Exploring parenting support in the wider Greater Glasgow and Clyde area: phase two of a qualitative research study

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Note: To support the reader's understanding of the terms used within this report, a glossary is presented at the end of the paper. All terms described in the glossary are shown in bold within the text.

Executive summary

Background
Positive family relationships and parenting play a vital role in promoting healthy child development. In recognition of the importance of this agenda, in 2009, NHS Greater Glasgow and Clyde launched a Parenting Support Framework. At the outset, **Triple P** was adopted as the main parenting programme. In addition to **Triple P**, a wide range of other interventions, support programmes and approaches have been utilised by health, social work, education and third sector staff across Greater Glasgow and Clyde.

Study aim
The aim of this research was to provide services and agencies involved in commissioning or delivering parenting interventions across the Greater Glasgow and Clyde area with a better understanding of the range and extent of parenting support currently on offer, and to make recommendations for future service delivery. The research builds on an earlier piece of work with the same aim which focused specifically on the Glasgow city area[1].

Methods
Face-to-face interviews were conducted by researchers during late 2016. Seven informants within Inverclyde, East Renfrewshire, Renfrewshire, East Dunbartonshire, and West Dunbartonshire Health and Social Care Partnerships (HSCPs) were interviewed individually. Informants were recruited from health and social care, education and the third sector. Each informant was involved in the commissioning, planning or delivery of parenting support within NHS Greater Glasgow and Clyde.

Findings
In order to build on the first phase of research, data from this second phase were organised around the same five themes (discussed in more detail in the main report)**:**

1. Economic, social and cultural context.
2. Range and fidelity of parenting programmes.
3. Relationships and engagement.
4. Monitoring and evaluation.
5. Clarity of vision, leadership and future direction.

Conclusions
As in Glasgow city, parenting support is now firmly embedded as an important component of early intervention across the statutory and third sector. There is growing recognition of the importance of family support which can take account of and respond to a family's economic, social and cultural context.

Recommendations
Services and agencies involved in commissioning or delivering parenting interventions in Greater Glasgow and Clyde should:

1. ensure family/parenting support models are integrated, underpinned by the **'Getting it Right for Every Child'** (GIRFEC) principles that can take account of and respond to a family's economic, social and cultural context
2. recognise that no single programme fits all families and therefore parenting programme options should be broadened to ensure that the programmes and interventions available are appropriate and accessible to families
3. build on and replicate existing good examples of cross-organisational working through developing shared referral criteria, joint planning, funding and delivery of parenting programmes allowing for both universal and targeted approaches
4. provide greater clarity about what constitutes success and share monitoring and evaluation strategies that include a focus on outcomes for families
5. provide appropriate time, training and resources for staff involved in delivering parenting and family support to sustain continuity and impact
6. build relationships with families to help them take an active part in support plans rather than being viewed as passive recipients of programmes or services.

Introduction

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood[2]. Positive family relationships and parenting play a vital role in promoting healthy child development[3].

In recognition of the importance of early intervention in supporting healthy child development there has been a long-standing commitment by children's services in NHS Greater Glasgow and Clyde (NHSGGC) to provide parenting support to families. A city-wide Parenting Support Framework was launched in Glasgow in 2009 with **Triple P** adopted as the main parenting programme[4]. Alongside **Triple P**, a wide range of other interventions, support programmes and approaches are utilised by health, social work, education and third sector staff within Glasgow and the wider Greater Glasgow and Clyde (GGC) area.

This research forms the second phase of an initial qualitative study undertaken by a multi-agency evaluation group, led by NHS Greater Glasgow and Clyde Public Health Directorate. The initial study aimed to gain a clearer picture of the range and scope of parenting support services currently being utilised by the statutory/third sector in Glasgow City and how these fitted with wider family support structures[1]. This second phase of qualitative research has similar aims, namely, to explore parenting support services within Inverclyde, East Dunbartonshire, West Dunbartonshire, East Renfrewshire and Renfrewshire HSCPs.

Findings are intended to inform future prioritisation, planning and delivery of parenting/family support across the Health and Social Care Partnerships (HSCP) within NHSGGC, as well as other partnership areas in Scotland.

Aim of the study

The aim of this research was to obtain a better understanding of the range and extent of parenting support currently on offer across the Greater Glasgow and Clyde area by exploring:

- types of parenting support delivered
- referral routes and pathways
- staff deployment and training
- monitoring of delivery and impact measures
- future plans.

Methods

This second phase of research involved face-to-face interviews by two researchers during late 2016. Seven informants were individually interviewed, each by one of the researchers.

Informants were recruited from health and social care, education and the third sector. Each informant was involved in the commissioning, planning or delivery of parenting support across Greater Glasgow and Clyde.

All interviews were transcribed verbatim and coded into primary themes. The analytic process was shared by two researchers taking an iterative approach. Researchers initially read transcripts individually in full, and then revisited the data in themed summaries individually and together, before synthesising and presenting key emergent themes which formed the basis of findings. Discussion and further consultation between the researchers helped identify consensus on key issues and meaning.

To ensure consistency, data was organised thematically building on the themes which emerged from the first phase of research**:**

1. Economic, social and cultural context.
2. Range and fidelity of parenting programmes.
3. Relationships and engagement.
4. Monitoring and evaluation.
5. Clarity of vision, leadership and future direction.

These themes are discussed in more detail below. Quotations have been used to illustrate key points. Each quotation is attributed to a numbered key informant (e.g. KI 12) in order to ensure anonymity.

Findings

This section sets out research findings from the wider Greater Glasgow and Clyde (GGC) area, building on the themes generated from the previous Glasgow city parenting support review[1]. The findings from the Phase 1 Glasgow city work are summarised under each theme heading, before reporting the second phase findings. The findings of this research broadly reflect those of the Glasgow city parenting support review presented in the Phase 1 report[1]. However, there are some notable exceptions which are discussed below.

Key points of note which differ from that discussed in the Glasgow city review are highlighted at the end of each themed section.

1. Economic, social and cultural context

The Glasgow city parenting support study highlighted respondents' understanding of the impact of economic, social and cultural factors on family life. There was recognition that rising levels of poverty, changes to welfare benefits and the application of sanctions were leading to increased stress and anxiety particularly among low-income parents. Poor childhood experiences and the lack of a good parenting model can leave families struggling to develop effective parenting skills and requires a sensitive approach to engagement. Families from other cultures, including asylum seekers, can face language barriers and often need time and support to adapt behaviours that are less acceptable and appropriate in the Scottish cultural context. Some families have specific needs (e.g. **kinship carers;** parents with substance misuse or mental health issues) that impact on parenting or caring for children and require a tailored approach to parenting advice in their situation.

Across the wider GGC areas there was a similar awareness of how hierarchies of need impact on the ability to deliver parenting programmes: *"...somebody was sent out to do a sleep Triple P [intervention] and only to discover that the child didn't have a bed"* (KI 12).

In comparison with Glasgow city, cultural diversity and language barriers did not seem to be a significant factor across the wider GGC areas. However, the socioeconomic pressures felt by families were acknowledged as having an impact on parenting practices and readiness to engage with parenting support programmes.

"There's very, very few families that you can go out and do a four week programme, as to what Triple P suggests, because [of] just how complicated families sort of circumstances are really." (KI 12)

Furthermore, it was recognised that engagement with parenting programmes can incur additional costs to families if they have to travel to venues or pay for childcare and the cost of reimbursement to parents was not generally met through programme budgets.

For some interviewees the acceptability of parenting programmes was associated with socio-cultural factors. In particular, **Triple P** was described as a *"middle class"* (KI 16) intervention requiring a level of confidence and communication abilities that do not come easily to all parents. In this sense it was considered to be inaccessible and unsuitable for many of those who could benefit from parenting support.

"I think it [Triple P] relies on parents having the ability to analyse, reflect, read. And a lot of the parents we work with, just don't have these skills. So I'm going to say it's a middle class… It's very middle class rather than challenging difficult behaviours. And giving parents the books to read when they can't read… they don't have literary skills to read." (KI 16)

The persistence of traditional cultures and practices in relation to parenting were highlighted alongside an implicit understanding that responses to the behaviour of children are often shaped by a person's own childhood experiences. One interviewee felt that while families and professionals tended to focus on challenging difficult behaviours first and foremost, 'parenting' may also be a vehicle for cultural change, to help parents understand child development and the impact of early attachment and nurturing.

"But still there are parents coming in and saying 'the wee one's woke me up all night, he's at it' or getting phone calls from professionals around a five-year-old or a six-year-old at school – 'I can't have him around the classroom; behaviour's out of order'. And actually our understanding about what this is needs to shift, I think." (KI 18)

In one area the **Solihull** approach was retained as basic training for health visitors to help focus on what needs to be in place for effective parenting to be possible.

*"...the **Solihull** groups. We're keeping the staff on that because I guess that's way back at the beginning bit about putting the foundations in about attachment, attunement and reciprocity. That all kind of needs to be there before you start that parenting intervention, so that's your building blocks."* (KI 14)

Economic considerations, notably in relation to the cost of training, impinged on service delivery as well as on families.

"Some parenting interventions or parenting programmes are very, very expensive and they do not allow cascading 'train the trainer' type approaches and in times of austerity that has presented real issues for sustainability." (KI 13)

One respondent reported an aspiration to extend the promotion of parenting beyond the six week universal intervention *"...but this takes resource"* (KI 13). Sustaining the service requires capital outlay for training to ensure a skilled and knowledgeable staff but also time to deliver. It was reported from one area that the school nursing service had trained staff in **Triple P** but they were unable to deliver due to low staff numbers: *"...that's probably more about capacity than desire to deliver"* (KI 14).

Interviewees reflected on the relationship between local resources and the way in which parenting services are configured: which programmes will be used, who will deliver them, and whether the approach will primarily be universal or targeted. In practice, parenting delivered universally tended to sit alongside a framework for targeted interventions. Targeted interventions did take account of the circumstances of children and families when offering services, based on socioeconomic factors or identification of need in relation to behaviour or development, or a combination of both. For example, in one area 'family navigators' supported families with more complex needs who live in areas classified as 'most deprived' by the **Scottish Index of Multiple Deprivation** (SIMD 1 and 2). Similarly, the **Psychology of Positive Parenting** (**PoPP**) model of parenting was offered to parents of children whose score on the **Strengths and Difficulties Questionnaire** (SDQ) suggested behavioural problems regardless of SIMD rating.

In areas where the third sector is the predominant delivery partner, targeting criteria are set in relation to specific contracts. Multiple contracts may operate at the same time in one area and criteria may be different for each one. For example, a contract to deliver parenting to families with older children (aged five to 12 years) may be agreed alongside a separate contract to deliver early years parenting services. Each contract can specify distinct eligibility criteria and different outcome measures (e.g. **SDQ** scores; **graded care assessments**, 'Getting it Right for Every Child' (**GIRFEC**) assessments). The resultant patchwork provision reflects an economic model that places the individual services under regular review and subject to cuts.

"There are gaps. I could talk all day about some of the gaps… There's lots and lots and gaps. But we basically try and pull bits of funding here and there so that we can plug the gaps where possible." (KI 18)

Key points:

- In contrast to Glasgow city, the impact of ethnic and cultural diversity was not reported as a personal barrier to parenting and family support for families in the wider GGC areas. However, the terminology of social class was used in relation to engagement in a parenting programme that was viewed as less accessible to some parents.
- There was an emphasis on highlighting the economic pressures on organisations to sustain the service while managing low levels of trained staff and the demands of working to short-term funding and variable contractual obligations.

2. Range and fidelity of parenting support programmes

In the Glasgow study it was widely acknowledged that no single parenting model could suit the variable needs of a population: the delivery of parenting interventions should be flexible and work within a broad model of family support. A range of parenting approaches were used across the city, influenced strongly by available resources in relation to funding and personnel.

As in Glasgow, parenting services in the wider GGC areas were developed against the backdrop of the NHSGGC Parenting Support Framework (2009)[4] that adopted **Triple P** as the main programme and provided training in its theory and delivery to all health visitors and selected staff in other professional groups. Over time the parenting landscape has become more varied with different interventions being delivered side-by-side by a range of staff including nursery nurses, social workers and family support workers, variously employed by health, social work, education and the third sector. **Triple P** has continued to be the main programme in some localities despite the fact that many of those trained have subsequently left their posts.

Ongoing training to sustain a commitment to **Triple P** has been difficult, largely due to the costs involved.

"...because the staff have moved on, we don't have the staff. I think we've only got one person trained on [Triple P] Level 4." (KI 16)

"...from my budget I resource all the training... next year will be the first year I do not have any surplus budget to fund training and parenting and the partners are in exactly the same predicament." (KI 13)

It was suggested that a 'train the trainers' programme could ease this situation but this is not permitted within most licensed programme contracts. However, training is only one issue; time to deliver is crucial and this requires a surplus of trained staff.

"There are probably enough people actually trained at the moment – but the time resource to deliver is a barrier. You need to have more than enough people trained to be able to deliver if people are sick or move on." (KI 13)

It was suggested that the approach to parenting in the early days of **Triple P** in NHSGGC where staff were asked to meet delivery targets, was damaging to its acceptability and effectiveness and that this has continued to affect practice today.

"…people were going out and they were using tip sheets and telling people what to do. They think, well, that's me done, I've done so many this month. And that was detrimental because a lot of people, obviously it didn't work for them. And they remember that as Triple P. So we've had to try and undo that. And it's taken some time to undo. And we're still doing that." (KI 12)

In many areas there was a recognised need for alternative approaches in order to utilise local expertise or to extend parenting to specific or more marginalised groups (e.g. families of children transitioning into teenage years; parents with substance misuse issues). In current integrated arrangements, a range of staff and third sector partners provide knowledge and expertise in other approaches and programmes including **Incredible Years**, **Five to Thrive**, **Family Systemic Practice**, **Solihull**, **First Steps**, **nurture services**, **Family First**, **Seasons for Growth** and **Early Bird**. **Mellow Parenting** has also been delivered although inherent costs can be prohibitive.

*"We used to have a very strong focus on **Mellow Parenting** but it is very, very expensive to run because of the taxis and the crèches and all to be provided... it is very difficult to maintain*." (KI 17)

The legacy of the Framework is a balance in favour of **Triple P** and this is further strengthened by the focus on **Triple P** (Level 4) and **Incredible Years** as the two approaches recommended by the **Psychology of Parenting Project (PoPP)** programme – a national implementation scheme instigated in 2013. While **PoPP** reflects the broad aim of the Framework – to deliver effective parenting initiatives – interviewees spoke of the targeted approach involved in the programme, rather than a universal approach advocated by the Framework. Engagement with the **PoPP** was central to the parenting model in two of the five areas included within this study, with a third area moving towards full participation.

Most areas had developed a formal delivery process for parenting services organised jointly across health, education, social work and, in some areas, the third sector. Referral criteria were shared and agreed. Invariably these included universal and targeted elements. In one partnership area staff worked to a centrally maintained and shared delivery calendar managed by the parenting lead for the area.

"*We have a parenting calendar, we always try to put in at least four Incredible Years groups in a year. And we've managed that most years, and its social work, we've got one health visitor trained, Young Family Support worker, some of the education staff. So its multi-agency and we work together."* (KI 12)

In this area, all referrals came through the central lead who had an overall perspective on the service and who could match the family to a programme that was appropriate to their needs. This sometimes involved further discussion with the referrer to clarify details and assess the level of need.

In another area the focus was on embedding parenting into everyday practice across early years services, as opposed to relying solely on the delivery of scheduled sessions (usually **Triple P**) by children and families / education services. Here, every family with a newborn was offered a Triple P intervention using universal tip sheets before the baby reached six weeks old. For young children, nurture programmes were run in early years establishments and drop-in family sessions were hosted. Any parent could self-refer through children and families teams, social work or education. Alongside this, group **Triple P** was available where behavioural issues were identified, as was **First Steps** for those with multiple issues affecting parenting. A universal joint referral process had been agreed across health, social work and education allowing any parent to self-refer (e.g. by request to the school teacher or health visitor). Although this is not a targeted approach, where need was identified (e.g. through the child's 27 to 30 month assessment) referrals were given priority and allocated to the next appropriate parenting group from an annual calendar of scheduled sessions. There was a strong commitment to preventive work – to respond before families reached crisis points. While waiting for the most suitable group, families in need of support were offered one-to-one interventions.

"*Triple P is not a critical intervention... we can't have parents who are in need of a parenting support, actually in need, waiting for a group, so they will receive one-to-one support so group [work] is never seen as a fire-fighting way or a crisis... and that is something we have really improved on because people were being referred to group Triple P when actually they weren't ready for that, they actually needed much more one-to-one or intensive support."* (KI 13)

In contrast, an interviewee from a different area felt that parenting groups were largely used as a tool for crisis management:

"...usually they go [to a parenting group] when something's wrong, behaviours. And that journey's painful and sometimes it's about reflecting on themselves. So it's about how do you keep them engaged through a difficult challenging journey whilst they're still trying to manage a challenging child's behaviour. And that's the challenge." (KI 16)

Where the service was managed by the third sector the delivery model was linked to specific contracts. Multiple contracts may operate at any one time leading to differences in targeting criteria although, to some extent, these can be set by local service managers. Referral pathways were open to health visitors and maternity services as well as other specialist or strategic groups through a multi-agency resource allocation group (MARAG) that include referrals in relation to domestic abuse or disability and in line with service contracts.

One respondent included health visiting when describing parenting services. In this area there was a stronger reliance on **Triple P** alone as the formal programme but also a view that while all health visitors have training in supporting families sensitively (e.g. using the **Solihull Approach**) the progression to delivering parenting programmes had undermined their role in promoting attachment, attunement and reciprocity. It was felt that supporting good parenting was wider than just delivering a programme but was a central part of the health visitor role and that this had been lost.

"I think there's a bit about we need to, in health, re-engage the communities. I think we're, from the health visitor perspective, we've become poor at that. And a lot of families don't know who their health visitor is. And that never used to be the case. They used to know the health visitor was at the clinic on a Wednesday afternoon. If you had a problem, you go along there and somebody would listen to you and offer some assistance. So separated parenting out as a parenting problem, there's a problem with the parents rather than, this must be really uncomfortable having to disclose this, and I'm looking for help. And actually what you're telling me is, fill a form in… we've disconnected with engaging with people." (KI 16)

Relationship building and personal engagement were viewed as the mechanisms that allow for direct delivery of parenting advice by health visitors during routine consultations. It might be argued then that core health visiting practice is crucial in establishing engagement, rather than in delivering parenting *per se*, and this will be discussed further in the next section.

Key points:

- There is less focus on delivering **Triple P** as the primary intervention in the wider GGC areas generally although this varies from one area to another.
- Training costs impact on ability to deliver.
- A wide range of organisations contribute to the delivery of parenting and family support. The research suggests that the parenting service model in the wider GGC areas is well integrated and multi-agency.

3. Relationships and engagement

In Glasgow city there was recognition of the benefits of fostering good relationships and working in partnership across organisations. This was facilitated to some extent by **Locality Planning Groups** or (Early Years) **Joint Support Teams** which also brought locally active organisations together in various combinations. While multi-agency delivery of parenting was rarely formalised as a core structure of the model, it was valued in its contribution to widening reach and better engagement with parents.

Interviewees recognised that families have competing needs that impact on family life and their ability to engage with a parenting intervention.

"*I mean the difficult bit I suppose is engaging parents.*" (KI 15)

For some, the lived realities of inequality – material poverty and health issues, for example – can exacerbate this difficulty. As parenting programmes often require commitment to a course over a number of weeks, "...*there's a huge drop-out rate*" (KI 16).

Several helpful strategies to support families' engagement were mentioned. For example, the **Strengths and Difficulties Questionnaire (SDQ)** is jointly completed with all parents of 27 to 30 month-old children as part of a universal developmental assessment delivered by health visitors. Resulting **SDQ** scores have been used to start a conversation with parents about concerns they may have about their child's development or behaviour and can encourage them to consider attending parenting sessions to address these concerns, where appropriate. Defined **SDQ** scores form part of the eligibility criteria for parenting through the **Psychology of Parenting Programme (PoPP)** and are built into the referral pathway as well as a means of engaging parents in areas where **PoPP** operates.

Parenting in the wider GGC areas was organised in various ways in order to widen its reach, to facilitate engagement, and to provide a *"non-stigmatised service"* (KI 13). This included hosting sessions in different venues, developing drop-in sessions, providing crèche services (where funding allowed), and using feedback from families to make service changes. Making the service as accessible and responsive as possible, and capitalising on a perceived window of opportunity with families, were cited as practical engagement tools.

"*I think it needs to be really accessible to the community. Now whether that's in the local library, in the drop-in clinic... When somebody asks for help, they can't say, 'well I'll make a referral'. Parents don't want that. They want some guidance fairly quickly because something's pushing them to come*." (KI 16)

Parenting appeared to be embedded in a 'family support' model and there was a keen sense of the need for pre-engagement activity to address other family issues that can prevent the uptake of parenting programmes. This means identifying the needs of families sensitively, including the needs of fathers, and responding with the offer of appropriate support rather than an automatic referral to parenting. If a parenting intervention is a response to crisis in the parent-child relationship, it was felt that difficulty in sustaining engagement can be exacerbated.

Staff were encouraged to develop skills in sensitive approaches and to work with and across organisational structures to deliver the best options available, even if these did not focus on parenting exclusively. *"It's not about the programme. It's about facilitating the programme and just that interaction with people."* (KI 12)

There was potential for the structure of parenting interventions to act as a barrier to further support. In some cases the completion of a **Triple P** course was a prerequisite for acceptance into the **Child and Adolescent Mental Health Service** (**CAMHS**). This can involve a ten-week commitment, which is unmanageable for some families.

There was a general perception that engagement was negatively affected by a weakened relationship between health visiting and the community. A sense of regret was expressed for the way health visitors in particular built relationships with families. The opportunity to meet wider family members at baby clinics – as they operated historically – provided a level of 'community intelligence' that was felt to have been lost.

"*I think we've lost something about connecting with the community and the health visiting... there's a bit of disconnect with communities... the bit about being credible... saying to people 'I know this can help you and it really will help you'. That bit, being able to endorse it and whatever. Because we don't have the relationship, we're losing that*." (KI 16)

Across the wider GGC areas there appeared to be a strong commitment to working in conjunction across agencies to share information about available sessions and to establish partnerships with other services or providers (e.g. education-based services, Barnardo's). Even where agencies were not included in formal integration arrangements they were said to work well together. Links into the third sector were more formal in some areas than others. One interviewee spoke of a third sector agency having been commissioned to take the lead for managing parenting services.

Key points:

- Parenting appeared to be well embedded into a family support model. This was seen in the provision of tailored support to facilitate engagement and address need.
- Family support, including parenting, was delivered by a range of organisations. While generally led by one agency (often health), in some areas referral criteria and a calendar of parenting sessions were agreed and shared across agencies.
- The relationship between health visitors and families within the community was valued but felt to have weakened over time.
- Parenting interventions can be a barrier to other services if prescribed as a prerequisite. This is more likely to be the case for families who find it difficult to engage or to sustain engagement.

4. Monitoring and evaluation

On the theme of monitoring and evaluation, variable approaches were found in the Glasgow parenting support study. Capacity for this type of activity differed across organisations. The research found an overall lack of systematic quantitative information regarding the delivery and impact of the parenting support programmes and initiatives across Glasgow.

Across the wider GGC areas a similar picture was evident. Again, although all interviewees spoke of efforts to evaluate parenting support activity, much of what was described was monitoring rather than looking for evidence of the impact of their work on child and/or family outcomes. Typically, data collection was guided by use of the pre- and post-intervention booklets associated with particular parenting programmes, which tend to be self-completed by parents. Where **Triple P** is delivered, the **SDQ** is also used. Staff routinely noted the number of parents beginning a parenting group and the proportion that go on to complete it. There was awareness among interviewees that local evidence linking parenting interventions with improved outcomes for families is limited, and an appetite to know more about the impact of parenting interventions.

"I feel that assessing the impact of parenting is the most difficult thing to do… So I think that's where as a service we do fall down, we're not managing to capture the impact of a lot of this. You do all the work but then you forget to go back and find out what has happened. How has it worked? How have you benefited? How has the behaviour changed?" (KI 17)

"Whether the impact makes them better parents on some of these programmes is something that we don't know. Anecdotally the parents will tell you… but we don't have a systematic basis to collect that as routine." (KI 15)

There was a general sense of monitoring and evaluation work improving over time (*"...well, we're getting better at it…"* (KI 14)), with the **electronic medical information system** (**EMIS**) cited as being helpful in this regard. One area had recently introduced six-month follow-up *"...to see whether families are still using the strategies and how they are working*" (KI 12).

Another was exploring why some families do not engage and sought views on how to better support families: *"…actually you have some responsibility to follow this up yourself and support this parent to come"* (KI 12). However, in the main it was felt that knowledge, skills and resources to evaluate are limited.

"How can you measure, when parents are coming back and saying 'this has changed how I look at my child, this has changed how I am with my child', how do you measure that?" (KI 18)

"Who would do that [the evaluation] and who would analyse it? Our health visitors certainly can't do that. It takes them all of their time to deliver their parenting. We would have to use validated tools, people would have to be trained to use them. We would have to make sure the parents completed them. We would then have to get them analysed. We would then have to write reports on it and we don't have any capacity for that." (KI 15)

Interestingly, there was evidence of self-reflection and peer evaluation, in some cases utilising video recordings of staff interactions with families (video interactive guidance (**VIG**) and video enhanced reflective practice (**VERP**)).

"…we have developed a self-evaluation, a reflective tool, so that facilitators can get together at the end of the programme and reflect on how the actual group went, and what went well, what didn't go so well." (KI 12)

Where third sector involvement in the provision of parenting/family support was strong, evaluation was reported to be driven by the relevant funding bodies, which influenced the approach to monitoring and evaluation.

"I've got multiple contracts that we have to report on. So we have to evidence that we're making a difference. …you still write a glossy report but you have to know you are making a difference… and I think that's why that feedback from parenting is really important, and other professionals as well." (KI 18)

The **Central Parenting Team** that operates from a Glasgow base was mentioned as a potential conduit to sharing learning across areas. However, it was also felt that efforts to collaborate in this way had been hampered by a lack of common information and mismatched timescales across the geographical areas involved. Sharing practice was raised as a future aspiration.

Key points:

- The monitoring and evaluation of parenting support in the wider GGC areas closely resembled what was found in terms of monitoring and evaluation in Glasgow city.
- Although there was an expressed desire to know more about the impact that parenting support is having on children and families, it was felt that capacity, skills and ability to evaluate well was limited.
- Self-reflection, peer support and sharing learning were thought to be valuable.

5. Clarity of vision, leadership and future direction

The Glasgow city parenting support review[1] found that the vision for current and future parenting support across Glasgow was varied: there was a call for identification of an agreed set of outcomes that should be pursued by parenting support programmes in the city. Leadership styles differed across the organisational landscape, which may influence how parenting support is viewed and delivered across organisations and sectors. There was an apparent lack of clarity regarding universal versus targeted services and the concept of **proportionate universalism**; and, lastly, centralisation of processes and services was raised as a potential difficulty given the localised delivery of parenting support by the third sector in line with a neighbourhood approach. A number of these issues emerged from the research across the wider GGC areas.

Interviewees across all areas spoke of staff roles, responsibilities and the thinking behind staff deployment. As with the Glasgow city parenting support review[1], universal provision versus targeted parenting support was a strong theme. Again, **proportionate universalism** was not articulated *per se*; although there was some evidence of the principles being applied in practice, described, for example, as *"a resource allocation model predicated on deprivation"* (KI 14). Examples were given of targeting resource to particular families in terms of the provision of additional, more intensive support (e.g. nursery nurse involvement, utilising the **PoPP** approach). Further, targeting was also demonstrated in caseload management – health visiting staff working in the most deprived neighbourhoods having smaller caseloads to manage than their peers, in some instances.

Across the interviews, discussions arose on the universal availability of parenting programmes. There was general recognition of a number of difficulties in this regard including barriers to attendance such as lack of childcare and financial issues. Despite recognition of such access issues, self-referral was discussed as a method of making parenting programmes available universally.

It was felt that there is a certain stigma associated with problematising parenting, which can dissuade parents from attending a parenting group.

"…that's what we're working really hard [on] in here is to try and make parenting groups universal… these parenting groups are for everyone. And once people see they're for everyone, then more and more people will access them. Health visitors are waiting until there's big problems before they actually refer in." (KI 12)

Across the wider GGC areas nursery nurses and other support staff were cited as part of the skill mix through which parenting and family support was being delivered on the ground. Partnerships with other statutory services and with the third sector featured across the areas, although there were differing types of arrangements in place with some of these relationships appearing to be better integrated than others. In general, services / agencies appeared to be integrated and working well together. Perhaps unsurprisingly given their smaller scale, a sense of knowing the local area and understanding local issues emerged across the GGC partnership areas.

The move to a **Central Parenting Team**, based in Glasgow, was reported to have disadvantages for the areas outlying Glasgow city. There was a perception that Glasgow city is favoured in terms of, for example, the availability of training.

Some of the gaps reported were linked to resources, including financial resources, as discussed previously. Others were about the coverage of parenting programmes – for example, the focus on early years may mean support for families with older children is lacking.

"...from ten and eleven, transitioning into secondary schools and adolescence can be challenging for parents. I don't know honestly if we can meet that demand." (KI 16)

As discussed previously, there has been a gap in training for some staff. One interviewee said: *"There's no training. We've got what we've got… staff trained and that's it. There's been no ongoing training for staff"* (KI 16).

Meanwhile matching staff and their skills to the delivery of parenting support was reported as an issue:

"They're not comfortable doing group work. And we've trained them in group work to level three. Why did that happen?" (KI 16)

Across the wider GGC areas there was some evidence that parenting is moving away from stand-alone parenting programmes and is being seen as a key element of broader family support. More informal support can be accessed not only through health services but also through schools and local community organisations. Interviewees welcomed this approach.

"I think we put parents and children into blocks… families don't work like that… I would like to see future funding around systemic practice, working with a whole family, that's co-created with families rather than pulling programmes out." (KI 18)

However, there were varying views on whether parenting support should remain an important part of the health visiting role, should be shared across agencies, or should reside within a designated team.

"It's our… kind of bread and butter. If we can't deliver that [parenting support] then what are we doing?" (KI 14)

"I think a lot of the family support work, I mean at the moment it's a bit of a jigsaw. It'll continue to be a jigsaw. Probably education will be where a lot of the family support work will hopefully end up, but who knows." (KI 18)

"It would just be lovely to have a parenting team. It would just be absolutely lovely, with a group of staff that that was their primary role to engage, to motivate, to encourage, to just take on all of the parenting. And we'd just refer into them and they would take over the lead role." (KI 17)

The imminent increase in health visitor numbers was felt to be positive for the provision of parenting and family support, in the main. However, one interviewee cautioned: *"But that increase in health visitors will only probably identify more problems"* (KI 17) and so resources to support health visitor teams to address such problems will also be required.

The **PoPP** approach was seen to be useful but a number of caveats were mentioned including capacity and sustainability of this way of working. Combined with the proposed move away from use of the **SDQ**, on which referral into a **PoPP** programme is based, it is not clear whether the **PoPP** approach will be a key part of the future direction of parenting and family support across the wider GGC areas.

*"We've been looking at **PoPP**. It is, it's difficult, it is very difficult… But because we need 14 practitioners to give one day a week, there are issues around capacity. So we need to look very carefully at how we could use that.*" (KI 17)

Key points:

- Universal versus targeted provision of parenting support was a strong theme, although a lack of clarity regarding the concept of **proportionate universalism** was apparent. The **PoPP** approach was considered to be useful in terms of targeting, but capacity for and sustainability of this way of working were cited as concerns.
- At least in some cases, parenting support is being utilised as a response to crisis which can lead to stigma associated with accessing a parenting programme.
- There was evidence that parenting is moving away from parenting programmes alone and is being seen as parenting and family support more broadly – a shift that is welcomed by staff.
- Difficulty in accessing appropriate training for staff and a lack of financial resources were identified as limiting factors in offering parenting support across the wider GGC areas.
- Ongoing changes to the health visiting profession are associated with risks and opportunities in terms of parenting and family support.

Discussion

This second phase of research resonates strongly with the findings from the Phase 1 Glasgow city study[1]. However, it suggests that a greater diversity of programmes, interventions and approaches operate in the wider GGC areas than in Glasgow city. These are utilised and adapted by different agencies and sectors in a flexible way contingent on capacity and organisational practices as well as knowledge and understanding of available local resources/pathways.

Many informants, particularly those from the third sector, expressed a view that evidence-based programmes worked best within a broader context of flexible, practical family support that recognises and responds to a family's economic, social and cultural context. As well as being the most appropriate response to family need, it was felt that this approach was more effective in helping parents/carers reach the stage of being 'ready' to take part in parenting support activities. Working across agencies to deliver broad-based family support that both draws on and contributes to a cohesive community appeared as the most promising model for parenting. Multi-agency partnership approaches were found to operate in a structured way within the wider GGC areas through shared processes and systems.

The GCPH early years' synthesis paper[5] provides strong supporting evidence for this approach, proposing actions to improve child health and wellbeing that include a focus on the health and wellbeing of parents as a crucial dimension of improving outcomes for children. This also highlights the importance of extending parenting support beyond parenting advice to sources of help for difficult life circumstances and to social networks with other parents.

In comparison with Glasgow city, testimonies from the wider GGC areas suggested that delivery models within each area are more integrated and cohesive. The organisation and planning of parenting tended to be embedded in a model that encompassed family support more broadly by including other parenting and related support programmes and drawing upon the skills and capacity across all agencies.

As in the Phase 1 study, fathers' roles in parenting, their potential positive contribution and the sort of support they might need was touched upon in discussion. A recent systematic review recommended more routine inclusion of fathers in parenting interventions and a greater awareness of gender-differentiated and co-parenting issues in the design, delivery and evaluation of parenting programmes[6].

The benefit of collaborative relationships that supported better communication and the sharing of information and ideas was acknowledged in the Phase 1 study. Findings from Phase 2 found that in some areas agreement on referral criteria and calendars for group delivery sessions were more readily shared across agencies and geographies than in other areas.

There is potential to build on joint working in new and inventive ways. Given the imminent introduction of '**Named Person**' responsibilities for health visitors and education professionals as part of the Children and Young People (Scotland) Act 2014[7], partnership working and establishment of coherent cross-organisational relationships with a wider range of stakeholders seems helpful and timely.

There is also the potential to build more explicit community development approaches into parenting/family support programmes as described by third sector informants. Recent GCPH evidence highlights the importance of community development in strengthening social networks in a community and for empowering residents by supporting their capacity to influence decisions and take action to make the community they live in better and safer for their children[5].

In relation to monitoring and evaluation there is a lack of robust quantitative data on the impact of parenting support programmes on parenting behaviour/child behaviour. This is unsurprising given the wide range of programmes in use with very variable approaches to measuring success – and in comparison with Glasgow city, the range of parenting support available across the GGC area is even broader. However, even for those programmes that involved a more structured monitoring/evaluation process there were issues with data quality and completeness. For commissioned parenting support programmes, although commissioners discuss projects with and make personal visits to the organisations they fund, they do not ask for robust monitoring or outcome data. Without the obligation to produce evidence of impact, evaluation of parenting support mainly seems to involve largely unsystematic collection of observations from staff and feedback from participants.

Across all areas there was a lack of clarity about whether parenting support is, or should be, universally provided. Resource issues appear to have driven a shift towards more targeted models, particularly in those areas adopting the **PoPP** Programme, despite the universal ethos of many other parenting programmes.

There was widespread concern about the implications of how to sustain a full complement of trained staff to deliver family support services while funded through a variety of diverse, short-term funding schemes. Some organisations had contingency plans in place but the lack of resources for training and parenting support delivery emerged as a pertinent issue.

Conclusions and recommendations

As was found in the Glasgow City study, parenting support is firmly embedded in Greater Glasgow and Clyde as an important component of early intervention across the statutory and third sector. In both phases of this study, findings suggest a growing recognition of the importance of family support that is integrated into wider service provision. This can take account of and respond to a family's economic, social and cultural context, and can address the range of issues that families and their children face today.

Drawing on the issues identified in the Phase 1 research and findings from this study, the following six recommendations are proposed.

Services and agencies involved in commissioning or delivering parenting interventions in Greater Glasgow and Clyde should:

1. ensure family/parenting support models are integrated, underpinned by the 'Getting it Right for Every Child' principles, that can take account of and respond to a family's economic, social and cultural context
2. recognise that no single programme fits all families, and therefore parenting programme options should be broadened to ensure that the programmes and interventions available are appropriate and accessible to families.
3. build on and replicate existing good examples of cross-organisational through developing shared referral criteria, joint planning, funding and delivery of parenting programmes allowing for both universal and targeted approaches
4. provide greater clarity about what constitutes success, and should share monitoring and evaluation strategies that include a focus on outcomes for families.
5. provide appropriate time, training and resources for staff involved in delivering parenting and family support to sustain continuity and impact
6. build relationships with families to help them take an active part in support plans rather than being viewed as passive recipients of programmes or services.

Glossary

CAMHS	Child and Adolescent Mental Health Service – one of the Specialist Children's Services in NHS GGC.
Central Parenting Team	A small team of staff who co-ordinate the training and recording of outcomes in relation to Triple P programme delivery in Glasgow.
Community Planning Partnerships (CPP)	Community Planning is a process which helps public agencies to work together with the community to plan and deliver better services which make a real difference to people's lives. In addition to the core partners (Health Boards, the Enterprise Networks, Police, Fire and Regional Transport Partnerships), all Community Planning Partnerships (CPPs) involve a range of other organisations. These vary across Scotland's 32 CPPs but can include Jobcentre Plus, Further and Higher Education institutions, Scottish Natural Heritage, Skills Development Scotland and business representatives. The voluntary sector is represented by the Third Sector Interface.
Early Bird	A support programme for parents and carers of children under five years with autism. It offers advice and guidance on strategies and approaches for dealing with young autistic children. It aims to support parents in the period between diagnosis and school placement, empowering and helping them facilitate their child's social communication and appropriate behaviour in their natural environment. It also helps parents to establish good practice in handling their child at an early age, so as to pre-empt the development of inappropriate behaviours.
EMIS (Electronic medical information system)	This system was introduced to health visiting across Glasgow in 2015. Health visitors use EMIS on tablet computers that they use to record all patient information.
Family First	Parenting support programme designed to improve outcomes for children, young people and families. It places an emphasis on early intervention, prevention, and providing support for whole families, rather than individuals. The programme promotes greater multi-agency working to ensure families receive joined-up support when they need it. The intention of the programme is to provide early support for families with the aim of preventing problems escalating.
First Steps	A quality, targeted, intensive, flexible service which offers support to midwifery and public health staff and the families they work with. It offers support in addition to existing services and provides continuity between the antenatal and post-natal period until the baby is age three. The amount of contact time depends on the needs of the family. Examples of activities carried out within the home include cookery, play, establishing routines and home safety, etc. Examples of activities outside the home include walking, shopping, swimming, supporting clients to attend other services/groups, for example, Bookbug sessions in local libraries, toddler groups and baby massage.
Five to Thrive	A set of resources built around the promotion of five key activities: respond, cuddle, relax, play and talk. Printed guides, posters and banners help parents and practitioners gain an appropriate awareness of the science of brain development while ensuring that the focus remains practical rather than academic. They support creative, individualised work with families as well as offering a range of suggestions to meet the needs of children at different ages.

Geeza Break	A voluntary organisation providing family support and flexible respite services to parents with children aged 0-16 years (up to 18 years for children with disabilities), predominantly within the North East Area in Glasgow.
GIRFEC (Getting it Right for Every Child)	The national approach in Scotland to improving outcomes and supporting the wellbeing of children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them. It provides the guiding principles for all health and social services.
Graded Care Assessment	Contributes to the Graded Care Profile which is designed to be used with families where someone is concerned about the care of a child.
Incredible Years	A series of interlocking evidence-based programmes for parents, children and teachers. It is aimed at preventing and treating young children's behaviour problems and promoting social, emotional and academic competence. In NHSGGC it is often used with families whose children are making the transition into primary school. It is sometimes referred to as 'Webster-Stratton' after its founder.
Joint Support Team / Early Years Joint Support Team	Joint Support Teams (JST) are formalised structures headed by statutory organisations operating as a mechanism to assess need and agree appropriate pathways, including into parenting, on an individual case basis. They meet regularly to discuss progress, share information and plan any additional support that a child/young person may require. They bring together representatives from key local agencies (e.g. education, social work, health, third sector, housing, addictions, and appropriate others) who can usefully contribute to discussion around the needs of families who have been identified as 'just coping'. The JST should agree an integrated care package of support services based on family need that will help the family to move towards coping effectively.
Kindship carer(s)	Kinship care is an arrangement where a child who cannot be cared for by their parent(s) goes to live with a relative or a family friend – the kinship carer.
Life Link	A third sector organisation delivering stress, mental and emotional management services for young people and adults. It seeks to reduce people's needs for illness services through early intervention and supporting individuals to make positive changes in their lives which will have a constructive, long-lasting impact.
Locality Planning	Through the Community Empowerment (Scotland) Act 2015, the statutory responsibilities of Community Planning Partnerships (CPPs) have been expanded and consolidated. This latest set of changes introduces a new socioeconomic inequalities duty for CPPs in which they must agree to reduce inequalities of outcome. The creation of Locality Plans relates to this duty. Spatially, these Plans are intended for localities that 'experience significantly poorer outcomes which result from socioeconomic disadvantage' in comparison with other localities in the Local Authority area and to the rest of Scotland. Localities have been broadly defined legally as smaller areas within a Local Authority CPP area.
Mellow Parenting	A Scottish organisation who research, develop and implement evidenced-based parenting programmes including: Mellow Bumps for Mums and Dads-to-be, Mellow Mums, Mellow Dads, Mellow Futures, a perinatal programme for parents with learning difficulties and Mellow Ready, a preconception programme for young people.

Mend The Gap	Mend The Gap is a UK registered charity. Its mission is to help individuals and communities to mend the widening gap between cultures, races, generations and people of different wealth for current and future generations.
Named Person	Scottish legislation to provide children and young people from birth to 18 (or beyond if still in school) and their parents access to a Named Person to help them get the support they need. A Named Person will normally be the health visitor for a pre-school child and a promoted teacher – such as a head teacher, or guidance teacher or other promoted member of staff – for a school-age child. At time of writing the Named Person is delayed subject to legal challenge. Scottish Government anticipate that it will be operational by August 2017.
Nurture services	Nurture groups are founded on evidence-based practices and offer a short-term, inclusive, focused intervention for longer term benefit. Nurture groups are classes of between six and 12 children or young people in early years, primary or secondary settings supported by the whole staff group and parents. Each group is run by two members of staff. Children attend nurture groups but remain an active part of their main class group, spend appropriate times within the nurture group according to their need and typically return full time to their own class within two to four terms. Nurture groups assess learning and social and emotional needs and give whatever help is needed to remove the barriers to learning.
Psychology of Parenting Project (PoPP)	The PoPP programme was conceived as a preventive strategy to address behavioural problems in young children through the implementation of high quality, evidence-based parenting initiatives. It supports services to families of children aged under six years and is structured around specific eligibility criteria in relation to Strengths and Difficulties Questionnaire (SDQ) scores. PoPP is funded through the Mental Health Division of Scottish Government and hosted within NHS Education for Scotland. Fidelity to the PoPP programme is required and outcomes are measureable using the SDQ. Funding for training is attached to the programme.
Proportionate universalism	Provision of universal care and support but with a scale and intensity proportionate to the level of need. Sometimes called 'progressive universalism'. *"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."* [8]
Seasons For Growth	A programme for children, young people or adults who have experienced significant change or loss. It is based on the belief that change, loss and grief are a normal and valuable part of life. The core intentions of the programme are the development of resilience and emotional literacy to promote social and emotional wellbeing. The programme is educational in nature and does not provide therapy. Peer support is a key element of the programme, and confidentiality is strongly emphasised.
SHANARRI	The acronym SHANARRI is formed from the eight indicators of wellbeing: Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible; and Included. They are used to record observations, events and concerns and as an aid to creating an individual plan for a child.

Scottish Index of Multiple Deprivation (SIMD)	A ranking system that identifies small area concentrations of multiple deprivation across all of Scotland in a consistent way. It allows effective targeting of policies and funding where the aim is to wholly or partly tackle or take account of area concentrations of multiple deprivation.
Single Outcome Agreements	A Single Outcome Agreement (SOA) is an agreement between a Community Planning Partnership (CPP) and Scottish Government which sets the priority outcomes for each area, and how the CPP will work towards achieving them.
Solihull Approach	The Solihull Approach provides professionals with a framework for thinking about children's behaviour to develop practice that can support effective and consistent approaches across agencies. All NHSGGC health visiting team staff are trained in Solihull Approach to help them with their work with individual families.
Strengths and Difficulties Questionnaire (SDQ)	The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds. In NHSGGC it is used for all children at their 27 to 30 month universal assessment.
Systemic Family Therapy	Family therapy, also referred to as systemic therapy, is an approach that works with families and those who are in close relationships, to foster change. These changes are viewed in terms of the systems of interaction between each person in the family or relationship.
Triple P	An evidence-based parenting programme offering one-to-one, group and a universal service. Most NHSGGC health visiting staff and many social work and education colleagues are trained to deliver Triple P. It is widely used across NHSGGC.
VIG (Video Interactive Guidance)	An intervention that aims to improve effective communication. In the context of this report it refers to the use of video recordings of interactions between parent and child. It involves reflection and feedback, drawing attention to elements that are successful to support parents to make changes that will enhance sensitivity to their child[9].
VERP (Video Enhanced Reflective Practice)	An approach to professional development that enhances attuned interactions through a specific way of using video reflection. It is based on the same method, principles and values as VIG.

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Appendix 1: Principles and values of 'Getting it Right for Every Child' [10]

Promoting the wellbeing of individual children and young people: this is based on understanding how children and young people develop in their families and communities and addressing their needs at the earliest possible time.

Keeping children and young people safe: emotional and physical safety is fundamental and is wider than child protection.

Putting the child at the centre: children and young people should have their views listened to and they should be involved in decisions that affect them.

Taking a whole child approach: recognising that what is going on in one part of a child or young person's life can affect many other areas of their life.

Building on strengths and promoting resilience: using a child or young person's existing networks and support where possible.

Promoting opportunities and valuing diversity: children and young people should feel valued in all circumstances and practitioners should create opportunities to celebrate diversity.

Providing additional help that is appropriate, proportionate and timely: providing help as early as possible and considering short and long-term needs.

Supporting informed choice: supporting children, young people and families in understanding what help is possible and what their choices may be.

Working in partnership with families: supporting, wherever possible, those who know the child or young person well, know what they need, what works well for them and what may not be helpful.

Respecting confidentiality and sharing information: seeking agreement to share information that is relevant and proportionate while safeguarding children and young people's right to confidentiality.

Promoting the same values across all working relationships: recognising respect, patience, honesty, reliability, resilience and integrity are qualities valued by children, young people, their families and colleagues.

Making the most of bringing together each worker's expertise: respecting the contribution of others and co-operating with them, recognising that sharing responsibility does not mean acting beyond a worker's competence or responsibilities.

Co-ordinating help: recognising that children, young people and their families need practitioners to work together, when appropriate, to provide the best possible help.

Building a competent workforce to promote children and young people's wellbeing: committed to continuing individual learning and development and improvement of inter-professional practice.