight measures were completed by parents for the PuP service and evaluation⁴. One of these measures assessed social-emotional and behavioural problems and competencies in infants aged 1–3 years. This measure was completed on the child for whom the referral to PuP was made. However, if the parent had more than one child within this age range then the parent focused on just one child; either the younger of the children or the child they felt they had the biggest parenting challenges with. The remaining seven measures assessed the parent's emotional wellbeing, alcohol use, daily parenting challenges, significant life events within the past year, levels of actual and ideal parenting support, social support, and their levels of mindful parenting.

Table 1 within the separate Technical report provides a description of these measures and the number of parents completing each measure at T1, T2 and T3. The measure of infant social-emotional and behavioural functioning (BITSEA) and parental emotional wellbeing (DASS) were also used in the NSPCC-commissioned RCT of PuP. The remaining measures were used only in this evaluation.

Demographic questionnaire

Practitioners also asked the parents who consented to the evaluation to complete a demographic questionnaire during the initial assessment to provide some baseline information on their substance misuse, current circumstances like their employment status, and children (for example, number of children, the status of any intervention by children's services, etc.). This demographic questionnaire was only used for evaluation purposes and, where the parent had more than one child, we collected data on the child for whom the referral to PuP was made. Where the parent had multiple children, they were asked to focus on the youngest child, or the child that presented them with the greatest parenting challenges. However, three parents who took part in the evaluation chose to complete the demographic questionnaire on a child aged 5–8 years and the demographic data on these children were included in the final analysis.

The questionnaire included a set of four screening questions to assess the presence of domestic violence (HITS scale; Sherin, Sinacore, Li, Zitter & Shakil, 1998), along with a short, five-item measure of substance use dependency (Severity of Dependence Scale [SDS]; Gossop et al, 1995). Further details on these measures can be found in Table 1 of the separate Technical report. Unfortunately, 56 parents (34 per cent of the evaluation cases) did not complete the demographic questionnaire and there were additional cases where

4 The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was also administered to measure children's (aged three to five) behavioural and social difficulties and competencies. However, the small amount of completed SDQs meant we could not use the data from this measure in the final analysis.

the demographic questionnaire was incomplete. We therefore used the NSPCC’s case recording system to gain some of the missing demographic information but not all of it could be retrieved due to the level of detail required.

The information collected through this demographic questionnaire was entered into a spreadsheet held securely by the NSPCC. Some parents were enrolled in both the RCT and the NSPCC service evaluation (24 per cent of the NSPCC evaluation cases) and, for these parents, the demographic data was collected by the RCT researcher and passed onto the NSPCC evidence team.

It should be noted that all of the measures included in the evaluation were self-report and completed by the same person (primary carer) throughout the evaluation. Scores were not validated against other sources of information and there was therefore no way of checking for accuracy in the information given, nor for issues that may have influenced the reliability of the data, such as socially desirable or defensive reporting.

Evaluation sample

In total, 223 parents accessed the PuP programme between February 2012 and March 2017 who were eligible to take part in the evaluation and had completed at least one of the service measures for at least one time-point. Of these, 166 parents consented to taking part in the evaluation; a consent rate of 74 per cent. Table 1 provides details of the measure response rates at T2 and T3. See pages 11-13 of the Technical report for further discussion of the evaluation sample and evaluation attrition.

Table 1: Response rates throughout the NSPCC service evaluation of PuP

	Total number of eligible primary carers	Total number of evaluation consents and T1 measures	Total number of parents with T2 measures	Total number of parents with T3 measures
Number	223	166	111	91
Proportion of total number of eligible primary carers	n/a	74%	50%	41%
Proportion of total number of evaluation consents at T1	n/a	n/a	67%	55%

We compared the characteristics of the parents who agreed to take part in the evaluation (n=166) to those who did not (n=57) based on their age, gender, ethnicity, number of children they had, and how long they received PuP for. We also compared their scores on the service measures to explore differences in their needs and levels of social support at the start of the programme. This data had been anonymised prior to use. Tables 2 and 3 in the Technical report provide the data for the comparison of the demographic and measures data.

Our evaluation sample was found to be representative of the wider profile of parents receiving the PuP programme in terms of their age and ethnicity, emotional wellbeing, levels of social support, daily parenting challenges, significant life events experienced within the past year, and levels of mindful parenting. However, fathers were significantly under-represented in the evaluation sample (there were 14 fathers [25 per cent] in the non-evaluation sample and 10 fathers [6 per cent] taking part in the evaluation), as were parents with only one child (24 per cent in the evaluation sample compared with 79 per cent in the non-evaluation sample). Parents taking part in the evaluation also received PuP for a greater number of days than non-consenting parents (median 200 days compared with 144 days, respectively). Finally, the parents taking part in the evaluation reported significantly greater social-emotional and behavioural problems, and significantly fewer social-emotional competencies in their child, than the parents who did not participate in the evaluation. These factors may be interlinked in that parents with more than one child may require greater support and involvement from the PuP programme given the increased parenting demands they face. The higher scores on the child-focused measure may also stem from the parent having a choice as to which child they completed the measure on and they may have focused on the child that presented them with the greatest parenting challenges.

To summarise, our evaluation findings are likely to be more representative of mothers with more than one child than fathers and parents with just one child. The findings are also likely to be skewed towards parents who were involved with the PuP programme for longer, and possibly towards the parents of children with greater social-emotional and behavioural problems.

Data analysis

Information on how the data were analysed can be found in relation to each question within the Technical report along with the data tables to support the findings described below. There was some missing data due to incomplete questionnaires and parents not completing all of the measures at all possible time-points. Where we have reported the percentage of particular characteristics present with the sample, this is the proportion of the whole sample, including those with missing data. Where we have explored change over time, we have done this only for the parents who completed the PuP programme and completed each measure at all three time-points.

Once the data had been analysed, we held a teleconference with a small group of NSPCC staff involved in delivering and implementing PuP⁵ to help interpret the findings. Their feedback has been incorporated into the discussion of this report to help explore the meaning and wider contribution of the findings from this evaluation.

5 This included two team managers, three practitioners, the NSPCC clinical supervisor for PuP, and two Development and Impact managers responsible for implementing PuP within the NSPCC.

Findings

Question 1: What is the demographic profile and the needs of the parents and children who access PuP?

Primary carers receiving PuP

Demographic characteristics

Primary carers were aged between 18–45 at the start of the programme (average age = 31) and the vast majority were female (94 per cent) and White British/Other (92 per cent). The marital status of almost half of these parents was ‘single’ (49 per cent) and 33 per cent of parents were co-habiting. Very few (5 per cent) parents were noted as being in some form of paid employment, while 64 per cent reported that unemployment benefits, disability allowance or single parenting allowance were their main forms of income. Forty-two per cent of the primary carers receiving this programme were known to have committed a criminal offence and 36 per cent of parents had partners who had.

Substance misuse

Almost three quarters (72 per cent) of parents were referred to PuP due to drug misuse, while a quarter was abusing alcohol alone (19 per cent) or with other substances (8 per cent). The primary substance of use was:

- 36 per cent heroin (alone or with another primary substance, such as crack or heroin replacement)
- 22 per cent alcohol
- 14 per cent cannabis
- 13 per cent opiate replacements
- 13 per cent ‘other’ (for example, crack cocaine, benzodiazepines, etc)
- 2 per cent alcohol and cannabis

The vast majority of the 88 parents who completed the Substance Dependency Scale (SDS) reported that they had been dependent on substances within the past month (90 per cent).

Alcohol use. Alcohol intake over the previous six months (based on AUDIT-C scores) fell within safe/low-risk limits for the vast majority (81 per cent) of parents. A small proportion of parents (11 per cent) were classified as abusing alcohol and an even smaller proportion – just 9 per cent of parents – indicated a dependence on alcohol. Of

the 40 parents who were referred to PuP because of alcohol abuse alone [n=29] or alongside drugs [n=11], 55 per cent were drinking at safe levels at T1, 20 per cent at 'abusive' levels, and 25 per cent at 'dependent' levels.

Substance misuse treatment. Parents should have been in receipt of some form of treatment or support for their substance misuse to be eligible to receive PuP: 55 per cent were receiving opiate replacement treatment, 13 per cent counselling, 2 per cent opiate replacement and counselling, and 19 per cent some 'other' form of treatment. For 10 per cent of parents, their treatment status was unknown due to missing information on the demographic questionnaire.

Multiple adversities

Consistent with previous literature (Brandon et al, 2009; Sidebotham et al, 2016), many of the parents who accessed PuP were facing multiple adversities. Almost half (45 per cent) had previously experienced, were experiencing, or had perpetrated domestic violence. In addition, 43 per cent of parents were noted as having been diagnosed with a mental health difficulty and two thirds (66 per cent) of these parents were controlling this through prescribed medication. In the year leading up to assessment, parents reported experiencing an average of four significant life events (ranging from 0–8 events; see Table 4 of the Technical report for further detail). Mostly commonly, these related to major problems in their relationship with their partner, family member or a close friend (68 per cent of parents) and experiencing major money problems (57 per cent). However, the vast majority of parents felt that they had been coping OK with the significant life events they had experienced.

Emotional wellbeing, social support and parenting

Below is a summary of the findings from the measures completed by parents during the assessments. Table 3 of the Technical report provides details on the parents' scores on these measures.

Emotional wellbeing. Around two thirds of parents were scoring in the 'normal' or 'mild' range for stress (for example, difficulty relaxing, nervous arousal, being easily upset/agitated), depression (for example, dysphoria, hopelessness, devaluation of life) and anxiety (for example, racing heart, feeling sick or having "butterflies" in your stomach) in the week prior to completing the T1 assessments (based on the DASS21 measure). The remaining third of parents scored in the 'moderate', 'severe' or 'extremely severe' range of scores for these symptoms. In particular, 27 per cent had extremely severe levels of anxiety, 20 per cent for depression and 14 per cent for stress. Looking across these three areas of emotional wellbeing, just over one third of parents (n=61; 37 per cent) could be classed as having some form

of psychopathology. This is based on them scoring in the severe or extremely severe range in at least one of the above areas.

Social support. When assessed for the PuP programme, the vast majority of parents reported high levels of support from a ‘significant other’ (82 per cent; this person was defined by the parent) and more than half reported high levels of support from their family (56 per cent). On average, the discrepancy between actual and ideal levels of practical and emotional support in relation to the day-to-day tasks of being a parent was very small, suggesting that parents generally received as much support as they would like to receive. Friends’ support was lacking the most, with only 39 per cent of parents reporting high support from friends and the remaining 61 per cent reporting moderate levels of support or feeling unsupported by friends.

Mindful parenting and daily parenting challenges. We were unable to identify any population studies exploring average levels of mindful parenting for the parents of infants using the IMP-I measure. The only study we identified that has used this measure was based on a sample of 72 low-income mothers of infants less than 12 weeks old (Laurent et al, 2017). The mean IMP-I score for this group of mothers was 4.16, which compares with a mean of 3.81 among our sample of 159 parents. This suggests our sample of substance misusing parents, many of whom had children older than 12 weeks of age, were slightly lower in mindful parenting than in this previously reported sample. Out of a possible score of 40, parents scored an average of seven (range between 0–36) on the Daily Parenting Challenges Scale. This suggests that these parents, in general, are reporting fairly low levels of daily parenting challenges.

The profile of the children of the parents receiving PuP

For evaluation purposes, we collected measures data and demographic and safeguarding information on the named child who was referred for the PuP programme. When more than one child was referred, the youngest child or the child presenting the parent with the most parenting challenges was focused on for data gathering purposes.

These children were aged between ‘unborn’ and 101 months⁶ at the start of PuP (average 17 months) and 54 per cent were male. The safeguarding status of these children at the start of assessment varied, yet the vast majority (84 per cent) had some form of input from children’s services. This was most commonly a child protection plan (45 per cent) or Child in Need plan (24 per cent). For 11 per

6 Note that three parents chose to complete the demographic questionnaire for children up to eight years of age: 101, 96 and 66 months respectively. This data has only been included in the analysis of child demographic and safeguarding status and not in the analysis of the child-focused measures data.

cent of children, there were no current safeguarding concerns and the parents were not receiving intervention from children's services. Only 27 per cent of children were residing with both parents and 3 per cent of children were not in the care of the parent receiving PuP during assessment.

The majority of children (aged 1–3) were not classified as having social-emotional and behavioural problems and/or delays or deficits in social-emotional competence based on their parent's scores on the BITSEA (67 per cent and 77 per cent, respectively). However, a third of these children were shown to have potential difficulties in these areas. These figures are presented in Table 5 of the Technical report.

Most parents (79 per cent) had other children aside from the child we collected data on for the evaluation. Of these, 76 per cent were known to be receiving some form of input from children's services (24 per cent were on a child protection plan and 13 per cent on a Child in Need plan) and 23 per cent of these parents did not have these other children in their care at the time of the PuP assessment.

Summary of the profile of the parents and children receiving PuP

These findings suggest that parents are generally functioning well in terms of their emotional wellbeing, are receiving good support from at least their 'significant other' and report low levels of daily parenting challenges. Just one third of parents reported moderate, severe, or extremely severe levels of depression, anxiety, and/or stress. Parents also reported few significant social-emotional or behavioural problems or delays in their children (aged 1–3 years). Given the profile of these parents and the range of multiple adversities they were experiencing, these findings contradict the levels of emotional and parenting needs we would have expected to have identified in the parents being assessed for PuP. Particularly so as the majority of parents had exceeded the high thresholds held by children's services regarding their parenting needs and the risks posed to their children. As such, these findings bring into question the reliability of parents' reports on the measures at the start of the assessment period – an issue that will be explored further in the discussion section of this report.

Question 2: Are there any differences between the parents who started PuP and subsequently dropped out compared with those who completed PuP?

It is important to understand the characteristics of the parents who maintain engagement with a programme compared with the characteristics of those who are unable to complete the programme to the end. Related to this is the importance of understanding the reasons that parents do not complete a programme. By gathering this information, we are able to identify who the main beneficiaries of the programme were and can explore whether further work may be needed to help engage parents who are the most vulnerable to programme drop out.

This information also helps to ascertain whether the outcomes for the parents who complete the programme can be generalised to all parents, or whether there is something different or unique about them.

Programme duration and completion

The programme retention rate for the parents participating in PuP was good.

- Sixty-four per cent of parents completed PuP:
 - 70 per cent of these parents completed the full programme.
 - 30 per cent completed the set amount of work that had been agreed between them and the NSPCC practitioner during assessment. This did not amount to the full PuP programme as this was felt to be unnecessary in these cases.
- Thirty-five per cent of parents did not complete PuP for a number of reasons. This included:
 - 57 per cent of these parents disengaged from the programme.
 - 16 per cent no longer had the care of their children.
 - 28 per cent closed for other reasons as described in Table 6 of the Technical report.
- One per cent of parents were still receiving the programme at the time of data analysis.

Ideally, PuP should be delivered over a 20–24-week period, yet the parents who completed PuP within the NSPCC received an average of 20 sessions over 32 weeks (227 days). See Table 2 below for information on programme duration for those who did and did not complete the programme.

A description as to how we calculated the number of weeks the programme was open for and the type of work included in the PuP sessions is given in page 19 of the Technical report. The reason for the apparent over-running of the programme is likely to be due, in part, to the way in which the programme start and end dates are recorded on the NSPCC’s case recording system. More information on this is provided in the Technical report.

Table 2: The length of time the case was open for and the number of PuP sessions received by the whole sample of parents

		All parents (n=164)	Parents who completed PuP (n=106)	Parents who did not complete PuP (n=58)
Number of weeks open for	<i>Mean</i>	28	32	21
	Range	0–78	12–78	0–48
Number of sessions received	<i>Mean</i>	16	20	10
	Range	2–36	6–36	2–30

Differences between the parents

As displayed in Table 3, there were very few differences between the parents who completed the full programme or agreed programme of work and those who did not (see Tables 7–11 in the Technical report for the associated data tables and statistical analysis). However, parents with lower levels of family support were more likely to complete PuP than those with greater family support⁷. This was the only significant predictor of PuP completion, whereby parents with higher levels of family support at T1 were 0.7 times less likely to complete PuP than parents with lower levels of family support.

Parents who had other children who were not currently in their care had a significantly higher PuP completion rate than parents who had all of their children in their care (79 per cent compared with 56 per cent completion rate, respectively). However, this factor approached, but did not reach, statistical significance as a predictor of PuP completion. Table 12 of the Technical report provides the data for this analysis.

⁷ This difference did not reach statistical significance based on family support scores but was significant when analysing levels of familial support categorised into high/low/moderate categories; fewer of those who did not complete PuP reported low levels of family support compared with those who did complete PuP.

Table 3: Similarities and differences between the parents who did and who did not complete PuP

Similarities	Differences	Significant predictor of PuP completion?
Demographic characteristics <i>(gender, age, marital status, criminal offence)</i>	Family support	Yes
Emotional wellbeing <i>(diagnosed mental health difficulty, scores on the DASS21)</i>	Having other children who were not in their care during the assessment	No
Parenting factors <i>(mindful parenting, daily parenting challenges)</i>		
Characteristics and safeguarding status of the child included in the evaluation <i>(gender and age of child, social-emotional and behavioural competencies and difficulties, living with parent at start of assessment)</i>		
Victim/perpetrator of domestic violence		
Type of substance misuse (drugs misuse versus alcohol misuse with or without drug misuse)		
Level of alcohol use (based on AUDIT-C)		
Significant life events experienced in the past year		
More than one child		
Friendship support		
'Significant other' support		

Summary of the differences between parents who completed PuP and those who dropped out

In summary, the PuP programme was generally effective in retaining parents, with two thirds of parents completing either the full version of the programme or the amount of work that was deemed necessary for them during assessment. Parents with lower family support and those who had other children who had been removed from their care at the time of assessment were the most likely to complete the programme. These parents may have been more invested in the programme as they may have had more to gain from it.

Question 3: Is there evidence of change for the parents and children who complete PuP and how does change occur over time?

Of the parents who completed PuP (full programme or agreed programme of work), 84 per cent completed at least one evaluation measure at all three time-points. This allowed us to look at change over time and patterns of change over time for these parents.

Mindful parenting and emotional wellbeing (as measured using the IMP-I and DASS21 measures, respectively) are the two primary mechanisms of change through which PuP attempts to have an impact on parents. By improving emotional wellbeing and mindful parenting, the programme aims to improve outcomes for children, measured using the BITSEA within this evaluation to explore social-emotional and behavioural difficulties and competencies. The secondary outcomes for parents that we would hope to see improve throughout PuP relate to parents' levels of social support, alcohol intake, and experiences of daily parenting challenges.

For both our primary and secondary outcomes, we measured changes in average scores for the whole group of parents, as well as group changes in parents' levels of need (for example, low, moderate, high) over the duration of PuP. This allowed us to explore the stage of the programme during which the most change occurred (for example, the first half or the latter half). For our primary outcomes, we were also able to explore change on an individual level and to determine whether the amount of change made was clinically meaningful. We first discuss the primary then secondary outcomes for parents, followed by the outcomes for children. All data tables and analysis are presented in the Technical report, pages 26-41.

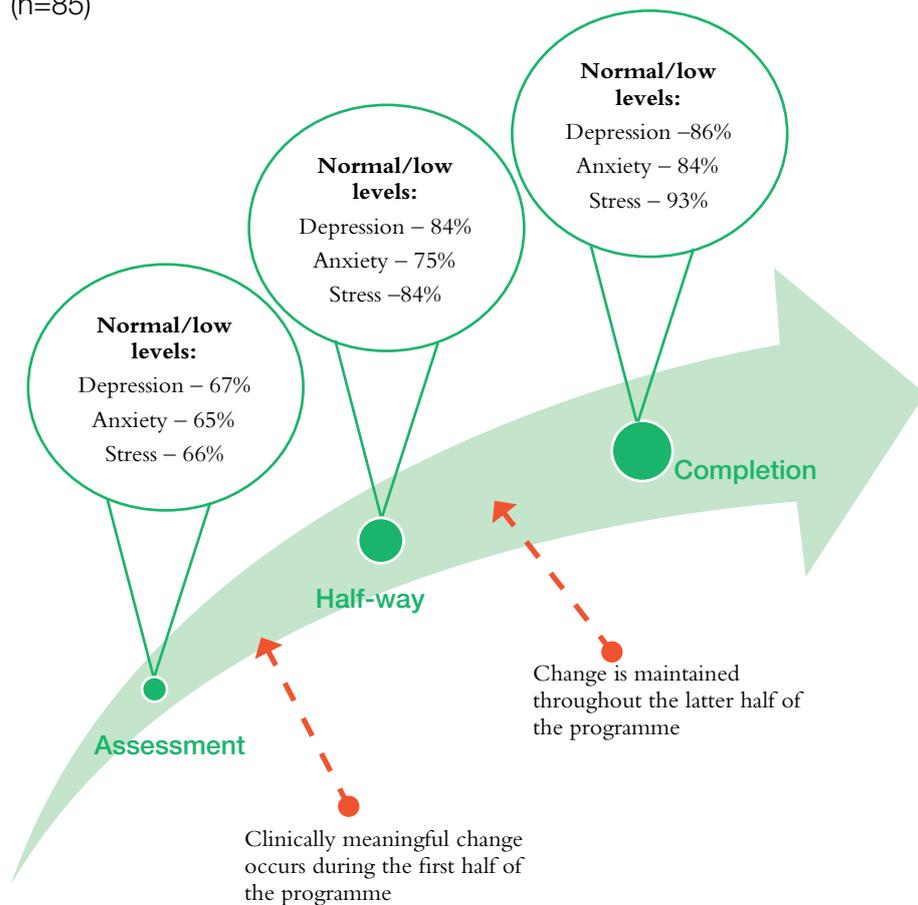
Change in parents' emotional wellbeing and mindful parenting

There was significant, positive change in parents' emotional wellbeing scores (for example, a reduction in scores for depression, anxiety, and stress) and an increase in levels of mindful parenting over the duration of PuP. The greatest significant change took place during the first half of the programme, although further significant change also occurred on these measures during the latter half (except for depression scores). Exploring the relationship between mindful parenting and emotional wellbeing revealed that mindful parenting scores increased as levels of stress, anxiety, and depression decreased.

In the NSPCC-commissioned RCT of PuP (Barlow et al, 2018), there was a significant reduction in parents' depression scores, but not anxiety or stress, between the start and end of PuP (although there was a trend for reduced anxiety) and this change was sustained at six-month follow-up. While the RCT did not measure change in mindfulness, interviews with parents who received PuP suggested that parents engaged well with this aspect of the programme.

Parents' emotional wellbeing scores were grouped into the following clinical categories of need: normal/low, moderate/severe, and extremely severe. As can be seen in Figure 1, parents' levels of depression, anxiety and stress significantly reduced during PuP so that more than 84 per cent of parents finished PuP reporting normal/low levels of symptoms. The significant change in these levels of need occurred within the first half of the programme and levels were maintained throughout the latter half. However, parents' stress levels also continued to significantly reduce throughout the latter half of the programme.

Figure 1: Pattern of positive change in the proportion of parents with normal and low levels of depression, anxiety, and stress during PuP (n=85)

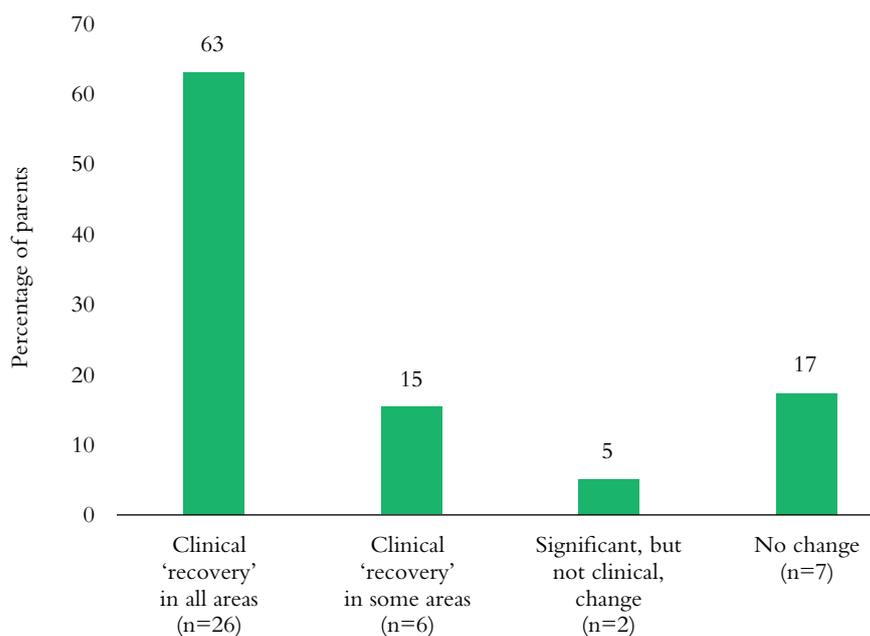


Although the mindful parenting scores changed during PuP, there were no significant group changes in parents' levels of mindful parenting between low, moderate, and high categories. However, the grouping of scores for this measure was based on a statistical calculation for this sample only and not on population norms or clinically validated scores. Most parents fell within the moderate range, which encompassed a large range of scores, meaning that large changes would need to have been made to identify any change in levels of need.

By exploring individual change in emotional wellbeing and mindful parenting (accounting for the reliability of the measures used), we are able to describe the proportion of parents who experienced clinically meaningful change in their emotional wellbeing and mindful parenting during PuP.

At the start of the programme, 41 parents (out of 85 who completed the programme and completed the DASS21 at all three time-points) were displaying moderate, severe or extremely severe levels of depression, anxiety, and/or stress. By the end of PuP, 32 of these parents (78 per cent) had experienced clinically significant change in at least one of these areas so that their symptoms reduced to a 'normal' or low level; we refer to this change as clinical 'recovery' to help with the presentation of the findings in this report. Only seven of these parents (17 per cent) did not show clinically meaningful change in any area of emotional wellbeing (see Figure 2).

Figure 2: Clinical change for parents who completed PuP and started the programme with moderate, severe, or extremely severe levels of symptoms in at least one area of emotional wellbeing (n=41)

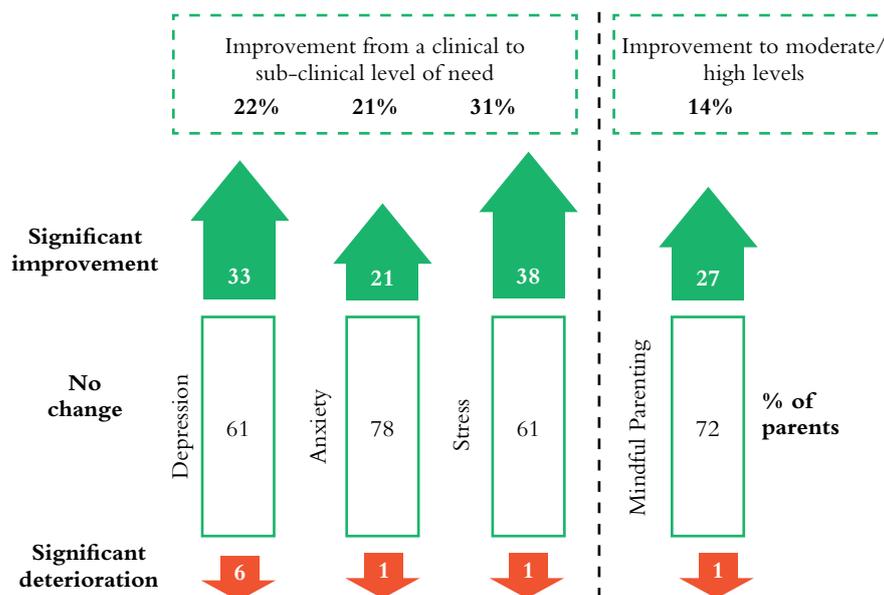


The proportion of parents who showed significant improvement, deterioration or no significant change in each area of emotional wellbeing and in mindful parenting is displayed in Figure 3. Between 21–31 per cent of parents showed significant clinical ‘recovery’ in their symptoms of depression, anxiety, and/or stress so that by the end of PuP they were experiencing low or normal levels of symptoms. This includes all of the parents who were reporting moderate, severe or extremely severe levels of anxiety at the start of PuP (n=19). An additional 7 per cent of parents showed significant improvements in their symptoms of depression and stress, although this either did not change their clinical level of need (the majority of these parents started PuP in the low/normal category) or improved but this improvement was from extremely severe levels to moderate/severe levels.

There were eight parents who experienced some significant level of deterioration in their emotional wellbeing during PuP. Two parents deteriorated from a low/normal level of depression to a moderate/severe level, as did one parent with initially low/normal levels of anxiety. A further three parents experienced significant, but not clinical, deterioration in depression (one who started in the moderate range and two who started in the low/normal range), as did one parent who started with low/normal levels of stress. None of these parents experienced significant change in any other area of their emotional wellbeing (positive or negative) during PuP and no parent showed significant deterioration in more than one area of emotional wellbeing.

Over a quarter of parents (27 per cent) experienced significant reliable change in their levels of mindful parenting between the start and the end of PuP. Of note, 14 per cent of parents (n=11) started with low or moderate levels of mindful parenting and experienced a significant increase in levels, completing the programme with moderate or high levels. An additional 13 per cent (n=10) of parents significantly increased their levels of mindful parenting over the course of the programme but remained in the moderate category. One parent experienced a decrease in their levels of mindful parenting but remained within the moderate category by the end of PuP.

Figure 3: Proportion of parents showing reliable and clinical change in their emotional wellbeing (n=85) and levels of mindful parenting (n=79) during PuP



Change in parents' experiences of daily parenting challenges, alcohol consumption and social support

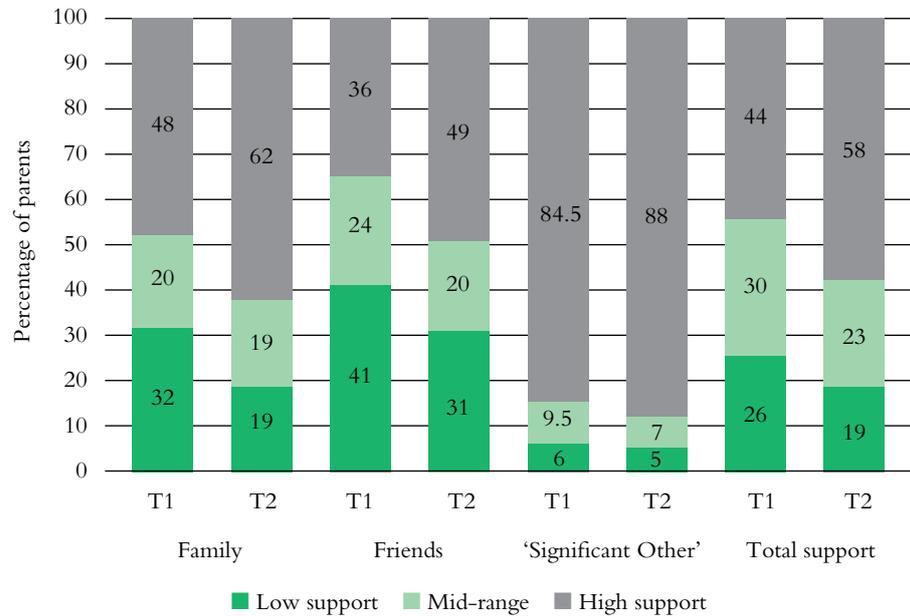
Looking at group scores on the PuP measures, parents showed positive change in most of the secondary outcomes explored. The daily parenting challenges reported by parents significantly reduced during the first half of the programme and continued to decline during the latter half.

There was significant change in parents' drinking patterns during PuP and this largely occurred during the first half of the programme. Four parents (6.5 per cent) were classified as having alcohol dependence during assessment while nine were categorised as abusing alcohol (14.5 per cent). By the middle of the programme, the number of parents considered to be alcohol dependent (n=1) and abusing alcohol (n=5) had reduced by around a half and by the end of the programme 93.5 per cent of the parents were reporting safe or low levels of alcohol consumption (compared with 79 per cent at T1).

As can be seen in Figure 4, there was a significant increase in parents' social support during the first half of the programme in terms of overall support and support from family and friends. For example, the number of parents reporting high levels of support from their family rose from 48 per cent to 62 per cent between T1 and T2. This increase was maintained throughout the latter half of the programme although there was no significant increase during this time period. There was a significant increase in parents' scores regarding support from a 'significant other' during PuP, but the categorisation of support

did not change, most likely because 85 per cent of parents reported receiving ‘high’ levels of support from this person at assessment. There were also no significant changes in parents’ reported levels of practical and emotional parenting support during PuP on a second measure focusing on parenting support.

Figure 4: Change in parents’ levels of social support during PuP (n=84)



Summary of change shown by parents during PuP

In summary, parents made significant positive change in relation to their emotional wellbeing and levels of mindful parenting by the end of the PuP programme. Specifically, around a third of parents showed a significant increase in their emotional wellbeing and a quarter in their levels of mindful parenting. Experiencing change in one of these areas was associated with change in another area. Our secondary analysis showed that parents’ reports of their daily parenting challenges and alcohol consumption reduced, and that their levels of social support significantly increased during PuP. The most significant change for parents appeared to occur within the first half of the programme, and these changes tended to be sustained or slightly improved on in the second half. The only areas assessed that did not significantly change during PuP were practical and emotional parenting support.

Change in infants' social-emotional and behavioural difficulties and competencies

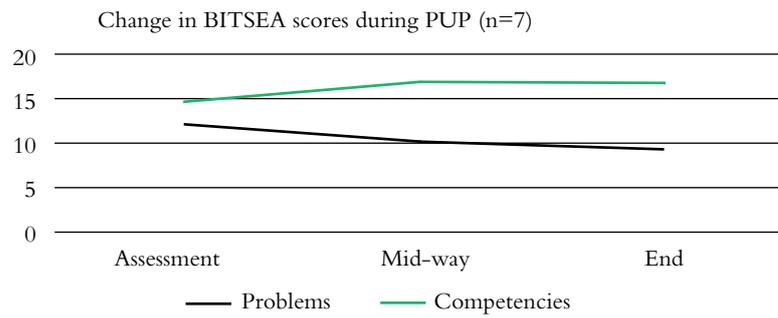
The BITSEA was used as part of the PuP programme to explore parents' reports of their infants' (aged 1–3 years) social-emotional and behavioural difficulties and their social-emotional competencies. The tightly defined age-range of the children this measure focused on contributed to the small number of completed measures, with just 17 parents completing this measure at all three time-points. There may also be bias in the findings from this measure as the parent may have had more than one child within the valid age range and they may have focused their answers on the child who presented them with the most parenting challenges. The findings for children must therefore be interpreted with a level of caution.

We explored change in BITSEA scores over the duration of PuP. Cut-off scores can also be used to indicate whether the child was experiencing possible social-emotional or behavioural problems and deficits/delays in their social-emotional competence. These findings are displayed in Figure 5.

Parents reported no significant change in the levels of their child's social-emotional and behavioural problems over time. However, the number of social-emotional competencies parents reported in their child did significantly increase, and this change appeared to take place during the first half of the programme. Looking at clinical classifications of need, there was a reduction in the number of parents reporting problems and deficits/delays in their children. However, this change was not statistically significant, which may relate to the small sample size included in this analysis, and therefore weaker power to detect change. These findings echo those from the [NSPCC-commissioned RCT](#) of PuP (Barlow et al, 2018), which also failed to identify any group differences in the number of children found to be at risk on either socio-emotional subscale post-intervention or at six-month follow-up.

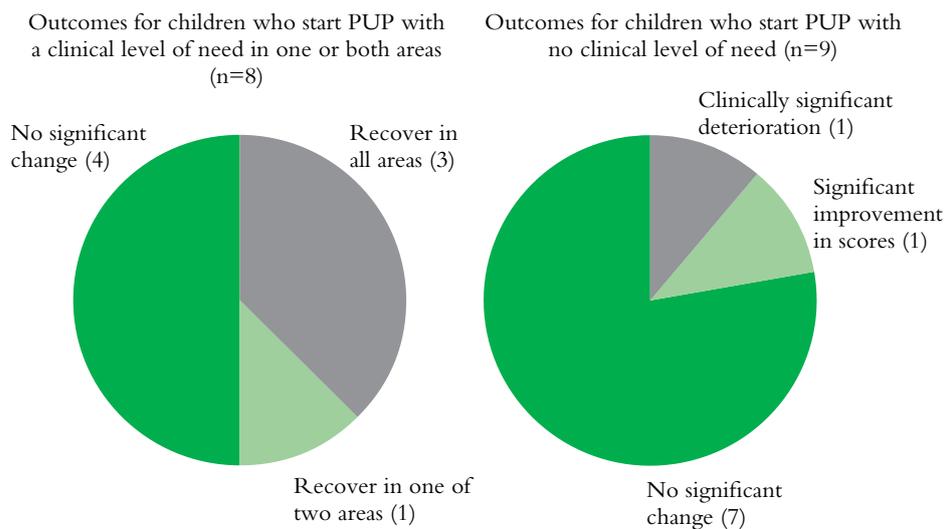
When we look at change on an individual level (bottom section of Figure 5), four of the eight children who were reported to have problems and/or deficits/delays according to their BITSEA scores improved so that they no longer had problems, deficits or delays in these areas. However, there was no change for the other four children who started PuP with a high level of need. There was also significant deterioration for one child who was reported to have no social-emotional and behavioural problems at the start of PuP but finished the programme within the clinical range. There is therefore no clear pattern of change for the children of the parents receiving PuP, as discussed further in the discussion for this report.

Figure 5: Change in the parents' reports of their child's (aged 1–3 years) social-emotional and behavioural functioning during PuP for those who completed the programme (n=17)



Assessment	Clinical level of need	Programme end
2	Clinically significant social-emotional and behavioural difficulties	3
2	Clinically significant deficits or delay in social-emotional competence	3
4	Clinical level of need in both areas	0
9	No clinical problems in these areas	11

← Number of children →



Changes in the BITSEA problem and competencies scores were not significantly correlated with changes in parental emotional wellbeing or mindful parenting. This suggests that parents' reports of the difficulties or delays with socio-emotional and behavioural functioning in their children did not differ as their emotional wellbeing or levels of mindful parenting changed. This should be interpreted with caution given the small number of completed BITSEA measures available.

Summary of change for the children of the parents receiving PuP

The small amount of data collected on the social-emotional and behavioural functioning of the children (aged 1–3 years) of the parents receiving PuP limits our ability to identify change for these children. Nevertheless, the findings suggest that parents reported more social-emotional competencies in their children by the end of the programme. The findings were mixed regarding the change in the number of children reported to be displaying social-emotional and behavioural difficulties or deficits/delays.

Question 4. What factors are associated with change experienced by parents and children during PuP?

An important question when exploring the change made by parents during PuP is whether any particular groups of parents experienced more change than others, and whether any programme-level factors influenced the amount of change made. We explored eight individual factors and two programme factors to see if they were associated with change in parental emotional wellbeing and mindful parenting (our primary outcomes for parents). These are described in pages 43–47 of the Technical report alongside the statistical data. This analysis was carried out only for the parents who were found to show statistically significant change on the measures and therefore the number of parents included in the analysis was small.

The findings suggest that the parents who received PuP did not experience change in a uniform way, and that some of their characteristics may have influenced how much change they experienced. Specifically, having some form of psychopathology, using only drugs versus alcohol or alcohol and drugs, and the age of their child all appeared to be associated with the amount of change parents made in relation to their emotional wellbeing.

Parents classified as having some level of psychopathology at the start of PuP made significantly greater improvements in their levels of depression and stress by the end of PuP compared with parents with no psychopathology. These parents presented with greater difficulties in these areas at the start of PuP and therefore had more room for change.

The amount of change parents experienced in their levels of anxiety was significantly associated with their type of substance misuse and the age of their child. Parents who abused drugs compared with those who abused alcohol or alcohol *and* drugs started PuP with similar levels of stress, yet those with drug misuse experienced significantly greater reduction in their anxiety. In addition, the parents of children over the age of one also experienced greater improvements in their anxiety than the parents of children under one year. However, the parents of these older children had higher anxiety to begin with and therefore had more room for improvement.

Programme factors were not significantly associated with change in emotional wellbeing and we did not identify any factors associated with the amount of change parents made in their levels of mindful parenting.

There were not enough children showing reliable change on the BITSEA measure for us to look at which factors may be associated with change for children.

Summary of factors associated with the change made by parents

These findings suggest that parents who have lower-levels of emotional wellbeing at the start of PuP, those who misuse drugs, and those with children over the age of one may make the most improvement in their emotional wellbeing during PuP. However, the parents accessing this programme have diverse characteristics and a range of needs and do not, therefore, experience change in a uniform way.

Question 5. Does the safeguarding status of the children change during PuP and are there any predictors of change?

Of the 106 parents who completed the PuP programme, we were able to establish the safeguarding status for the children of 96 of these parents at the start and end of PuP. This includes 36 of the parents who also took part in the RCT, and data collection varied slightly depending on whether the parent was part of the RCT or not. In all cases, the parent reported on their child's safeguarding status at the start of PuP using a tick-box questionnaire that listed a range of social care and legal safeguarding interventions (see Table 23 of the Technical report for more detail). For those who were part of the RCT, they also completed this questionnaire at the end of PuP and at six-months follow-up. Where they were not part of the RCT,

however, parents were not asked to report on this at the end of their time with PuP and this information came instead from the NSPCC’s case recording system.

When using parent-reported data, some parents ticked more than one option and for these cases we coded the intervention that was most intrusive/had the greatest level of surveillance in our analysis. We have used this approach to data collection to align the services evaluation with the RCT. However, there are limitations with both approaches to data collection on safeguarding status, which are discussed more in the Discussion chapter and should be borne in mind when interpreting these findings.

Figure 6 displays the change in the number of children on a child protection plan and Child in Need plan, the number of children removed from their parent’s care, and the number of children with no children’s services intervention. There was a small proportion of parents receiving other forms of children’s services intervention that are not displayed in Figure 6 but are discussed in more detail below.

In order to assess change in safeguarding status, we followed a coding system from least to most intrusive (for example, increasing surveillance, as outlined in Table 23 of the Technical report). We have focused our analysis on the official safeguarding status of the child only, but where a child was not living with their parent under a voluntary arrangement (for example, some kinship care), this is discussed in more detail below.

Figure 6: The number of children with differing levels of children’s services intervention before and after PuP (for the parents who completed PuP, n=96)

Start PUP		End of PUP
15	No Children’s Services intervention	25
19	Child in Need	25
47	Child Protection	29
2	Not in the parent’s care	7

No change in safeguarding status

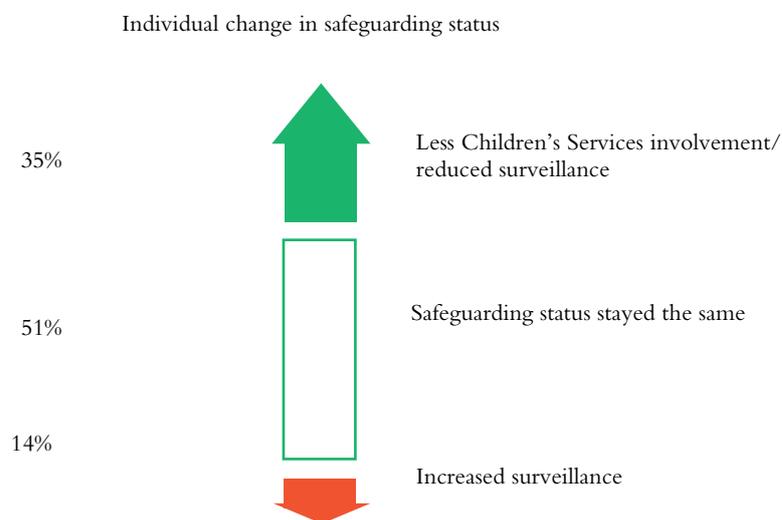
Looking at how change occurred for individual parents who completed PuP (see Figure 7), half (51 per cent; n=49) did not experience any change in the safeguarding status of their children from the start to the end of PuP: 23 remained on a child protection plan, 10 on a Child in Need plan, four ‘team around the child’, one interim care order, and one on a full care order. Ten children continued to receive no children’s services intervention.

Reduced surveillance or involvement from children's services

Over a third (35 per cent; n=34) of parents experienced a change in their child's safeguarding status so that the level of surveillance and involvement from children's services reduced. One went from a supervision order to a child protection plan and three went from pre-legal proceedings to a child protection plan (n=1), Child in Need plan (n=1) and to receiving no children's service involvement (n=1). There were also two parents who went from a Parenting Assessment Order to a child protection plan. An additional 19 parents went from a child protection plan to either a Child in Need plan (n=11), 'team around the child' (n=1) or to receiving no children's services involvement (n=7). It is important to note here that one of the children who went from being on a child protection plan to having no children's services involvement was no longer living with the parent at the end of PuP and was instead in a voluntary placement with grandparents. This was because the mother recognised she was not coping well with the care of her child.

Finally, seven parents went from a Child in Need plan to 'team around the child' (n=2) or to receiving no children's services involvement (n=5), and two went from 'team around the child' to no children's services involvement.

Figure 7: Individual change in the level of surveillance and children's services intervention for the parents and children who completed PuP (n=98)



Increased surveillance or involvement from children's services or removal of the child from the parent's care

Finally, there was a small proportion of parents (14 per cent, n=13) who received greater children's services involvement and greater surveillance over the course of PuP. One child went from an interim care order to a supervision order. Of the four children on a child protection plan at the start of PuP, one became the subject of pre-legal proceedings, one a supervision order, and two an interim care order. In addition, two children went from a Child in Need plan to a child protection plan (n=1) or an interim care order (n=1), and one child went from 'Team around the Child' to 'Child in Need'. Finally, five children who had no children's services involvement at the start of PuP were subsequently placed on either a child protection plan (n=1), Child in Need plan (n=3), or 'team around the child' (n=1). Within this category, four children were no longer living with their parents by the end of PuP.

Children's services involvement with the parents and children who did not complete PuP

We had information on the level of children's services involvement for 47 of the 58 parents who did not complete PuP at the point at which the programme ended. Comparing the safeguarding status of these families with parents who completed the programme revealed no differences between them at the start of the programme. However, 32 per cent of these parents experienced greater children's services involvement and surveillance by the time they finished working with the NSPCC, compared with 14 per cent of the parents who completed PuP. A large proportion of these (28 per cent of the parents who did not complete PuP) no longer had their children in their care at the point in which the programme came to an end, compared with 7 per cent of those who completed the programme. It is important to note, however, that this will be the reason that PuP ended for many of these families, as parents would not have been eligible to continue with PuP if their child had been removed from their care. It cannot be assumed, therefore, to be a negative consequence of their non-completion of the programme.

Increased children's services involvement and the greater surveillance of parents by the end of PuP do not equate to poor programme outcomes. Where children are placed on child protection plans, where legal proceedings are started, or where children are removed from their parent's care at the end of PuP, this may help to improve the longer-term outcomes for the children. The level of intervention parents received from NSPCC practitioners throughout the PuP programme may have helped professionals gain a more informed assessment of the family's needs, contributing to the change in safeguarding status to better protect the child.

Predictors of change in safeguarding status

We explored whether the following factors were associated with change in safeguarding status by the end of PuP:

- psychopathology at T1 (based on whether the parent had severe or extremely severe levels of depression, anxiety and/or stress)
- opiate replacement treatment
- having other children who were not in their care during assessment
- single parenting
- having experienced or perpetrated domestic violence

We did this analysis for all parents for whom we had information regarding their child's safeguarding status at the start and end of PuP (see pages 48 and 49 of the Technical report for more information).

None of these factors were found to be significantly associated with, and predictive of, change in safeguarding status.

Summary of the change in the safeguarding status of children during PuP

To summarise, the number of children on a child protection plan was reduced by a third by the end of PuP and the number of children who were not involved with children's services almost doubled. There was also an increase in the number of children who were removed from their parent's care, which is consistent with Harnett's (2007) argument that greater knowledge of a family as a result of therapeutic input can lead to a more accurate assessment of the family's needs and risks. The safeguarding status of around half of the cases did not change by the end of the programme, while a third of parents experienced reduced children's services surveillance and one in seven experienced increased children's services surveillance. These findings are in-line with those from the [NSPCC-commission RCT](#) of PUP which found a reduction in the clinical risk of child abuse potential amongst a third of families (Barlow et al, 2018). We did not identify any significant predictors of change in safeguarding status.

Question 6: What do we know about the fathers enrolled in PuP?

Ten fathers took part in this evaluation (42 per cent of the fathers who participated in PuP), facilitating a small case study of their profile when they started PuP. It should be noted that a greater number of fathers benefited from PuP as a secondary carer, yet we only collected evaluation data from them if they were a primary carer. The sample was not large enough to statistically compare fathers with mothers to explore any similarities and differences between them. The sample size also prevents us from generalising the findings to all fathers receiving PuP, as does the underrepresentation of fathers in the evaluation.

Demographic characteristics

Three of the 10 fathers did not complete a demographic questionnaire during assessment and others left some of the questions blank.

We therefore recovered as much information as possible from the NSPCC's case recording system. The fathers were aged 22 to 44 years with an average age of 34. Seven were misusing drugs (heroin=3, cannabis=2, opiate replacement=2), two were misusing alcohol, and one was misusing both. Six out of nine fathers had been or were in a violent relationship and four out of eight fathers had been diagnosed with a mental health difficulty, all of whom were currently on medication for this. Of the seven fathers who completed the demographic questionnaire, six had committed a criminal offence, six were unemployed, and all seven were in receipt of financial benefits. The profile of fathers was therefore largely the same as the mothers receiving PuP except that the proportion of fathers with a history of domestic violence (perpetration/victimisation) and a criminal conviction was higher.

All of the fathers were classed as their child's primary carer: four were single fathers and the remaining six were living with their child's mother. Eight out of 10 fathers had children under the age of 2.5 years (average age of the child was 21 months) and half of the children were male. One of these children was living in kinship care at the start of assessment, five were on a child protection plan, one a Child in Need plan, two were not receiving any form of children's services intervention, and the social care status of one child was unknown. Most fathers (n=8) also had other children, seven of whom lived with them (four were on a child protection plan, one a Child in Need plan, and two with no social care intervention) and one whose other children had been adopted.

Programme completion

Seven of the 10 fathers completed the programme (six completed the full programme and one completed an agreed amount of work), while three disengaged from PuP part-way through. The number of weeks that fathers received PuP for and the number of PuP sessions they received are displayed in Table 4. Fathers who completed PuP received the programme for an average of 37 weeks while mothers who completed the programme received it for an average of 32 weeks.

Table 4: The length of time the case was open for and the number of PuP sessions received by all fathers

		All fathers (n=10)	Fathers who completed PuP (n=7)	Fathers who did not complete PuP (n=3)
Number of weeks open for	<i>Average</i>	32	37	20
	<i>Range</i>	10–55	24–55	10–27
Number of sessions received	<i>Average</i>	18	21	11
	<i>Range</i>	5–28	18–28	5–17

Profile of the fathers at the start of PuP

Fathers' emotional wellbeing, social support, and alcohol use at the time of the PuP initial assessment are outlined in Table 26 in the Technical report and are summarised below, along with significant life events, daily parenting challenges and levels of mindful parenting.

Seven of the 10 fathers were reporting 'normal/mild' levels of depression and eight had normal/mild levels of stress and anxiety at assessment. Three fathers had moderate/severe depression and two had moderate/severe anxiety and stress. The fathers' mindful parenting scores were very similar to the mothers. Of the nine fathers who completed the AUDIT, five were drinking within safe/low levels, three were showing signs of alcohol abuse and one was showing alcohol dependency.

Half of the fathers reported low support from friends yet six had high family support and eight had high support from a 'significant other'. Total support was in the low range for two fathers, mid-range for four fathers, and high range for an additional four fathers. However, there was some discrepancy between actual and ideal levels of parenting support at T1, which suggested fathers were receiving slightly more parenting support than what they felt to be ideal.

As with the whole sample of parents, the most common significant life events experienced by fathers within the year preceding PuP were major problems in their relationship with their partner, family member or close friend, and major money problems. Problems with housing and experiencing a major trauma, such as an accident, assault, house broken into, or other traumatic event were also reported by six out of nine fathers. As with mothers, most of these fathers felt they were coping OK with the significant life events they had experienced.

Out of a possible score of 40, fathers had an average score of seven on the Daily Parenting Hassles Scale (range is three to 14). This suggests fathers, in general, were reporting fairly low levels of daily parenting challenges.

Only three fathers completed the BITSEA and none of their scores placed their children within a clinical range regarding social-emotional and behavioural problems or deficits/delays on their social-emotional competencies. We had information on the safeguarding status of nine of the 10 children at the start of PuP; six were on a child protection plan, one a Child in Need plan, and two were receiving no input from children's services.

Unfortunately, we are unable to report on change for the fathers who received PuP as there were only six fathers who completed these PuP measures at all three time-points.

Summary of the findings for the fathers accessing PuP

The small number of fathers included in this evaluation appear to show similar characteristics to the wider sample of mothers receiving PuP regarding their demographic profile, emotional wellbeing, and parenting challenges, and mindful parenting. Most had children's services involvement yet the majority of fathers reported low levels of problems and fairly high levels of social support on the T1 PuP measures. However, a greater proportion of fathers were in, or had been in, domestically violent relationships, had criminal convictions, and had experienced housing problems and major trauma within the past year compared with mothers. The fathers who completed PuP received the programme for longer than mothers. Given the very small numbers of fathers who completed the evaluation, these findings should be treated with caution and be used as a starting point for further analysis with a larger sample.

Discussion

This evaluation sought to establish the profile of parents being assessed for the PuP programme, parents' engagement with the programme, and reasons for non-completion, and the pattern and extent of change displayed by the parents and their children during PuP.

A large proportion of the parents receiving PuP through the NSPCC participated in this evaluation (74 per cent) and we were able to establish the amount of change made by approximately 41 per cent of all eligible parents. This is a respectable evaluation consent and retention rate given the range of difficulties faced by these parents and that drop out from the PuP programme precluded continued participation in the evaluation. The number of similarities between parents who did and did not consent to the evaluation allows us to extrapolate our findings more widely to the cohort of parents who accessed PuP. It also helps to strengthen the generalisability of the [NSPCC-commissioned RCT](#) of PuP (Barlow et al, 2018) given that both samples are similar. However, fathers and parents with just one child are underrepresented in this evaluation, and the findings may be skewed towards parents who received the programme for longer and reported greater social-emotional and behavioural problems for their child at assessment. Additionally, the findings regarding change may be more applicable to parents with lower familial support and possibly to those parents who had experienced other children being removed from their care (prior to assessment) as they were more likely to complete the programme. The findings should therefore be interpreted with these differences in mind.

Profile of the parents accessing PuP

Our findings highlight the diverse needs of this cohort of parents who misused substances and were accessing a parenting programme. The majority of these parents were misusing drugs and 55 per cent were receiving opiate replacement therapy. These parents experienced multiple adversities alongside their substance misuse, including domestic violence, financial difficulties, relationship difficulties, criminal activity, and mental ill-health. This is in line with previous research that has demonstrated the co-occurrence of parental substance misuse, domestic violence and mental health difficulties (Brandon et al, 2009; Sidebotham et al, 2016). The heightened risks posed to the children of these families as a result of these adversities is evident in the level of children's services involvement. For example, 45 per cent of children were on a child protection plan and 23 per cent of the parents who had additional children did not have care over all of their children. This finding supports previous research that has highlighted the prevalence of substance misuse problems among families receiving

children's services intervention (Forrester & Harwin, 2006). The ecological underpinning of the PuP programme is potentially significant, therefore, in order to recognise and help to address the complex and multiple problems experienced by these families.

Despite the range of problems faced by the parents accessing PuP, only a small proportion presented with difficulties during assessment based on the responses they gave on the PuP service measures. Specifically, just under two thirds of parents reported normal or low levels of symptoms of depression, anxiety and/or stress. The majority also reported good support from at least one significant person in their lives, few daily parenting challenges, and only slightly lower levels of mindful parenting than a low-income sample of non-substance abusing mothers of infants (Laurent et al, 2017). These findings are similar to those reported in previous UK and Australian evaluations of PuP. For example, a UK study of 35 pregnant mothers receiving PuP found that two thirds reported normal or low levels of depression, anxiety and/or stress (Harnett et al, 2018). Harnett and Dawe (2008) also found that six of the 10 parents in their Australian case study reported sub-clinical levels of symptoms in these areas when they started the programme.

There may be several reasons for these findings. In our sample, 90 per cent of parents reported substance dependency within the month prior to assessment and their substance use may have therefore influenced their ability to recognise and appraise their own thoughts, feelings, and experiences. Indeed, drug abuse is often an attempt to self-medicate against painful or distressing emotions that the individual is unable to regulate themselves (Khantzian, 1997). Another factor may be the introduction of the T1 measures during the assessment stage, which means the practitioner will not have had the time to build a trusting relationship with parents prior to measure completion. Parents may feel mistrust towards the NSPCC and are likely to be suspicious as to how the information may be used, particularly given the level of children's services involvement and potential fear over losing their children. This may have influenced their honesty and defensiveness on these measures and parents may have chosen to present themselves in a more socially desirable way. Some of the NSPCC practitioners we spoke to during a teleconference to help interpret the findings felt that parents were more honest in their reporting on the T2 measures given that more of a therapeutic relationship had been developed by this time-point. They also felt that parents had a better insight into their difficulties by this point and were therefore able to more accurately appraise their emotional wellbeing and parenting. This was also raised as an issue in the practitioner interviews carried out as part of the NSPCC-commissioned RCT (Barlow et al, 2018).

The reliability of the measures used within the PuP service may be another influential factor. While the measure of parental emotional wellbeing (the DASS21) has been well-validated, some of the other measures were designed specifically for this programme (for example, the daily parenting challenges scale) and others are relatively new and untested (for example, the IMP-I measure of mindful parenting). Our findings may therefore have highlighted problems with the reliability of some of the measures used. Alternatively, the findings may be an accurate representation of how the parents were feeling at the start of PuP. Two thirds of the 43 per cent of parents with a diagnosed mental health difficulty were controlling this through prescribed medication and this may therefore have meant that their mental health difficulties were under control and their symptoms low at the start of the programme. Knowing they were about to receive help with some of their parenting difficulties may also have positively influenced parents' emotional wellbeing and their appraisal of their current parenting stresses.

Engagement of parents in the PuP programme and reasons for programme non-completion

The retention of parents within the programme was good given the complex needs these parents had – 64 per cent of the 166 parents who took part in the evaluation completed the programme. Previous evaluations of PuP in Australia (Dawe & Harnett, 2007; Harnett & Dawe, 2008) have also reported good parental retention rates, whereby 20 out of 22 parents and 10 out of 10 parents respectively completed the programme. However, the Australian version of the programme was designed to be delivered over 10–12 weeks and all parents in the Dawe & Harnett (2007) and Harnett & Dawe (2008) studies received 14 or fewer sessions. In contrast, the NSPCC version of the programme was designed to be delivered in 20–24 weeks, yet it was delivered for an average 8–12 weeks longer than specified. This is likely to relate, in some way, to the recording system used by the NSPCC and the way in which PuP start and end dates were calculated (see pages 18 and 19 of the Technical report for more information). This is likely to have included the initial meeting with the parents and the gaining of their consent for the programme and the evaluation prior to the start of the PuP assessment.

Other factors relating to context and the role of the delivering organisations may also have influenced the length of time taken to deliver the programme. In Australia, parents referred themselves to PuP by responding to posters in methadone clinics (Dawe & Harnett, 2007), or were referred by a non-government agency working with parents who were involved with social services (Harnett & Dawe, 2008). As the studies were efficacy trials, the PuP clinicians delivering the programs were recruited and trained for the trial rather than

existing staff of the agency. Within the NSPCC, PuP practitioners were trained social workers delivering PuP within the wider context of a large charitable organisation that is focused on preventing child maltreatment. As such, it delivers a range of services and tackles a number of issues. The NSPCC practitioners may have therefore carried out a greater amount of additional case management work than the practitioners within the Australian PuP evaluations, given the organisational context within which PuP was being delivered. Parents were also mostly referred for PuP through a third party, such as children's services or substance misuse services, and practitioners may have needed to carry out more engagement work to motivate and retain families within the programme. NSPCC practitioners also noted other factors, such as staff sickness, NSPCC case review meetings and missed appointments, as contributing towards the length of the programme.

Despite these differences between the NSPCC and Australian versions of PuP, the design of the programme appears to have been acceptable to parents and was good at maintaining their participation. This is important as reviews of other parenting programmes for substance misusing parents show how they often struggled to engage parents in these programmes (Suchman et al, 2006). A recent review of 22 studies evaluating programmes that combine parenting intervention with substance misuse treatment reported parent retention rates of between 20–100 per cent (Neger & Prinz, 2015). Of the 10 RCTs in their review (all reporting parental retention rates of at least 50 per cent) those that introduced the parenting intervention a few months after the start of substance misuse treatment were the most successful in retaining parents. As the parents who enrolled on PuP had to have been in receipt of substance misuse treatment before they started the programme, this may be one reason for the good parental retention rate. Based on interviews with parents and practitioners, Harnett et al (2007) also suggest the good parental retention rate for PuP relates to the development of individualised support plans with the opportunity to provide regular feedback and monitoring to parents. This is consistent with previous research findings exploring which factors help to engage and motivate parents to change (Locke & Latham, 2002; Poulsen et al, 2015).

Nevertheless, not all parents who started PuP completed the programme and it is important to understand why this may be. The parents who were the most likely to complete the programme appear to be those who had the most to gain from it. These parents had lower amounts of familial support so may have had a greater need for support from the NSPCC and PuP. Parents who had had children removed from their care were also more likely to complete the programme compared with those who had retained the care of all of their children. Engagement in the programme may have therefore offered

them an opportunity to improve their parenting and to prove to professionals that they were motivated to change in order to regain or retain the care of their child(ren). This finding is interesting as reviews of other interventions for substance misusing parents has highlighted mixed findings regarding the impact of having their children removed from their care on their motivation to engage in treatment (Neger & Prinz, 2015). The current evaluation suggests these two factors may be worth considering when prioritising which parents should be offered intervention through the PuP programme.

Changes made by parents during PuP

Changes in parents' reports on the PuP measures

We collected evaluation measures for 91 parents at assessment, part-way through PuP and at the end of PuP, allowing us to explore their patterns of change through the programme. This is the largest number of parents included in an evaluation of PuP to date. On the whole, there was a significant positive change in parental emotional wellbeing, levels of mindful parenting, family, friend and total support, and parents' experiences of daily parenting challenges. Specifically, 78 per cent of the 41 parents who started PuP with a moderate, severe or extremely severe level of depression, anxiety and/or stress showed statistically significant clinical 'recovery' in one or all of these areas upon PuP completion. That is, they made significant progress in their emotional wellbeing and completed PuP with a 'normal' or low level of symptoms in these areas. This equates to 38 per cent of all 85 parents who completed the emotional wellbeing assessment at all stages of the programme. Just over a quarter of parents also gained significant improvements in their levels of mindful parenting by the end of the programme. These findings are similar to those reported in the NSPCC-commissioned RCT of PuP (Barlow et al, 2018), which also found a significant reduction in parental anxiety during the course of the programme.

These findings suggest that around a quarter to a third of parents show significant improvements in their emotional wellbeing and mindful parenting (our primary outcomes) while receiving the PuP programme. The remaining three quarters/two thirds do not show any significant change, which aligns with the initial finding that only a third of parents started PuP with self-reported difficulties with emotional wellbeing. It should also be noted that a very small number of parents experienced significant deterioration in their emotional wellbeing and mindful parenting during PuP. The true amount of change made by parents in these areas may be higher than we identified during this evaluation, depending on the honesty or accuracy of parents' reports of their symptoms and levels of mindful parenting during assessment.

These findings are largely consistent with those reported in previous evaluations of PuP. This is despite differences in the length of the programme, the ages of the children of the parents receiving PuP (up to 12 months in Harnett et al [2018] and children aged 2–8 years in Dawe & Harnett [2007] and Harnett & Dawe [2008]), and the sample sizes used (ours being the largest). In Australian evaluations of PuP, parents were also found to have experienced significant changes in their emotional wellbeing by the end of the programme (based on overall scores; Harnett et al [2018], or looking at the proportion of parents who show significant reliable change in this area; Dawe & Harnett [2007]), and to maintain these changes six-months later (Dawe & Harnett, 2007). Additionally, our findings replicate those that have shown how parents make significant improvements in their levels of social support (Harnett et al, 2018; Harnett & Dawe, 2008) and daily parenting challenges (Harnett & Dawe, 2008) during PuP. Together, these findings suggest that PuP may be an effective programme in helping to improve parental emotional wellbeing, social support and the perception of parenting daily challenges for the parents of children aged 0–8 years.

However, Harnett & Dawe (2008) did not identify significant change in parents' emotional wellbeing and our evaluation is the first to show significant change in parents' alcohol use during PuP (Dawe & Harnett, 2007; Harnett et al, 2018). The NSPCC-commissioned RCT of PuP also failed to show statistically significant change in anxiety and stress (Barlow et al, 2018). These differences in findings may relate to the larger sample size used in our evaluation, giving us more statistical power to detect change in parental self-report of alcohol use than the other studies. We have also demonstrated change in levels of mindful parenting during PuP that have not been explored in previous evaluations, although the NSPCC-commissioned RCT does note how parents engaged well with the practice of mindfulness, as noted throughout parent interviews.

Changes in the level of children's services surveillance or restrictions on parents

We had safeguarding information on 96 children at the start and end of PuP. From this information, we identified that over a third of parents (35 per cent) experienced a reduction in the amount of surveillance placed on them or the withdrawal of children's services involvement; around a half experienced no change; and one in seven experienced increased surveillance/intervention. These findings are consistent with the findings from the NSPCC-commissioned RCT of PuP, which found a reduction in child abuse potential among 31 per cent of the sample. They are also consistent with the 40 per cent of parents who experienced a reduction in children's services involvement in the Harnett et al (2018) evaluation of PuP

for pregnant mothers. However, 26 per cent of the mothers in their evaluation had legal proceedings instigated by the end of PuP, which is higher than the proportion of parents who experienced increased surveillance or the loss of their child in our evaluation. This difference may relate to the fact that the mothers in the Harnett et al (2018) study started PuP during pregnancy, thus allowing children's services to make an earlier, more informed decision about the best placement of the child to prevent further harm and multiple placements.

Despite the multiple adversities faced by some families, this evaluation shows that change is possible and that concerns regarding the risk parents pose to their children can be reduced. However, there are also some families where greater safeguarding input is made by the end of PuP, resulting in some children being removed from their parents' care. Harnett (2007) described a procedure for assessing parental capacity to change that involves setting clear goals and monitoring progress towards these goals; therapeutic processes that are integral to the PuP programme. Thus, implementing PuP may highlight concerning situations, especially a lack of any change in the family despite the input from PuP. In addition to assessing capacity to change, PuP may provide a common focus and language for the multiple agencies involved with a family, bridging the worlds of children's social care and adult substance and alcohol abuse.

It should be noted that the information on safeguarding status was captured at the start and end of PuP but not part-way through the programme. This means that interim changes in safeguarding status have been missed. Anecdotally, practitioners referred to cases where children's services became involved with families during the PuP programme at a lower level, such as 'Team around the Child', but stopped working with the family by the time PuP was complete. There are likely, therefore, to be additional changes for families regarding the involvement of children's services that have not been captured in this evaluation. It may also be the case that children's services reduce their level of intervention with and/or surveillance of families when they become part of PuP on the basis that they are receiving this intervention and not necessarily because a reduction in risk has been evidenced.

It is important to note the different ways in which the information was gathered regarding the safeguarding status for the parents taking part in the two PuP evaluations; parental-report only for those in the RCT; and parental report (T1) combined with NSPCC case file notes (T3) for those who were in the service evaluation only. There are therefore likely to be differences in the quality and reliability of the information gathered. Parents may feel confused by the legal safeguarding status of their children and have a limited understanding of the statutory terms used. Indeed, some parents ticked multiple safeguarding options on

the parent-report form and, in these instances, we included the most intrusive children's services intervention in our analysis. In contrast, the NSPCC practitioner reports regarding safeguarding status within the parent's case file may be more reliable as practitioners will have a better grasp of the safeguarding system and associated terms. However, the quality and accuracy of the information depended on the detail recorded in the case notes. Future evaluations should consider the most accurate way of gathering safeguarding data.

Which parents benefit from PuP?

As evidenced in previous evaluations of PuP (for example, Dawe & Harnett, 2007), the current evaluation found that the parents accessing this programme do not experience change in a uniform way. It is important to understand which parents are most likely to benefit from PuP as this may help to target any future revisions of the programme. To date, this has not been explored in any previous evaluations of PuP.

Although our analysis was based on a small number of parents who showed significant change, we found that psychopathology (based on parents scoring in a severe or extremely severe range of depression, anxiety, and/or stress), parents using drugs versus alcohol or alcohol and drugs, and the age of the child were all associated with significant reductions in depression, anxiety and/or stress symptoms. Those with psychopathology and children over the age of one had higher levels of emotional symptoms at the start of PuP and more room for improvement in these areas as a result.

These findings, therefore, suggest that PuP may have the greatest impact on the emotional wellbeing of parents with clinically significant levels of depression, anxiety, and/or stress. It is important to note that 'psychopathology' as measured here is based on self-reported emotional symptoms at the start of the programme. The greater change for these parents may therefore reflect something about their willingness to be honest and open with the PuP practitioner and/or a greater insight into their difficulties. This may have influenced their willingness and motivation to engage with the programme. Future implementation of PuP may therefore consider self-reported emotional wellbeing as a factor in prioritising which parents should receive the service.

These findings demonstrate that PuP does not have a significant impact on all parents. This may relate in some ways to the honesty of the parents on T1 measures, which hampers our ability to demonstrate change given that the baseline assessment of needs was low and the T2 assessments may have been higher and more honest. Nevertheless, motivation for engaging in PuP may be something to explore in

future evaluations of the programme in relation to parents' completion of the programme and the amount of change made. This finding may also relate to the complex needs faced by these families and the ability of PuP to be able to address all of the factors contributing to the outcomes we are interested in within a relatively short space of time. There may be more of a need for greater joined-up working with other agencies to address the multiple adversities faced by these families, which will have a cumulative impact on emotional wellbeing and parenting ability. As noted in Dawe and Harnett (2007), more research is needed to explore the mechanisms for change in families facing multiple adversities who access parenting interventions. This will help to better target and adapt the programme to improve the outcomes for more families. What the findings do show, however, is that these parents present with different problems and benefit in different ways from services and therefore an intervention like PuP, which works to address multiple domains of functioning, is likely to offer the most effective approach.

Patterning of change

We explored the way in which parents evidenced changed during PuP, which is an area that has not yet been investigated. This learning is important as it helps us understand how parents change through the programme and this should be developed in further research exploring trajectories of change and associated factors. Note, however, that while we are assuming that PuP is the reason for the change for these parents, and this is largely supported by the overall findings from the NSPCC-commissioned RCT of PuP, we do not have a comparison group in this evaluation and cannot be confident, therefore, that this is the causal factor.

Parents made the greatest significant changes in their emotional wellbeing, mindful parenting, perception of daily parenting challenges, alcohol consumption, and social support during the first half of the programme. Smaller improvements were also made during the second half of the programme in some areas, and in other areas the change made during the first half was maintained (ie did not go up or down) until the end of PuP. The findings from the RCT of PuP (Barlow et al, 2018) also tell us that the change made during the programme was maintained at six-month follow-up. This pattern whereby the most significant change is made during the first half of the programme and is sustained by parents within the latter half of the programme and up until six-months later is interesting. If parents did feel they could report more honestly at T2 than T1, we may have expected the severity of scores to increase by T2, making it difficult to detect positive change, and may have observed a more reliable decline between T2 and T3. As such, we may conclude that parents were reporting honestly at T1 or that the amount of change made during

the first half of the programme was greater than the increased needs that would have been identified through more honest reporting at T2.

Practitioners reflected on the therapeutic relationship between the parent and practitioner, which may be very impactful during the initial stages of the programme and sit behind this initial change. Some of the more significant presenting issues, such as severe depression, are also more likely to be the focus of the initial work through PuP and may therefore show earlier change. By addressing these significant areas of need in the first instance, changes in other areas like the parent–child interaction may be more likely to occur during the latter half of the programme. However, some practitioners felt that the ‘true change’ for many parents occurred during the latter half of the programme. It may be that this stage of the programme is vital in embedding the changes made during the first half of PuP, contributing to the sustained change identified six-months later in the RCT.

The children of the parents accessing PuP

We are limited in what we can say about the children of the parents accessing PuP due to the small sample sizes available for analysis. Nevertheless, we identified significant positive change in parents’ reports of their child’s (aged 1–3 years) social–emotional competencies from the start to the end of the programme – we did not identify significant change in their reports of their child’s social-emotional or behavioural problems. Of the eight children who started PuP with a possible clinical level of social-emotional and behavioural problems and/or deficits or delays, half of these children were no longer reported by their parents to be showing difficulties in one or both areas at the end of the programme. This represents significant improvement for around a quarter of children in this age range.

As noted, the parents accessing this programme were facing multiple problems and a high level of children’s services involvement, highlighting varying levels of concerns regarding their parenting ability and the risk to their children. This suggests that significant and sustained changes would need to be made by parents in order for their children to show improvements in their social–emotional and behavioural functioning. As PuP was delivered for an average of 32 weeks, this may not have been enough time for this change to occur and be highlighted in parents’ reports of their children at the end of the programme. Practitioners noted, however, that closure meetings often revealed changes in parents’ interactions with their children and their perceptions of their child’s behaviour. A measure of parent–child interaction would therefore be useful to capture this change and a longitudinal assessment of children may more accurately show the impact that PuP has on children.

We did find, however, that over a third of parents experienced reduced children's services surveillance by the end of PuP, suggesting that the perceived risks they posed to their children had been reduced. This aligns with findings from other PuP evaluations that have identified clinically significant reductions in the risk of child abuse among one third of parents accessing PuP compared with 17 per cent of those in the control group (Dawe & Harnett, 2007).

Fathers accessing PuP

Our small case study of 10 fathers taking part in this evaluation suggests they are very similar in their characteristics and needs to the mothers who access PuP. However, they may present with a greater experience of additional adversities on top of their substance misuse and appear to experience change in a slightly different way. More needs to be done to engage fathers in future evaluations of the PuP programme as we know relatively little about their needs and the progress they make. Indeed, Harnett and Dawe (2007) found that mothers were more likely to take part in the PuP evaluation than fathers, replicating the findings from our current evaluation. If we are able to learn more about their needs and their engagement in parenting programmes, more may be done to help support them in caring for their children.

Methodology and PuP measures

The measures used for this evaluation of PuP are those used to help inform practice during the programme, as chosen by the PuP programme developers. The high evaluation consent rate (74 per cent) and the reasonable level of measure completion at all three time-points (55 per cent of the evaluation sample completed measures at T3) suggests that embedding the measures within the programme, and making this part of practitioner accreditation, increases the likelihood that they will be completed and that parents will consent to these being used for evaluation purposes.

Future evaluations may wish to consider incorporating reports from additional respondents in order to gain a more accurate assessment of the primary caregiver and child's functioning. A partner or close family member, for example, could also report on the primary caregiver's emotional wellbeing, parenting skills, etc to triangulate the information and validate parents' self-reported information. Behavioural observation of parent-child interaction and parenting may also provide additional information to help assess parents' levels of mindful parenting, and these have been found to correlate well with parent-reported IMP-I scores (Duncan et al, 2015; Gannon et al, 2017). Secondary caregivers or (nursery) teachers could also report on the behaviour and social-emotional functioning and wellbeing of

the child in order to provide a more reliable exploration of the child's functioning and wellbeing. There are two versions of the Strengths and Difficulties questionnaire (Goodman, 1997), for example, that can be completed by the child's nursery teacher or school teacher (aged 2–4 and 4–17, respectively) and could corroborate the parent's report of their child's emotional symptoms, peer relationships and behaviour.

Measures of defensiveness or socially desirable reporting could also be included among the PuP measures. These assess the respondent's repression of unpleasant emotional experiences and negative emotional affect in order to preserve vulnerable self-esteem (see Norem, 2009; Uziel, 2010). This may be relevant to this population of adults given their substance misuse, which is likely to be a way of repressing traumatic past experiences or emotions (Khantzian, 1997). Indeed, Dawe and Harnett (2007) found that 12.5 per cent of the 64 parents in their evaluation of PuP were 'faking good' on their responses to the measure of child abuse potential.

It seems important to include more assessment of the parents' interaction with their children and their parenting ability in future evaluations of PuP to move the focus on from exploring mainly the parents' thoughts, feelings and recent experiences. Inclusion of the Brief Child Abuse Potential Inventory (B-CAP; Ondersman et al, 2005) to explore the risk of child maltreatment, or a measure of parenting style and parent-child interaction, for example, would help extrapolate these findings further to consider impact on the child. The B-CAP also includes a measure of 'faking good', 'faking bad' and 'random response', which would help to assess the reliability of parents' reporting on the measures. An assessment of past trauma and adverse life experiences would also be useful, using something like the Adverse Childhood Experience (ACE) Questionnaire (2017; www.knowledge.scot.nhs.uk/deciderskills/aces.aspx). This would help practitioners to understand the range and impact of the parents' trauma, which would seem appropriate given the range of adversities that parents in this study had faced or were currently experiencing. A fuller understanding for the practitioner is likely to generate a more meaningful relationship with parents and to better inform how PuP is delivered and what other challenges may need to be addressed.

Finally, the PuP measures include an assessment of mindful parenting and this is one of the key mechanisms of change underlying the programme. However, measures of mindful parenting (as opposed to general mindfulness) are relatively new and untested. The IMP-I, in particular, has not been used in a large sample of mothers caring for young children and has not been tested or validated on a large population of parents. The reliability of this measure is therefore unknown and means we are unable to compare the levels of mindful parenting reported by our sample of parents to a normed population

of parents. As such, it is unclear if mindful parenting is low, moderate or high in the PuP group. Nevertheless, we did identify change in levels of mindful parenting using this measure and the proportion of parents who showed change in this area was largely consistent with the proportion of parents who showed change in their emotional wellbeing.

Limitations of this evaluation

There was no control group of parents who were not receiving PuP to compare the amount of change made and we are not able to state, therefore, whether the change occurred as a result of PuP. Other factors may have contributed to change, such as substance abuse treatment and the involvement of other agencies. There was also no longer-term follow-up past the end of the programme to explore how change was sustained. Nevertheless, the RCT of PuP commissioned by the NSPCC (Barlow et al, 2018) includes many of the parents involved in this evaluation and does have a comparison group and six-month follow-up. This shows change for the parents accessing PuP in a number of areas and we can therefore be more confident that the change for these parents was related to the PuP programme and is likely to be sustained for at least six-months after PuP.

All of the measures used in this evaluation were self-report and we have some concerns over the reliability of the information given by parents, particularly during assessment. There was also a high level of missing data regarding the demographic profile of parents (for example, diagnosed mental health difficulty) and therefore the prevalence of certain characteristics reported in this evaluation are likely to be higher than we were able to report.

Conclusion

This evaluation includes information on 166 parents and explores change in around 85 parents, representing the largest evaluation of PuP to date. It complements the findings from an RCT of PuP that has been commissioned by the NSPCC (Barlow et al, 2018), by exploring the pattern of change made by parents during the programme. Together, these reports help us understand the trajectory of change for parents through the programme and at six-month follow-up. The current evaluation also provides a more detailed exploration of the needs of the parents who access PuP, the differences between parents who do and do not complete the programme and places a focus on what we know about the fathers who access the programme.

The evaluation findings highlight that parents who misuse substances and access a parenting programme like PuP are likely to have complex needs and experience a range of multiple adversities. However, PuP and the associated evaluation (using service measures) appear to be acceptable to parents with a good parental retention rate and a large proportion of parents agreeing to their data being used for evaluation purposes.

Not all parents maintained their engagement with the programme, and change is experienced differently by parents with different characteristics. Those who have low family support when they start the programme and those who have lost the care of their other children may be the most motivated to engage or participate in PuP. Parents who have more to gain, by regaining the care of their other children or retaining the care of the child they still have, may also make the most significant change in their parenting capacity. This is evidenced by the greater proportion of these parents experiencing reduced social services involvement by the end of the programme. Additionally, parents with the greatest emotional difficulties may also make the most significant positive changes in these areas of functioning. If necessary, these three factors could be considered at the referral stage and when accepting parents onto the programme in order to target those most likely to engage and make changes throughout.

The evaluation highlights a significant positive trajectory of change for parents from the start to the end of PuP in all of the primary and secondary outcomes assessed (with the exception of child social-emotional and behavioural difficulties). Around a third of parents demonstrated clinically relevant, significant change in their emotional wellbeing, levels of mindful parenting and ability to parent their child without significant social services involvement. However, there was no significant change in the remaining two-thirds of parents,

which may be because they are functioning well at the start of the programme, as suggested by the baseline measures. However, the programme may also prompt subtle, but non-clinical, amounts of change that alters the trajectories of these families and their ability to parent their children.

Future evaluations of the programme should consider the reliability and validity of the PuP measures used, particularly for assessment purposes, and try to incorporate alternative respondents (for example, partner report and observed interaction between parent and child) and measures of socially desirable or defensive reporting. It should also include more of a focus on the outcomes of the programme for parenting styles and parent–child interaction in order to more directly explore the potential impact of the programme for the children. Considering how long we would need to follow up these children before we could expect to see a change in their functioning would also be useful.

This evaluation has a number of limitations, not least the lack of a control group to allow us to attribute the change made by parents to their participation in the PuP programme. However, it provides promising evidence that the PuP programme is effective at maintaining parental participation and that those who engage in it show positive change in a number of areas. The NSPCC, in collaboration with the PuP programme developers, are now considering the possibilities and opportunities for PuP within the UK.

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