



CHILD NEGLECT AND VIDEO INTERACTION GUIDANCE

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

Paul Whalley and Mike Williams
NSPCC Evaluation Department

November 2015

NSPCC

EVERY CHILDHOOD IS WORTH FIGHTING FOR

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.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	4
KEY FINDINGS: YOUNG PEOPLE'S VERSION	5
KEY FINDINGS	6
EXECUTIVE SUMMARY	8
Chapter 1: Introduction	12
1.1 Background	12
1.2 Theory of change	15
1.3 Aims and methodology	17
Chapter 2: Outcomes for children	22
2.1 Change in emotional and behavioural problems	22
2.2 Comparison with previous family support data	24
Chapter 3: Outcomes for parents	27
3.1 Parents' perceptions about changes in their parenting: the Parenting Scale	27
3.2 Changes in relationship with child: the Parent-Child Relationship Inventory	28
Chapter 4: Views from parents on change and the factors that helped them achieve change	30
4.1 How families became involved in VIG and early expectations	30
4.2 Experiences of and attitudes towards VIG	32
4.3 Barriers towards engagement and participation	34
4.4 Parents description of what changed and how things changed	35
4.5 Attitudes towards VIG after finishing the intervention	40
Chapter 5: Conclusion and discussion	42
References	46
APPENDICES	48

ACKNOWLEDGEMENTS

The authors would like to thank:

- the parents who consented to take part in the evaluation and to complete questionnaires throughout the programme
- the parents who consented to take part in the interviews and share their insights about the programme
- team managers, practitioners and administrative staff at the VIG service centres of Belfast, Glasgow, Grimsby, Hull, Peterborough, Sheffield and Southampton, who all supported the implementation of the evaluation by explaining its importance to parents and ensuring that data was gathered for analysis
- members of the IPIP Commission Delivery Group for their advice, encouragement and promoting the evaluation within the service
- Matt Barnard and Richard Cotmore for reviewing the evaluation plans and reports
- Susan Purdon, of Bryson Purdon Social Research, for statistical consultancy.

KEY FINDINGS: YOUNG PEOPLE'S VERSION

Video Interaction Guidance (VIG) is a way of helping parents to look after their children. The NSPCC has been doing this with families where parents may not be looking after their children very well. VIG works like this:

- The parent chooses what they most want to change about how they get on with their child.
- The NSPCC worker films the parent and their child together.
- The worker chooses the most positive parts of the film to share with the parent – and their child, if they are old enough.
- They look at the film and decide what has gone well, and then the parent tries to do more of that.

We found that:

- To start with, children had lots of problems with their feelings and how they behaved.
- Things had got a lot better for children by the end of VIG.
- Parents changed a lot too, for example in how they listened to their children.
- Parents felt they understood their children a lot better by the end of VIG.
- How parents and children got on with the NSPCC worker was important for helping things change.
- VIG helped bring about some good changes, similar to another NSPCC service that was provided for parents.

KEY FINDINGS

Video Interaction Guidance (VIG) is a supportive programme of parent counselling that uses video to help parents become more attuned and responsive to their child's communications, both verbal and non-verbal. It has been offered by the NSPCC in the context of concerns over possible neglect by parents.

AVIGuk¹ has supported and trained NSPCC practitioners in the principles and use of VIG. Parents decide on what they want to change and on specific goals. Interactions between parent and child are then filmed and edited to focus on positive moments, with work done to replicate and build on these moments.

Key findings of the evaluation are:

1. Children had very high levels of emotional and behavioural difficulties at the beginning of the VIG programme. This is concerning, given that the programme was targeted at families with early concerns about neglect and hence not yet in the child protection system.
2. Levels of emotional and behavioural difficulties experienced by children were significantly reduced by the end of the programme.
3. The level of improvement for children was very similar to a historical comparison group who had received another NSPCC family support service.
4. Despite the improvements in children's wellbeing, over half remained with clinically high levels of need by the end of the programme, suggesting that further support may be necessary.
5. Parents had faced many challenges in their parenting role, in the context of multiple losses and stresses. Some had struggled to access appropriate support and found it frustrating that things had to be so bad before hearing about this programme.
6. Parents reported significant changes in their parenting and in their relationship with their children. Parents also discussed the ways in which they had gained a better understanding of their parenting role and of their children's needs, and how to meet these needs.

1 AVIGuk is an incorporated limited company with charitable objectives that supports the development of VIG within the UK.

7. Partnership between parent and practitioner is vital: parents specifically mentioned the value of a practitioner being respectful and non-judgmental.
8. Other aspects of the VIG programme also highlighted as being helpful in bringing about change included the visual aspect, which enabled parents to see things they had not seen before; the focus on positives; the requirement of the programme to spend one-to-one time with their children, and the parents themselves leading the analysis of the film clips.
9. Further evaluation would be needed to test the effectiveness of VIG in the context of neglect, requiring a more robust evaluation design.

EXECUTIVE SUMMARY

Background

Video Interaction Guidance (VIG) is a programme that aims to improve relationships within families (Kennedy et al, 2011). It does this by training practitioners or ‘guiders’ to work with service users on relationships, focusing on positive interactions with their children and modelling these more widely.

VIG involves filming the parent and child doing an activity together. The practitioner then edits the footage in order to highlight something that the parent does well, and this edited film is then reviewed with the parent. The process uses reflection to promote and reinforce behaviour that shows greater sensitivity to the child’s needs. Parents are helped to recognise behaviour that is emotionally neglectful, and to model more positive attunement.

Initial studies reported on behavioural improvements in children, and later studies have also reported on improvements in parents, including parental sensitivity. A meta-analysis of 29 studies on the use of video feedback to parents (Fukkink 2008: page 912) concluded that:

“On completion of the program, parents are more skilled in interacting with their child and have a more positive perception of parenting.... parents improve their interaction skills, which in turn help in the development of their children.”

Methodology and aims

VIG has been used by the NSPCC where concerns have been expressed over possible parental neglect in cases where the focus child is aged 2–12, and where the child is not the subject of a child protection plan. It has been provided at seven service centres across Northern Ireland, Wales, Scotland and England.

The theory of change of the service is that it provides activities that will

- increase parental understanding of what is expected of them
- increase parental understanding of their child’s needs
- increase parental commitment to their child
- increase parental sensitivity to their child
- increase parental capacity
- reduce the emotional and behavioural difficulties of children, and
- meet their developmental needs.

These primary outcomes are expected to lead to changes in parenting behaviour, reducing the risk of harm to the children in order to ensure that they are physically safe and that their emotional needs are met.

The evaluation measures the impact of VIG and explores the parents' experience of the programme, reporting on any barriers and facilitators to success. The impact evaluation uses a before-and-after design, comparing three measures completed by parents at the start and end of the programme: the Strengths and Difficulties Questionnaire (SDQ); the Parenting Scale, and the Parent-Child Relationship Inventory.

The impact evaluation also uses a historic comparison group to compare children's emotional and behavioural difficulties through SDQ scores. This comparison group had also received an NSPCC family support service between 2006 and 2009 to address concerns about neglect. Qualitative interviews were also carried out with a sample of parents to understand the factors that helped them, or were a barrier to them, in achieving good outcomes.

Key findings

SDQ results show that parents reported reduced emotional and behavioural difficulties of their children by the end of the VIG programme. The changes were statistically significant and related to challenging behaviour such as temper tantrums, fighting with other children, disobedience, lying or stealing; emotional symptoms, such as headaches, worries, fears and nervousness; hyperactivity such as fidgeting, lacking concentration, restlessness, not seeing things through; and pro-social strengths such as being considerate, sharing, helpful and kind.

There was also a statistically significant reduction in the number of children experiencing very high needs, from almost three-quarters (72 per cent) of children at the start of the programme, to just over half (56 per cent) by the end of the programme.

The SDQ results for the comparison group showed similar amounts of overall change in children. But whereas the comparison group showed slightly greater reductions in emotional difficulties, hyperactivity, conduct problems and peer problems subscales, the VIG programme achieved slightly greater improvements in pro-social strengths. However these differences were not statistically significant.

The Parenting Scale shows that parenting problems reduced following Video Interaction Guidance: about half (49 per cent) of the parents reported severe difficulties in their parenting at the start of the programme but by the end of the programme this figure had fallen to 40 per cent. There were statistically significant reductions in all three of the subscales as well as the total parenting score:

- laxness, ie parents not following through what they say to the child
- overreactivity, which measures overly harsh or punitive disciplinary strategies
- verbosity, ie getting drawn in to long verbal exchanges that may confuse the child and become ineffective.

The proportion of parents who reported high need for these subscales also reduced over the time of the VIG programme: laxness from 43% to 29%; overreactivity from 53% to 31%; and verbosity from 40% to 32%.

In interviews, parents reported that changes in their relationship with their child had been prompted especially by the following:

- the level of practical and emotional support they had received as parents, for instance in relieving financial strain or being able to call on others to help with parenting duties
- their propensity to show an interest in their child's activities, reflected in the amount of time they spend with a child or how much they know about them
- their awareness of how well they communicate with their child in a variety of settings, including simple conversation
- the effectiveness and nature of their disciplinary techniques, including setting limits that the child knows and understands when they are exceeded.

Parents also described factors related to the programme that helped effect change, including the practitioner being flexible and non-judgemental in their approach; helping the parent to focus on positive aspects of their relationship with their child, and having practical suggestions to try. Work in the parental home was also seen as helpful for promoting change.

Positive aspects of the VIG programme itself that were identified as potential change enablers were: the visual aspect of the programme, which made it possible for parents to see things they had not previously seen; the requirement of the programme to spend one-to-one time with their children, and parents leading the analysis of the film clips.

Barriers for some parents included feeling that they had needed help for some time before the programme was made available to them. Some had also been fearful that the VIG programme might be a way for professional services to monitor families and ultimately remove their children, reinforced by an association of the NSPCC with child abuse and removal of children from their families. Initial fears about being filmed were overcome by support from practitioners.

Implications

These evaluation findings demonstrate the potential of VIG in achieving positive change for families where there are concerns of potential neglect. The key changes were that parenting strategies and the parent-child relationship in the areas of parental support, involvement, communication and limit setting improved, and children's emotional and behavioural difficulties were reduced. However, the findings also highlight the high level of need reported by these families even though they were not in the child protection process at the start of the VIG work, and that high levels of need were still present at the end of VIG. This suggests the potential importance of longer-term follow-up with these families in supporting them to continue to improve in their relationship with their children and to maintain that improvement.

The structure of VIG was viewed positively by those parents interviewed, in spite of some initial concerns about being filmed in their interactions with their children.

The importance of the relationship with the NSPCC practitioner was seen by parents as a key factor in helping them to achieve change. The importance of establishing a good rapport from the start of the programme was emphasised, knowing that the worker would be supportive, non-judgemental and clear in their dealings with the parent.

The historical comparison group was helpful in creating a more complex and nuanced picture of outcomes for children. However, a stronger evaluation design would be required in order to be able to make claims of effectiveness for the VIG service in the context of neglect.

Limitations

The comparison data has been limited to one of the three measures; comparison across other measures would also be helpful. A more robust evaluation of VIG would require a 'business-as-usual' sample at the same time as VIG is delivered to parents who have been assessed with similar needs. In addition, interviewing more parents who have not progressed so well would be helpful in identifying further barriers to using VIG in this context.

Chapter 1: Introduction

This report discusses an evaluation of Video Interaction Guidance (VIG), one of two programmes offered by the NSPCC to parents where there are concerns over potential parental neglect. The other programme is Pathways Triple P (PTP), which is the subject of a related report (Whalley, 2015). This chapter sets out the approach to the evaluation of VIG.

1.1 Background

Neglect is different to other categories of child abuse in that it refers to the absence of care rather than the presence of certain forms of abuse. The NSPCC (2015) describes neglect as:

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

The definition of neglect in the four nations of the UK is based on common principles, though as each nation is responsible for its own policies and laws on education, health and social welfare, there are some differences in wording (see Appendix 2). Neglect is the most common reason for a child being on a child protection plan in the UK (see Table 1).

Table 1: Percentage of child protection plans or registration where neglect is the reason for being at risk

Country	Percentage
England	42
Scotland	41
Wales*	42 (50)
N Ireland*	33 (47)

Source: Jutte et al (2015)

*Both Wales and Northern Ireland collect information where neglect is the only reason for registration as well as cases where neglect is one of several reasons for registration. If all cases are considered then neglect features in 50 per cent of registrations in Wales and 47 per cent in Northern Ireland.

These definitions of official ‘neglect’ can underestimate an experience that is both wider and deeper than the figures suggest. Brandon et al (2013) studied more than 800 serious case reviews covering the

period 2003–2011 in England, where a child had died or suffered very serious harm. They found that at least 60 per cent of these cases had an element of neglect, even if the first category of registration or concern was another form of child abuse (Brandon et al, 2013).

A population prevalence survey carried out by the NSPCC found that child neglect had been experienced by 10 per cent of 11–17-year-olds (Radford et al, 2011). The impact of child neglect, which can include a lack of stimulation and interaction as a baby, can lead to:

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

It is in this context of child neglect that the NSPCC has offered two well-researched programmes for parenting. The service offered is a development of an earlier programme of Quality Parenting and Family Support (QPFS) services provided by the NSPCC between 2000 and 2005, which provided child and family centres, outreach and home-based services and parent education programmes. The evaluation of QPFS by Gardner and Bunn (2005:6) recommended:

- providing a range of services that demonstrably achieve objectives and provide evidence of impact
- developing methods to replicate success
- a wider study of structured parenting training in a number of locations with a controlled evaluation.

Evaluation data was collected from families referred to the NSPCC due to concerns over neglect in the period 2006–2009. This is used as a comparison group for the current study.

The NSPCC offered a choice of approaches to referrers as well as parents. The programmes were Video Interaction Guidance (Kennedy et al, 2011), designed to help parents view their interactions with their child and become more attuned to their child's needs, and Pathways Triple P (Sanders and Pidgeon, 2005), which teaches parents behavioural approaches to improve the parent-child relationship and their availability to the child.

The two programmes were designed to address poor parenting where neglect or other harm presented as a risk. Both programmes were initially estimated to be 10–14 weeks in duration, and were offered to separate samples of referred children with similar needs. Initially, the criteria for inclusion were:

- The target child is aged 4–10.
- A Common Assessment Framework (CAF) in England or an equivalent assessment in Scotland, Wales and Northern Ireland has been used to establish that this is a child in need where parental unavailability or neglect are active concerns and likely to result in emotional harm or behavioural difficulties.
- The target child has never been subject to a protection plan.
- No sibling has been subject to a protection plan within the previous two years.

After one year of offering the service, the criteria were amended to include a wider age range of 2–12, and that the target child should not be the subject of a protection plan at the time of the service starting. Further information on eligibility criteria is contained in Appendix 1.

Earlier studies have reported improvements in the behaviour of children with disabilities (Dowrick, 1999), infants (Benoit et al, 2001; Robert-Tissot et al, 1996) and in educational settings (Hitchcock et al, 2003), while later ones have reported on the increased sensitivity of parents to their children (Bakermans et al, 1998). A meta-analysis of 29 studies on the use of video feedback to parents (Fukkink, 2008: page 912) concluded that:

“On completion of the program, parents are more skilled in interacting with their child and have a more positive perception of parenting.... parents improve their interaction skills which in turn help in the development of their children.”

Video Interaction Guidance (VIG) is disseminated and supported by AVIGuk, who have trained practitioners within the NSPCC. In addition to this training, AVIGuk have held regular practitioner support teleconferences and organised internal events to disseminate learning within the NSPCC. The current study looks at the effects of VIG in families with children in a wider and older age range than many previous studies. It focuses on concerns of possible neglect within those families and compares results to a comparable dataset of parents who received another family support service. It is the largest study of this kind in the UK. Further information on VIG is contained in Appendix 1.

The decision to provide either VIG or PTP was made early on in most of the 480 cases for which this information was recorded. The referrer stipulating VIG in just over one-quarter of cases, another quarter recorded attachment or bonding issues for the parent and child, and a further 15 per cent noted the need to work on the relationship between the parent and the focus child. In 15 per cent of cases, the referral had actually been for Pathways Triple P, but there

had been no practitioner capacity at the time and it was acceptable to both parent and referrer to receive VIG instead. Other reasons for providing VIG rather than PTP included that the parents themselves requested it (5 per cent), or that the decision was informed by discussion with manager or colleagues (5 per cent), or that the parent had already had some previous parenting programme input that had been considered unsuccessful (2.5 per cent).

1.2 Theory of change

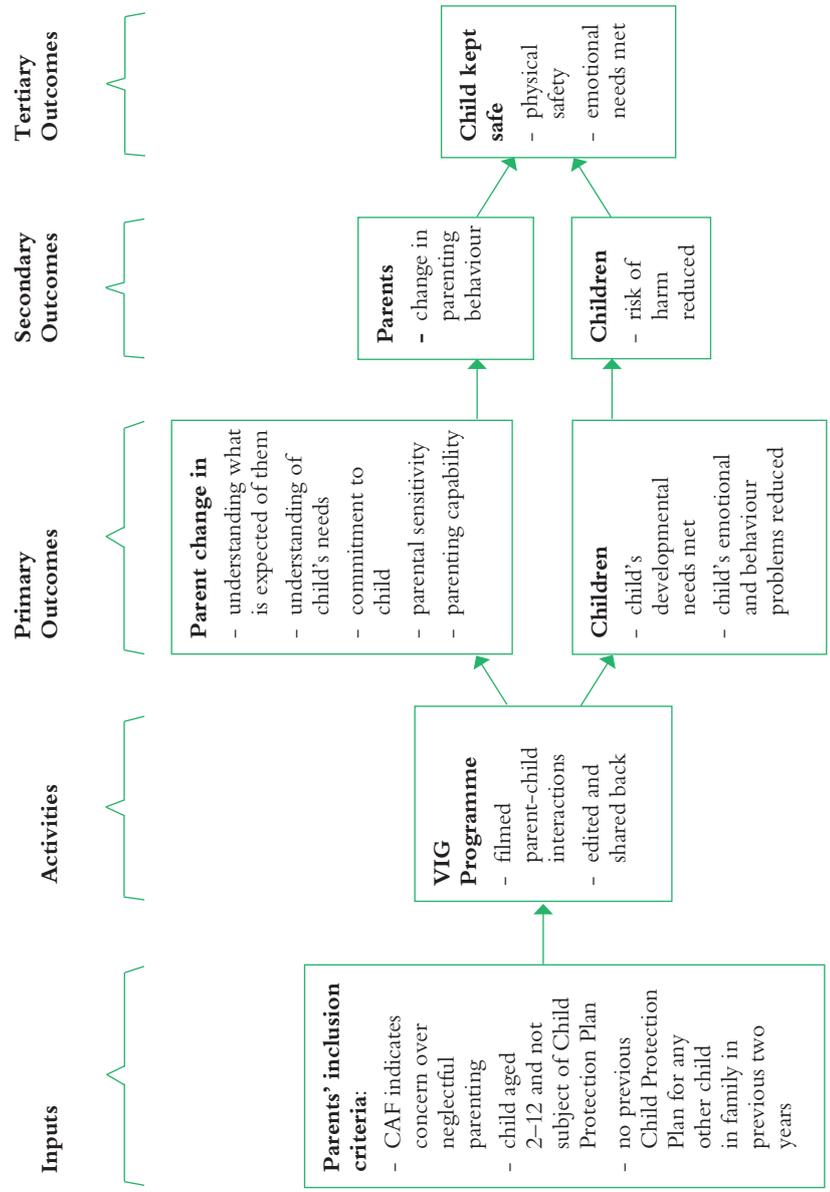
The theory of change is a way of providing a framework for the evaluation design and is the foundation for the evaluation questions and methodology section. It shows how the different elements of the design relate to the way in which the programme is thought to work. It was developed by the evaluator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

The theory of change conceptualises the programme in terms of inputs, activities, and outcomes. It does this is to delineate different parts of the intervention so that it is clear how one element links to another. The intention is also to be clear about what the outcomes of the programme are, and what parts of the programme are intended to link to which outcomes.

The third reason for considering the programme's theory of change is to understand the proximity of the different outcomes to the intervention and therefore help estimate the degree of change that might be expected. The outcomes vary according to their distance from the intervention:

- The primary outcomes relate to parents having greater understanding of what is expected of them; a greater understanding of their child's needs; a greater commitment to their child; greater sensitivity, and greater parenting capability. For the child, the primary outcomes are that their developmental needs are met and their emotional and behavioural problems reduced.
- The secondary outcomes are actions that the programme is expected to affect indirectly, and these are described as changes in parental behaviour and for children as reduced risk of harm.
- The tertiary outcomes are those outcomes that are affected by many factors, not just the programme, and include the physical safety of the child, which is also influenced by their peer group, the behaviour of other family members, housing and other environmental factors experienced by the family. Further information on the theory of change is in Appendix 1.

Figure 1: Theory of change for Video Interaction Guidance within the NSPCC



1.3 Aims and methodology

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

The impact evaluation measured three outcomes for children and parents using standardised scale measures. There was also a comparison group for children's outcomes. This group consisted of children in families who had received the previous NSPCC family support (QPFS) service and was similar to the VIG intervention group in that children were referred due to concerns over neglect, but this had not yet reached a level requiring a child protection plan.

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

Evaluation measures

Parents were asked to complete evaluation measures prior to beginning the work (Time 1), and again, by the same parent or parents, at the end of the work (Time 2).

Strengths and Difficulties Questionnaire (SDQ)

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

Parenting Scale

The Parenting Scale is a rating scale that measures dysfunctional discipline practices in the parents of young children. It can be used for children aged 2–10 and reports on three aspects of parenting attitudes and behaviour: laxness, over-reactivity and verbosity. For children aged 11 and 12, there is an adolescent version of the scale, which has 13 statements and reports on two subscales: laxness and over-reactivity.

Parent Child Relationship Inventory (PCRI)

The PCRI reports on how parents view the task of parenting and how they feel about their children. Its 78 items cover domains such as parental support, satisfaction with parenting and involvement. It can be completed in about 15 minutes. Seven subscales relate to parental support, satisfaction with parenting, involvement, communication, limit setting, autonomy and role orientation (Gerard, 1993).

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

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

Further details of each of the measures are contained in Appendix 3.

Table 2: Overview of pre- and post-measures and number of completed questionnaires

Outcome	Tool	Perspective	Number of T1 & T2
Parents show understanding of what is expected of them	Parenting Scale (PS)	Parent	52
Parents show understanding of child's needs			
Parents show parenting capability			
Children's emotional and behavioural issues are reduced	Strengths and Difficulties Questionnaire (SDQ)	Parent	52
Parents show commitment to child	Parent-Child Relationship Inventory (PCRI)	Parent	45
Parents show greater parental sensitivity			
Parents meet the child's developmental needs			

Just over 600 families were accepted and assigned to VIG, and 280 parents have completed VIG at the present time. The number of paired questionnaires varies between the three measures: a similar number of SDQs and Parenting Scales were completed, but the third dataset, the PCRI, is a longer questionnaire than the other two and practitioners noted more parental non-completion for this reason.

There are also validity indicators within the PCRI that meant the evaluator had to discard some paired data due to inconsistent responses or unusually high, socially desirable responses.

For means of comparison, the current VIG dataset has been compared to a historic dataset from NSPCC family support services provided from 2006 to 2009. These services included home-based work by practitioners with parents and in 54 cases the presenting concern was child neglect. The average time period of the intervention was six months, as compared to five months for the VIG sample. The comparison data set also had low difficulty scores at T1 than the VIG dataset. Therefore, to make a valid comparison between the two datasets, a statistical weighting process was carried out on the comparison dataset so that both datasets had similar statistical properties at Time 1 (T1).

Sample of parents selected for qualitative interviews

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

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

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

Pre-/Post-change reported on measures	Parents/ carer
Improved	7
Same/Got worse	2
Total	9

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

Table 4: Gender of parents interviewed

	Parents/carer
Male	3
Female	6
Total	9

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

Table 5: Distribution of interviews according to location

Location	Number of Parents/Carers
Hull	1
Peterborough	7
Sheffield	1
Total	9

The interviews were done individually, face to face with the evaluator at the parent's home in all nine cases, and lasted from 25 minutes to about one hour. The interview schedule is attached in Appendix 4.

Ethics

The main ethical requirements of the evaluation were:

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

Before the study started, it was approved by the NSPCC's Research Ethics Committee (REC). The REC includes external professional experts and senior NSPCC staff members. This ethics governance procedure is in line with the requirements of the Economic and Social Research Council (ESRC, 2012) and Government Social Research Unit (GSRU, 2005) Research Ethics Frameworks. A note on the ethical considerations is attached in Appendix 4.

Analysis

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

Limitations of the research

This report uses a comparison dataset of SDQ data taken from parents who received an NSPCC Family Support service between 2006 and 2009 and whose main reason for referral was neglect. A stronger comparison would be a contemporary ‘business as usual’ sample from parent referrals generated at the same time as the VIG service but it was not possible to generate such a sample.

The VIG programme was compared on change between pre- and post-measures with the historic dataset rather than with the Pathways Triple P service that was being offered at the same time. This was in part because the assignment between VIG and PTP was not random but based on three-way discussion between referrers, parents and NSPCC manager.

The number of evaluation returns of the Parent–Child Relationship Inventory, which contains 78 statements, was lower than for the SDQ and Parenting Scale (only 25 and 30 statements respectively), as parents were more likely to complete shorter questionnaires.

Interviews with parents were conducted at three sites, despite attempts to recruit interviews from all seven service sites. In addition, most interviews were conducted with parents who felt there had been an improvement in the level of their child’s difficulties, despite an attempt to recruit more of a balanced sample. The interviews were conducted with parents who had completed the programme, so we did not gauge the views of parents who had stopped receiving the service prematurely.

Chapter 2: Outcomes for children

The programme's envisaged outcome for children is a reduction in their emotional and behavioural problems, as measured by the Strengths and Difficulties Questionnaire (SDQ), normally completed by parents at the start and end of the VIG programme. Data from the SDQ is used to measure parents' perceptions of the behaviour of their child. This chapter examines the extent to which outcomes for children had been achieved at the end of VIG.

2.1 Change in emotional and behavioural problems

Parents' perspective: SDQ

The SDQ measures children's behavioural difficulties over four subscales (conduct problems, emotional difficulties, hyperactivity and peer problems) and one pro-social (helpfulness) scale. It provides an insight into children's level of emotional and behavioural difficulty. The SDQ is completed by one or both parents or carers with whom the work has been conducted at T1 (before the programme starts) and T2 (at the end of the programme). The evaluation sample is made up of 52 paired SDQs.

The mean SDQ score decreased from 20.52 pre-programme to 17.44 at the end of the programme. This change is statistically significant, reflecting an overall reduction in emotional and behavioural problems experienced by children and young people at the end of VIG.

Table 6: Change in mean SDQ subscale scores, pre- and post-VIG (n=52)

SDQ subscale	Mean at T1	Mean at T2	P Value
Emotional difficulties	4.58	3.56	0.006*
Conduct problems	5.12	3.90	0.000*
Hyperactivity	7.06	6.50	0.040*
Peer problems	3.76	3.48	0.195
Pro-social	6.04	6.96	0.019*
Total score	20.52	17.44	0.023*

* Statistically significant at p=0.05

As shown in Table 6, there were statistically significant reductions in three of the four ‘difficulty’ subscales, with a decrease in conduct problems – temper tantrums, fighting with other children, stealing and lying – reported by parents. The decrease in hyperactivity included phenomena such as fidgeting, lacking concentration and restlessness. The decrease in emotional symptoms observed by parents in their children included issues such as fewer headaches, worries or fears. The decrease in peer problems was not statistically significant, but nevertheless showed on average a reduction in solitary behaviour, having few friends or being picked on or bullied by other children.

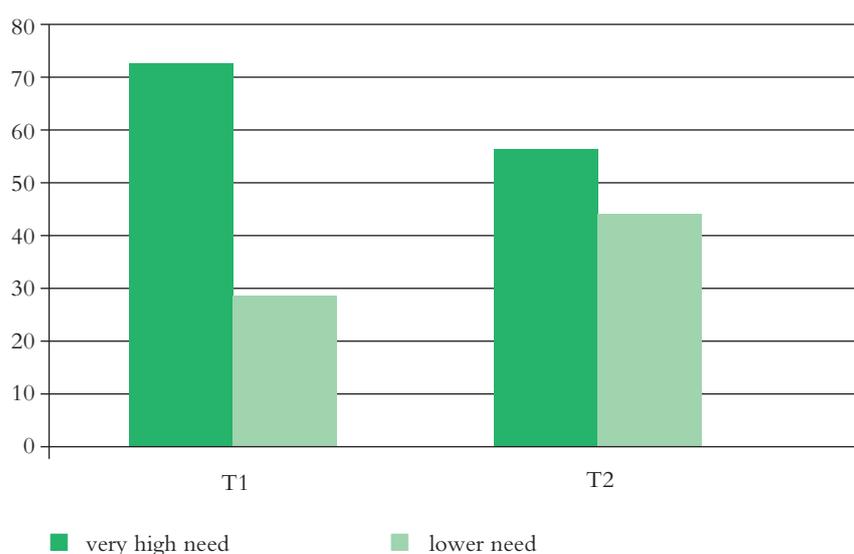
The ‘strengths’ of the SDQ include statements relating to children being more considerate, kind and helpful. This subscale showed a significant increase at the end of the programme.

Change in level of difficulties experienced by children

The SDQ has been normed by Goodman (1997) and has defined cut-off points for scores that identify varying levels of difficulty experienced by children. Cut-off points are used to define very high need, high need, slightly raised and close to average levels of difficulty.

A clinical level of difficulty is indicated by a total SDQ score that falls within the ‘very high need’ scoring band. Figure 2 indicates that almost three-quarters of the children (72 per cent) fell within that clinical range of difficulty at the start of the programme, but at the end of the programme this had dropped to just over half (56 per cent). This reduction is statistically significant.

Figure 2: Proportion of children in clinical and normal ranges in SDQ pre and post VIG (n=52)



Goodman and Goodman (2011) have estimated that 5 per cent of the children aged 5 to 16 years are scored as ‘very high need’ on the SDQ, so the proportion of ‘very high need’ children within this VIG sample has dropped from 14 times the national average to 11 times. This indicates that the VIG sample is a very high need sample compared to the population at large and there is considerable change reported by parents from the start to the end of VIG. However, there is still a high level of need among this sample group at the end of the programme, and it is likely that other family support services will be required to maintain this decrease in very high need over time.

2.2 Comparison with previous family support data

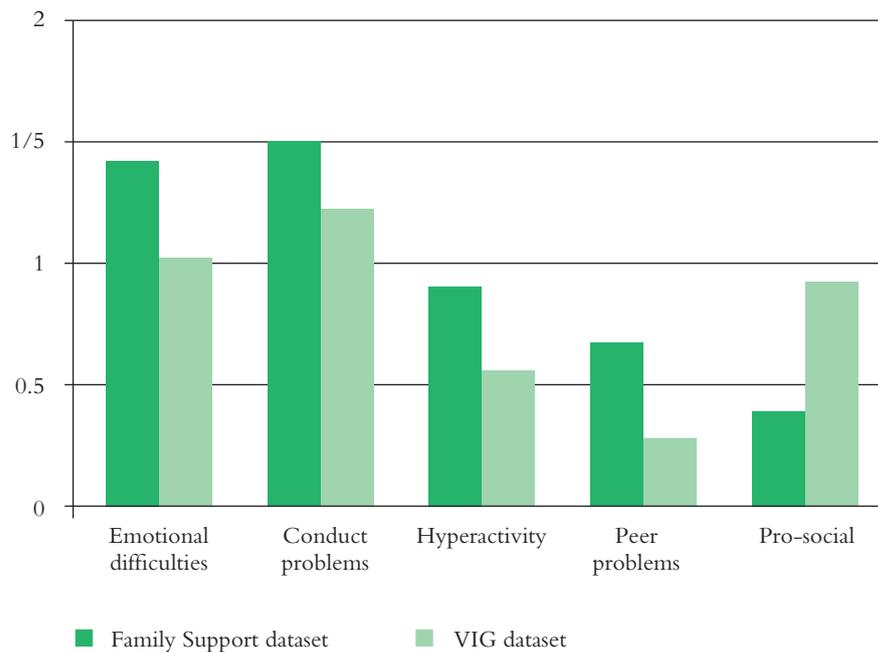
The NSPCC provided family support services prior to VIG in 2006 to 2010. These services included a professional providing one to one sessions with the carer or the child, either at the service centre or at the carer’s home. There were also groups ran by professionals offering support and advice or parenting skills to carers or to children. There were 54 cases where this service was provided due to concerns over neglect, where the focus child was aged 2 to 12 years and where SDQ data has been collected at the start and end of the service. These provide a comparison to the VIG sample. Details of the SDQ scores for the historic family support comparison group are provided in Appendix 5.

As with the VIG intervention group, there were reductions in all of the difficulty subscales and the total difficulty score in the comparison group, although changes for two of the subscales (hyperactivity and peer problems) were not statistically significant, suggesting that these changes may have been due to chance factors. In addition, the pro-social scores remained the same between the beginning and end of the service. However, there was a significant reduction in the proportion of children in the ‘clinical’ range of need.

The analysis of change between the VIG intervention group and the historic family support comparison group found differences in the patterning of outcomes, as shown in Figure 3:

- more change in pro-social strengths through the VIG programme, but
- more change in the emotional symptoms, conduct problems, hyperactivity and peer problems through the Family Support service.

Figure 3: Comparison of mean differences on SDQ subscales between T1 and T2 for VIG programme and weighted comparison group of NSPCC historic family support services



When the four difficulty subscales are combined into one overall difficulty score, there is some difference between the change reported across both interventions, with the comparison data reporting a reduction of 4.87 and the VIG dataset reducing by 3.08. However in a weighted comparison this difference is not statistically significant (see Appendix 5 for more detail).

It is possible that the differences between the two samples help to explain the differences in outcomes between the two groups. The VIG group had higher levels of need at the outset than the comparison group, for example. There were also some differences in the average length of the interventions: the average time spent on the VIG programme was just under 5 months while the average for the historic family support services was a month longer. The range of intervention lengths, however, varied greatly: for VIG the longest case was open for 10 months but for the comparison family support service there was a much longer ‘tail’ with the longest case open for 18 months. It is possible that the cases that were open the longest have skewed the results but, given the limitations of the existing datasets, it is difficult to test for that.

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

- There are statistically significant decreases in emotional symptoms, conduct problems and hyperactivity among children between the beginning and the end of VIG, as well as the total difficulty scores.
- There is a statistically significant increase in pro-social strengths among children between the beginning and the end of VIG.
- There is a drop in the proportion of children experiencing difficulties at a very high level of need, from 72 per cent to 56 per cent of the sample.
- The findings for the VIG programme show similar levels of impact to those from a comparable dataset of NSPCC family support services attended in 2006–2009.
- However, the patterning of outcomes is very different: a greater reduction in emotional symptoms, peer problems, conduct problems and hyperactivity within the historic comparison dataset, but a relatively greater increase in pro-social strengths in the VIG dataset.

Chapter 3: Outcomes for parents

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

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

There was a significant decrease in the mean pre- and post-programme score in all three subscales of the Parenting Scale as well as in the overall score, as shown in Table 7.

Table 7: Changes in mean scores on the Parenting Scale between pre- and post-VIG (n= 52)

	Mean at T1	Clinical cut off	Mean at T2	P Value
Laxness	3.05	≥ 3.2	2.59	0.000*
Over-reactivity	3.03	≥ 3.1	2.50	0.000*
Verbosity	3.93	≥ 4.1	3.47	0.000*
Overall	3.33	≥ 3.2	2.88	0.000*

* Statistically significant

The Parenting Scale has recommended clinical cut-off scores, indicating that the VIG parents had high levels of need at T1: the mean score for laxness, over-reactivity and verbosity are just under the clinical cut-off point and for overall parenting just over the clinical cut-off point. However, at T2, the mean scores for all subscales and the total score are further below the clinical cut-off.

The clinical cut-off points also mean that we can report the percentage of cases that was considered 'high need' and compare this between T1 and T2. Table 8 shows that there were reductions in need among those with the highest levels of need at T1. Two of the subscales – laxness and over-reactivity – show a significant reduction at the end of the VIG programme. The third subscale, verbosity, showed a reduction from 40 to 32 per cent, but this was not statistically significant. The proportion of parents in clinically high need in terms of overall parenting score did show a significant reduction, from 57 to 41 per cent.

Table 8: Proportion of parents in the clinical range of high need on the Parenting Scale before and after VIG (n=52)

	Pre-programme	Post-programme	P Value
Laxness score	43%	29%	0.010*
Over-reactivity score	53%	31%	0.003*
Verbosity score	40%	32%	0.238
Overall score	57%	41%	0.017*

* Statistically significant

3.2 Changes in relationship with child: the Parent-Child Relationship Inventory

The increase in the mean scores for five of the six PCRI subscales indicate that there were improvements in these areas by the end of the VIG programme. The autonomy score on the other hand shows a very slight reduction. The improvements in four of the subscales were statistically significant, as shown in Table 9.

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

	Mean at T1	Mean at T2	P Value
Parental Support	22.71	25.07	0.01*
Satisfaction with parenting	32.60	34.34	0.230
Involvement	38.57	41.68	0.002*
Communication	25.37	27.42	0.001*
Limit setting	29.53	33.13	0.000*
Autonomy	25.43	25.17	0.946

* Statistically significant

The PCRI also give scores that can indicate whether parents feel very stressed or overburdened by their parenting task. Table 10 shows in which aspects of parenting they moved from high level of need to within the normal range by the end of the programme. This happened in four of the six subscales, notably in their involvement in the lives of their children (proportion reduced from 75 to 55 per cent) and communication (a reduction from 54 to 37 per cent).

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

	Pre-programme	Post-programme	P Value
Parental Support	22%	9%	0.016*
Satisfaction with parenting	10%	2%	0.631
Involvement	75%	55%	0.05*
Communication	54%	37%	0.035*
Limit setting	22%	5%	0.002*
Autonomy	7%	14%	0.125

* Statistically significant

In summary, the quantitative data collected from parents on their parenting and on the relationship with their child indicates that parents perceived a reduction in ineffective parenting practices and improvements in their relationship with their child. There are improved scores for parents across all the VIG objectives and the implications of these findings are explained according to the theory of change in Chapter 5. How the programme has helped parents is the focus of the next chapter.

Chapter 4: Views from parents on change and the factors that helped them achieve change

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

4.1 How families became involved in VIG and early expectations

Families' involvement in VIG was often triggered when a member of staff in the school attended by one of the family's children became aware of a concern. If the member of staff knew of VIG, they sometimes asked the parent if he or she would like to receive the service.

On other occasions, the school referred the family to Children's Services, who would introduce the family to the NSPCC and the VIG programme. There was one exception to this, where the mother had approached a GP for family counselling, but was then referred to a multiagency support team. A member of the support team had then suggested VIG. There was some criticism of the lack of accessible information about the VIG programme and a suggestion that schools should make such information more easily available.

Concerns raised by the school included a child exhibiting disruptive or aggressive behaviour; refusing to attend school or absconding; making an allegation of abuse, or bearing a physical mark suggestive of abuse. On one occasion a parent, suffering from what she referred to as a 'mental breakdown' over a two-year period approached the school for help. In another, the mother feared for her relationship with her new partner as they had such different expectations of parenting and she felt her child was suffering because of this inconsistency.

In addition to concerns about the child's behaviour, parents sometimes faced particular challenges in communicating with their children, as in this example of a child with learning difficulties:

"... because... he's eight now, it's hard to talk to him like he was a five-year-old... Because that's where ... his mental age is around. So it was hard to communicate with a child of that age..."

Some families had been referred to VIG in the context of multiple losses and stresses, as in this example:

“We had such a horrible time, me and her father had broken up but we’d also just lost my nan who was basically... there four or five times a week... every day for me and [daughter], and [daughter] was very close to her. So we’d lost her, my stepdad had died of motor neurone, my mum was living with us at the time that me and my ex broke up and she had to go back to London, so it was a two-year period of absolute hell.”

In one family where the parents had separated, the mother had welcomed the involvement with VIG, as she felt it validated her parenting in the context of acrimonious accusations between the parents.

Parents reported that their children could exhibit very high levels of stress and depression:

“Probably two years ago he was having troubles with relationships at school, forming friendships and things, and became quite withdrawn; was talking about wanting to die.”

Some parents had been frustrated that things had to get so challenging before help was offered:

“... and again, why does a child have to be in trouble before they get to know about it?”

In spite of such situations of high stress, parents reported that the support they had already been offered through school, paediatrician or CAMHS had not been sufficient to address their difficulties satisfactorily.

Not all parents had a clear set of expectations about VIG even after agreeing to participate. One parent, who said she had not been given “a great deal of information up front” said “we weren’t sure what to expect” and suspected “it might be a waste of time”. Otherwise, parents held a range of expectations, reflecting both their understanding of the service and their needs. Parents commonly expected an improvement in their parenting and in the quality of family relationships. Dealing with tantrums, being able to better understand one’s child, working with one’s partner to deliver ‘consistent’ parenting were all mentioned. One mother hoped that participation would allow professionals to dispel allegations of physical abuse that her child had made. Another hoped that her daughter would come to appreciate how much she and her boyfriend cared for her.

In addition to positive expectations, some parents also harboured fears about the service. Fears included that they were being blamed for the child's difficulties and VIG was being used to spy on them to see if they had any problems. On one occasion this fear was provoked because of worries about the stigma that the NSPCC, 'comes when your kids are in danger'. There was a feeling that VIG could be used to monitor and control parents, with cameras permanently installed in the corners of the house, subjecting the family to a 'Big Brother' or 'Super Nanny' experience:

"I thought 'Oh God, I've got to remember to put my dressing gown on if I go downstairs."

Some parents had felt a little anxious about seeing themselves on film and they reported that their children had sometimes felt the same. They acknowledged that initially, they were concerned about their appearance, such as being overweight or their hairline receding.

One parent said she had worried about whether she had the emotional resource to cope with the distress caused by criticism of her parenting style. The ultimate fear held by a few parents was that engaging in VIG would lead to the removal of their children.

At no point in any of the interviews did a parent mention the word neglect or that their family had been selected for the service because of a concern about neglect. Furthermore, aside from the term 'neglect' not being mentioned, and despite one or two references to family life indicating possible neglect, it was not immediately obvious through most interviews that children were being neglected. Although it was clear that parents had reported an increased or reinforced understanding of the need for interaction, they did not present their initial situation as one in which their children were being harmed as a result of a lack of stimulation or interaction.

4.2 Experiences of and attitudes towards VIG

Parents

Many parents enjoyed the experience of receiving VIG. When they expressed their appreciation of the service, it was most often for the care and support provided by practitioners. The level of support provided by practitioners often went far and beyond filming and reflecting on the interaction between parents and their children. Practitioners were commonly reported to have given their work mobile number to the parent, and to have made themselves available to listen to and discuss all manner of problems faced by the family. Support also included practitioners advocating for families in

conversations with schools and Children's Services, and in one case attending a doctor's appointment with the parent.

"The woman is amazing because in the year we were seeing her so many other bad things happened... and every time she came she would give me time, she would let me unload."

In such cases, parents' experience of VIG appeared to be determined by how they felt about what the practitioner added to their personal or familial wellbeing, of which the VIG intervention was a part.

"She just became part of the family; she became somebody we all trusted."

A key feature that underpinned such warm relationships was respect, as one parent reflected:

"Well, it was his mannerism and I was treated with respect. I respected his views as much as he respected mine. And I was never on edge with him, never doubtful with him, he always made me feel at ease. It was almost as though he was a friend, and I could talk to him, and I found that really helpful."

The practitioner's style and their approachability were seen as significant, including their being non-judgmental, as one mother highlighted:

"He is a good listener and he is very, very approachable. You can talk to him about things. He's not judgemental..... I fight for my kids in every shape and form, but it was very relaxed and you welcome him into your house, you don't feel like 'oh God, whatever'."

In addition to the approach adopted by the practitioner, parents also commented on their appreciation of the opportunity that the VIG intervention offered them to reflect on their parenting style:

"Being able to see myself on screen was very helpful to me, because you can think yourself a great parent but actually there's always room for improvement isn't there? It's like someone holding up a big mirror so you can pick up on things you might miss."

Being encouraged to take the lead in analysing their parenting and to focus on what was working were critical to parents' satisfaction with the VIG process. In addition, one parent appreciated being able to learn from the practitioner's insights from the film.

Parents reported that their children were often happy to see the practitioner, some waiting for the practitioner's visit with great anticipation. They put this down to the ability of the practitioner to relate to the children in a friendly way, but also to the practitioner together with the parent engaging the children in 'fun' activities, such as making omelettes. One child was said to have enjoyed being filmed, feeling 'special' because of it.

There was not much criticism of VIG from parents. Even those parents who seemed least impressed with it reported being happy enough to give it a go. However, given the possible bias in the sample towards those with positive experiences – as explained in the section on methodology – this is perhaps not surprising.

4.3 Barriers towards engagement and participation

None of the parents interviewed were able to pinpoint significant barriers that had effectively stopped them from engaging in VIG. Some parents mentioned obstacles that could have potentially stopped them from engaging, but these had been overcome.

Fear

While parents had positive expectations of VIG, these had sometimes been mixed with fears (see 4.1 above), but parents explained how practitioners had helped them overcome these fears. Parents valued how practitioners emphasised that VIG focused on supporting the parent and looking for positives to build on. The focus on family support was reinforced by families doing 'fun' activities and by early relationship building with the practitioner. Parents reported that practitioners had invested considerable time and effort in creating rapport before starting filmed activities. Examples of how they had done this included the practitioner listening, referring to her own family experiences, giving gifts and having an approachable style.

"Before he'd even introduced himself he was sat outside in reception with us both having a chat about the weather and being very personable. So he got that kind of human level first before introducing himself... and that was a very good way of putting your mind at rest."

Finding a time and a place

Finding a time and place to film interaction between a parent and child that suited both the practitioner and parent could be a challenge. Some parents were only able to do weekends or evenings, times at which practitioners tend not to work. The solution to this problem came with practitioners agreeing to work with families in workday evenings. This included sessions on a Friday evening for one family, as the parent only had their child to stay with them at weekends. While some parents, on occasion, failed to make their appointments, this did not seem to stop the practitioner and parent from completing the VIG intervention. All the parents who were interviewed had received VIG at home. Some felt that this had helped put their family at ease in a way that would have been hard to achieve had VIG been delivered in a room at a service centre.

The ‘corporate’ language of the values sheet

Part of the VIG programme includes the use of a ‘values’ sheet, which practitioners use with parents to help identify positive parenting and areas of parenting that could be improved. One parent described the style of language in the sheet as “corporate”, which she speculated could be a barrier to some parents. The parent in question, however, felt her “training background” meant she could identify with the language.

4.4 Parents description of what changed and how things changed

Understanding

Parents reported that participation in VIG allowed them to develop a better understanding, or reinforced their existing understanding, of the following aspects of good parenting:

- giving each of their children one-to-one time
- giving children space to make choices and develop skills
- listening to children and not interrupting
- making eye contact when talking to children
- taking children out to parks and finding activities for them to do
- the importance of good relationships between separated parents

In one example of improved understanding, a parent felt that the VIG programme had helped change their understanding of their parenting and its impact on their child. She had feared that she was being overbearing prior to the programme but came to see this was not the case. Aside from gaining a better understanding of how to

improve parenting, parents felt they had a better insight into the behaviour, needs and problems experienced by their children. In one case a parent felt VIG had helped him realise that his daughter, who was being bullied at school and perceived as ‘naughty’, was capable of being “a lovely relaxed girl” and was “not an outright naughty child”.

Rather than always introducing new ideas to parents, the VIG programme sometimes helped parents realise what they already knew:

“The VIG made me realise I already knew the principles, I just didn’t realise I knew them. So doing the actual VIG itself just brought those principles to the surface, made me more conscious of them instead of unconscious.”

When parents talked about understanding, they referred to the principles of good parenting, but also to their particular practice of parenting. One parent outlined how they felt their improved understanding of their child’s needs had resulted in a change in their relationship:

“It helped me to understand when he’s frustrated, when he can’t communicate what he wants.. rather than obviously just clashing when he has... something that could turn into an argument and a tantrum. It’s more understanding him and the reasons why now.”

In the context of their own parenting, parents felt that their improved understanding helped them in their realisation that change was needed. Hence, increased understanding resulted in increased motivation for change. When parents developed a better understanding of the need to change their parenting practice, it was because the film had provided them with an insight into their own parental behaviours of which they would otherwise not have become aware.

“Yeah, I think he’s blossomed because I’m not trying to control every aspect of what he’s doing. And I wouldn’t have seen that, had I not had that video experience.”

Understanding the need to engage their children in more activities was also prompted when a mother saw the film and discovered the enjoyment on her daughter’s face:

“... because when you’re doing it, you don’t see the joy in your child’s eyes because you’re involved in it. If you’re painting you’ve got your head down but watching it afterwards and seeing the smile on her face and the laughter in her eyes, works brilliantly for me.”

This parent identified the visual aspect of VIG as the key to the change process, as did this parent in understanding the significance of spending time with their child:

“We do stuff with the family, obviously, but I think just having that one-to-one time, perhaps that is something we’ve done differently since then, actually. We’ve perhaps seen the effect it has in the video.”

Promoting understanding of parenting practice was often facilitated when parents were enabled to take the lead in identifying what was working and what could improve. The values sheet, which identified what positive interaction looked like, was useful in allowing a focus on aspects of interaction in the film that they could celebrate or improve upon. Parents explained how the experience of giving one-on-one time to their child, a requirement of the VIG intervention, helped them realise how important it was to spend more time with their children.

While parents benefited from taking the lead in analysing their own parenting, the practitioner also had a decisive influence. In one case, for example, a stepfather acknowledged the value of the practitioner’s input in highlighting what he might need to do to make a positive change. This acknowledgement was underpinned by a respect for the practitioner’s training and experience:

“I was screaming with banners and he wasn’t listening to me... and it just took somebody that could say: I’ve done this in school, this is my skillset, and I’m not saying you’re wrong but is it worth sticking to a principle that’s going to lose you everything for the sake of saying ‘well, this is how I’ve always lived’?”

Another example of this was a stepfather who said that he had become more relaxed about giving his stepdaughters a choice of food to eat, after he had been challenged by the practitioner to reflect on why he was being controlling, and on the need to allow children to go through stages of different food preferences.

Confidence

Parents recognised that improved understanding of their parenting and of their children’s needs could improve their confidence in their parenting ability and in making judgments about what their children could safely do. For example, a mother explained how involvement in VIG had led her to feeling calmer about allowing her child to engage in activities that involved an element of risk, eg playing in the sea. In another example, a mother felt her child was now safer when playing at friends’ houses, because having followed the VIG programme, she

felt she had more confidence as a parent to check the whereabouts of her child with her neighbours.

Improved confidence as a parent led to changes in other aspects of their life. For example, one mother attributed her enrolling in education to her involvement in VIG.

Parenting

Parents identified the following changes they made in their parenting:

- increase one-to-one time spent with their children
- the ways in which they resolved disputes
- the ways in which they disciplined their child
- greater encouragement to children to make choices and express themselves
- enabling and encouraging their children to be involved in a greater range of activities.

As an example of the final point, a father reflected humorously on a sandwich making activity he had done with his children. He had not only repeated the activity but had gone on to encourage his children to make the sandwiches themselves:

“My daughter ... had ham, cheese and liver sausage and tomato sauce [in her sandwich].”

Parents had also taken other measures to improve safety at home. For example, one mother said she had fire alarms installed in her house as a result of the practitioner persuading her to invite the fire service around to address the issue of fire safety.

Family relationships

Changes in parenting behaviour were acknowledged to have a positive impact on relationships. One parent noted that his willingness to listen more to his son meant he was better able to support him, which resulted in fewer clashes between the two. In another case, a mother felt that her daughter's trust in her, which had been increased by the demonstration of her mother's care in the film, had led to an improved sense of wellbeing, which had helped her to develop a positive relationship with her stepfather.

Parents suggested that their children's views of the parent-child relationship could be altered by the child's participation in the discussion of the film. Parents felt that such discussions had convinced their children of the care and attention that was paid to them by their parents. Hence, the parents felt that their children trusted them more:

"But for her, I think it brought us sort of closer and... she realised that I only do things for her benefit and that she can put her trust in me."

Relationships between children also improved. One parent explained, for example, how she had learned the value of giving each child one-on-one time. This had allowed her to create a better environment for the children, which resulted in them getting on better. She realised this even more when she volunteered to look after a friend's children:

"I'll spend a little bit of time with her eldest while the others play, and then I'll move on to her youngest and I'll move around and then when I've spent some time with them they all tend to play together really nicely."

Parents felt that the VIG programme helped parents to support each other's parenting. One father, for example, said he now supported his partner when she tried to discipline their child rather than overrule her.

There were improvements, too, in families where the parents had separated. For example, in one family a child put photos and stories about his family life into a 'family book'. This allowed the child to show each of his separated parents what he did with the other. The sharing of the book and the films was said to have contributed to a better relationship between the parents, to the extent that they were able to start talking to each other again.

Child outcomes

Children were reported to be more settled, focused and able to talk calmly about things that were upsetting or frustrating:

"The school could not believe that the little boy sat at my table painting, [who] sat still and focused, was the same child they had in their classroom."

Parents explained how changes in their parenting practice had led to improvements in their child's wellbeing, because they felt they had learned to listen more:

“The second thing was the change in the way I deal with him... because I could listen to him more effectively. That had a real prominent effect on him too, because he knew that he didn't have to rush out this thing that he had to say to me just in case Mummy completely steamrolled him. And he relaxed, you could visibly see over the video process that he changed from being quite an uptight, very guarded child to rushing around and being like a bull in a china shop and slapdash and unsettled, and jumping off his chair and doing all these things to get attention, to this very relaxed, very focused child at the end of the process.”

Furthermore, children were perceived to show an increased interest in creative activities. Parents felt that this motivation to engage in new and creative experiences was triggered by their enjoyment of the VIG activities. They also believed that their encouragement to their children by providing more opportunities to be creative had helped them to engage in new activities.

Parents also suggested that for the child, the knowledge that others know about the quality of their relationships through the VIG programme could have a powerful effect. In one example, a mother said her child had previously made false accusations of abuse against both his parents, who were separated. She felt that the greater transparency of their family relationships that their involvement in VIG had brought about meant her son would no longer feel he could make false accusations of abuse.

Not all parents felt that participation in VIG had improved outcomes for their children. For example, one mother felt that her son's problematic behaviour, which had been the reason for referral to VIG, was specific to school, and had been unaffected by VIG because VIG did not address the school environment.

4.5 Attitudes towards VIG after finishing the intervention

In reflecting on their experience of participation in VIG parents were mostly positive, even those parents who seemed least impressed with it. Parents were generally very appreciative of the impact of the programme on their parenting, family life and the quality of their children's lives:

“Right from beginning to end I can't thank you guys enough, because actually it's made a massive difference in my home and we've gone from being very stressed to now being very relaxed and you can't buy that, so thank you!”

Some parents were also concerned, however, about the exclusive focus on positives and on practitioners' avoidance of negative feedback. Where practitioners had avoided giving negative feedback, they felt they were being denied the opportunity to learn and improve. One mother felt that communicating negative parenting styles could in fact be done constructively:

"I think I would have liked to see if there'd been anything that she'd spotted if we'd done anything major that was blaringly bad, then would have been told about it. She did make it clear that it was just focusing on the positives."

In terms of how VIG could be provided in the future, parents felt that the number of carers worked with could be widened to include more than just the mother or father of the child in question. Interviewees pointed out that it would have been good to have involved the child's 'nan' or a 'school support worker', both of whom spent a significant amount of time with the child in question. There was a suggestion that a follow-up at six months would be helpful to families, to see if and how they had managed to sustain the changes they had made.

Parents also felt the programme should be aimed at all parents, not just those whose children were exhibiting behavioural difficulties. One single father felt many men would be in the same position, not knowing how to interact with their children, who could benefit. Parents also felt that VIG would be good in schools, to help children relate better.

In terms of how VIG is 'sold' to parents, one suggestion was to emphasise the 'fun' aspect of the intervention, in the same way that the parenting TV programme, 'Super Nanny', is sold as entertainment. If VIG were to continue to be delivered by the NSPCC, parents recommended that there should be greater promotion of the family support work that the NSPCC does, to address the barrier for some parents who will see the NSPCC as only being involved in cases of child abuse with the objective of removing children from their families.

Chapter 5: Conclusion and discussion

Child outcomes

There were statistically significant decreases in three of the four subscales of SDQ among children between the beginning and the end of VIG: emotional symptoms, conduct problems and hyperactivity. In addition, there was a statistically significant decrease in the total difficulty score and an increase in the children's pro-social strengths.

There was a significant reduction in the proportion of children experiencing difficulties at a very high level of need in the clinical range by the end of the VIG programme. Hence the results have both statistical and clinical significance. They appear to be reinforced by the parents' descriptions of changes in their children, commonly referring to their child as more 'settled'.

The findings from the comparison with the historical NSPCC family support service are intriguing, as they show a very different patterning to the outcomes with greater change: for conduct problems and pro-social strengths in the VIG programme group; for emotional symptoms, hyperactivity and peer problems in the comparison group. However, these differences between VIG group and comparison group are not statistically significant, which means that we cannot conclude that one of the interventions is better than the other. These findings do show the value of having a comparison group, as it allows for a more complex and nuanced picture to emerge than if we simply compared before and after scores.

There is a large evidence base demonstrating the effectiveness of VIG. This study shows the patterning of outcomes that families where there are concerns about neglect may experience. In terms of child outcomes and the SDQ measure specifically, there are significant changes.

The evaluation design for this study has limitations, in that we do not know what would have happened if families had not received a defined intervention, and a stronger process for generating the comparison group would have been preferable. It is likely, for example, that the comparison group differs from the VIG group but with the existing datasets this is difficult to test further. Hence, claims of effectiveness of the VIG programme in the context of neglect would need a stronger evaluation design.

Almost three-quarters of children had clinical levels of need indicated by the SDQ at the beginning of the VIG programme. This is concerning, not least as the eligibility criteria required that a child should not have an existing child protection plan. The programme was pitched at an earlier stage of intervention and yet these levels of need were so high. It suggests that many children are suffering harm yet not identified as requiring a child protection plan, which resonates with the findings of the How Safe report (Jutte et al, 2015).

A limitation of the evaluation design was that there was no follow-up data, hence we do not know if outcomes were sustained or if there were further improvements or a deterioration. This is significant, given that just over half of children remained at a clinically high level of need by the end of the VIG programme. This suggests that there is likely to be a need for further support in the future, unless future evaluations are able to establish that the trajectory of outcomes through time show reduced levels of need at follow-up.

Parent outcomes

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

- Understanding of child's needs – improvements were reported in communication with children and parental involvement in the lives of their children. Time spent talking with their child and being concerned for their wellbeing is associated with having a better understanding of their child.
- Parenting capability – improvements in laxness and limit setting mean that children will be able to feel more secure in their relationship and know when they have exceeded an acceptable boundary in their play or interaction.
- Commitment to child – parental support indicates having sufficient emotional and practical resources to provide adequate care for their child and that they demonstrate their commitment to their child.
- Greater parental sensitivity – less over-reactivity to behaviour or interaction from their child will give the child greater confidence in their own development and not fearing harsh or authoritarian punishments for relatively minor transgressions.
- Helping to meet the child's developmental needs – increases in stimulating autonomy of the child allows for the child to develop greater maturity within the family and in other aspects of life, such as schoolwork.

Qualitative perspective on outcomes and process

Parents gave descriptions of a wide range of outcomes for themselves and their families. These included changes in their understanding of their parenting role and of their child's needs; their parenting behaviour; their relationship with their child; relationships within the family; child wellbeing and parental wellbeing.

They spoke powerfully of the impact of these changes. Their descriptions also conveyed that they felt that the different outcomes could reinforce each other. One example was a parent who had more confidence in their parenting, which spilled over into other areas of their life, so that they felt able to enrol in education.

In this way, the qualitative insights in this mixed-methods study added value, not just by providing a richer description of the outcomes, but also by focusing on how those outcomes might be related to each other.

The interviews reinforced the insights reported by Macdonald (2014) who interviewed four parents in Belfast who had been involved in the NSPCC's VIG intervention there (see also Kennedy, Macdonald and Whalley, 2015). She found that parents who had almost lost hope for their distressing and conflictual relationships with their children and had participated in VIG had achieved improved communication, improved understanding of their child's thoughts and feelings, while their children had reduced emotional and behavioural problems.

In addition to these outcomes, parents were able to reflect on factors that contributed to their achievement. Key to this was the relationship with the VIG practitioner and in particular the practitioner's approach and style. Parents described the importance of not feeling judged and being respected. They acknowledged the practitioner's skilled pacing of the sessions, and valued that the video had not been introduced into sessions too quickly.

There were also aspects of the programme that parents identified as being critical for enabling change. These included the visual element, enabling parents to see things they previously would have missed; taking a lead in the analysis of each film; spending one-to-one time with their children, as required by the programme, and the focus on positives. Macdonald (2014) also noted the importance of parents seeing the interaction on video rather than just being told that change had happened in their interactions.

Worryingly, parents described their early experience of trying to find appropriate support with their parenting, and their struggle with many difficulties in situations of multiple losses and stresses. Often it had taken a long time to get support, and they were upset that things should have to be so bad before help was offered. In addition, the ways in which they found out about the available services felt like something of a lottery. Schools were identified as a potentially helpful source of information, but this study would suggest that there is some way to go to make information about local services available to families who need them.

When describing the challenges they were facing, none of the parents referred explicitly to neglect. There could be many reasons for this – the right sorts of families were not included in the study or for interview, or parents may not have been aware that neglect was why they were referred, or the term ‘neglect’ is very stigmatising for parents, who might prefer to refer to child behaviour or family relationship difficulties. This is in contrast to professional discourses, where the concept of neglect has a significant profile.

Parents’ fears of being stigmatised were potentially heightened through delivery of the VIG service by the NSPCC because of their association with child abuse and of children being removed from families. Parents therefore suggested that the nature of the service and its constructive focus on family support should be promoted more widely.

References

- Arnold, D.S., O’Leary, S.G., Wolff, L.S. and Acker, M.M. (1993) *The Parenting Scale: A measure of dysfunctional parenting in discipline situations*. *Psychological Assessment*, 5, 137-144.
- Bakermans, M., Juffer, F., and van IJzendoorn, M. H. (1998). Interventions with video feedback and attachment discussions: Does type of maternal insecurity make a difference? *Infant Mental Health Journal*, 19(2), 202–219.
- Benoit, D., Madigan, S., Lecce, S., Shea, B., & Goldberg, S. (2001). A typical maternal behavior toward feeding-disordered infants before and after intervention. *Infant Mental Health Journal*, 22(6), 611–626.
- Brandon, M., Bailey, S. Belderson, P. and Larsson B. (2013) *Neglect and serious case reviews*. Norwich: University of East Anglia.
- Department of Health, Social Services and Public Safety (2003) *Co-operating to safeguard children*. Belfast: DHSSPS.
- Dowrick, P. W. (1999). A review of self-modelling and related interventions. *Applied & Prevention Psychology*, 8, 23–39.
- ESRC (2012) *ESRC Framework for Research Ethics (FRE) 2010* Updated September 2012 accessed at <http://www.esrc.ac.uk/files/funding/guidance-for-applicants/esrc-framework-for-research-ethics-2010/>
- Fukkink, R.G. (2008) Video feedback in widescreen: A meta-analysis of family programs, *Clinical Psychology Review* 28, 904–916.
- Gardner, R. and Bunn A. (2005) *Evaluation of Quality Parenting and Family Support Services*. London: NSPCC.
- Gerard, A.B. (1993) *Parent Child Relationship Inventory*, Torrance California: Western Psychological Services.
- Goodman, A. and Goodman, R. (2011) Population mean scores predict child mental disorder rates: validating SDQ prevalence estimators in Britain. *Journal of Child Psychology and Psychiatry*, 52, 100-108.
- Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581–586.
- Government Social Research Unit (2005) *GSR Professional Guidance: Ethical Assurance for Social Research in Government*, London: Civil Service accessed at http://www.civilservice.gov.uk/wp-content/uploads/2011/09/ethics_guidance_tcm6-5782.pdf

- Hitchcock, C. H., Dowrick, P.W., and Prater, M. A. (2003). Video self-modeling intervention in school-based settings: A review. *Remedial and Special Education*, 24(1), 36–45.
- HM government (2015) *Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children*. London: DFE.
- Jutte, S., Bentley, H., Tallis, D., Mayes, J., Jetha, N., O’Hagan, O., Brookes, H., and McConnell (2015) *How safe are our children?* London: NSPCC.
- Kennedy, H., Landor, M. and Todd, L., eds (2011) *Video Interaction Guidance: A Relationship-Based Intervention to Promote Attunement, Empathy and Wellbeing*. London: Jessica Kingsley.
- Kennedy, H., Macdonald, M. and Whalley, P. (book chapter forthcoming 2016) *Video Interaction Guidance: providing an effective response for neglected children*.
- Macdonald, M. (2014) Like getting your wee boy back: Video Interaction Guidance and Child Neglect, doctoral dissertation in *Educational, Child and Adolescent Psychology*. Queen’s University Belfast.
- NSPCC (2015) *Factsheet on Neglect* – available online at <http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/>
- Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011) *Child abuse and neglect in the UK today*. London: NSPCC
- Robert-Tissot, C., Cramer, B., Stern, D. N., Serpa, S. R., Bachmann, J. P., Palacio-Espasa, F., et al. (1996). Outcome evaluation in brief mother–infant psychotherapies: Report on 75 cases. *Infant Mental Health Journal*, 17(2), 97–114.
- Sanders, M.B. and Pidgeon, A.M. (2005) *Practitioner’s Manual for Pathways Triple P*, Brisbane: Triple P International Pty. Ltd
- Scottish Government, (2014) *The national guidance for child protection in Scotland*. Edinburgh: APS Group Scotland.
- Welsh Assembly Government (2007) *Safeguarding children: working together under the Children Act 2004*. Cardiff: Welsh Assembly Government.
- Whalley, P.A. (2015) *Child neglect and Pathways Triple P: an evaluation of an NSPCC service offered to parents where initial concerns of neglect have been noted*. London: NSPCC.

APPENDICES

Appendix 1: Video Interaction Guidance programme and the evaluation

Overview

Video Interactive Guidance (VIG) is an intervention that aims to enhance communication within parent and child relationships.

A short video is filmed (about ten minutes) of the parent and child interacting, normally in the home environment. The NSPCC VIG worker will evaluate the film, identify positive behaviours, and through edited video clips reflect these back to the parent. VIG builds parents' understanding and confidence by identifying positive interactions and reinforcing this behaviour.

There will normally be a series of four to six filming and feedback sessions over an 8–12-week period. At the end of the intervention, the parent is given a DVD of the edited clips to help provide a longer-term aid to improvement.

VIG worker accreditation

It was agreed that the evaluation would only take information produced by practitioners who had reached level 2 accreditation. Typically, level 2 accreditation is achieved after approximately 18 months of supervision and practice. This has had the effect of reducing the number of evaluation measures included in this evaluation study.

NSPCC Improving Parenting Improving Practice (IPIP) programme inclusion and exclusion criteria

Original inclusion criteria from 1 October 2011

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

Commission criteria:	<ul style="list-style-type: none"> • Target child aged between 4 and 10 years • A CAF or equivalent assessment has established that this is a child in need • Parental unavailability or neglect are active concerns, and that this is likely to result in emotional harm or behaviour difficulties • The target child has never been subject to a protection plan • No sibling has been subject to a protection plan within the past two years • Care proceedings are not underway (nor should the child be subject to a Legal Order following proceedings) • The child should not be accommodated (S.20) • The child should ideally have a lead worker (though the absence of a professional in this role will not exclude delivery)
----------------------	--

Subsequent inclusion criteria from 1 December 2012

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

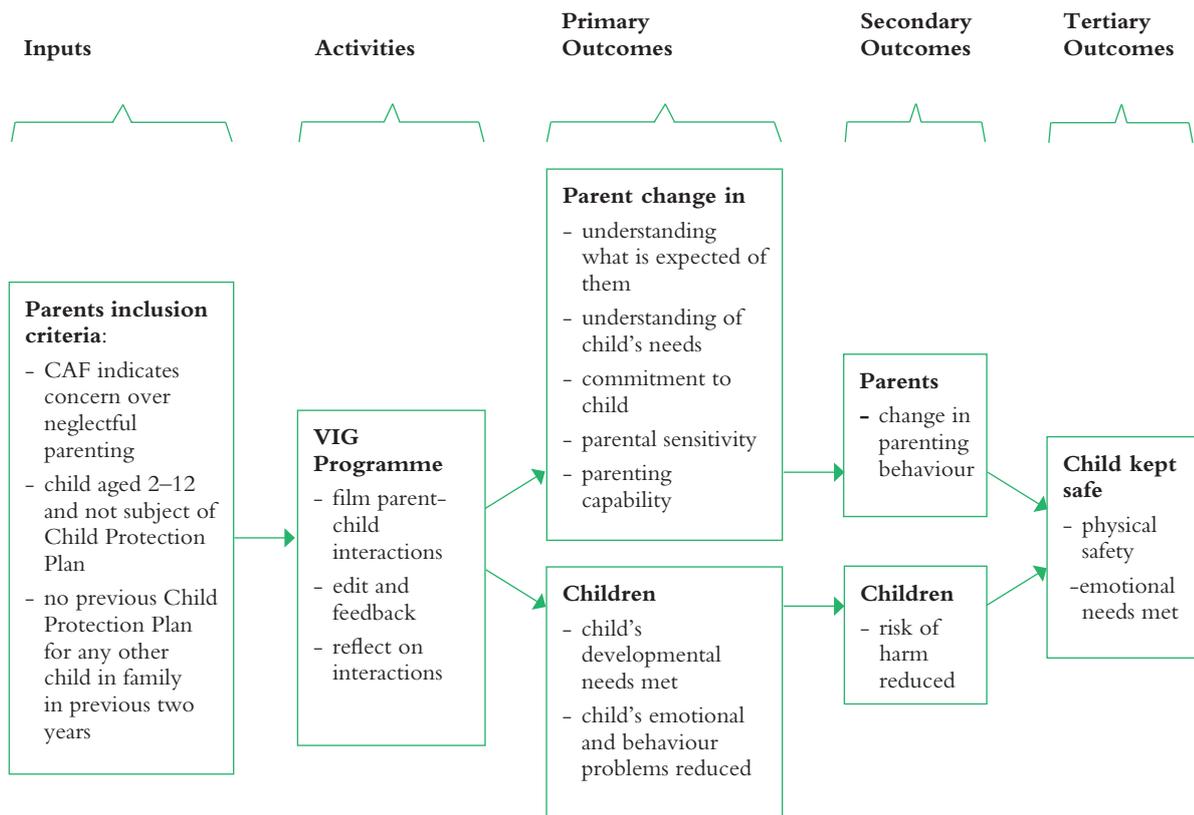
Revised Commission criteria	<ul style="list-style-type: none"> • Target child aged between 2 and 12 years • A CAF or equivalent assessment has established that this is a child in need • Parental unavailability or neglect are active concerns, and that this is likely to result in emotional harm or behaviour difficulties • The target child should not be subject to a protection plan (referrals will be accepted for children coming off a plan, though work will not commence until the plan has concluded) • Care proceedings are not underway (nor should the child be subject to a Legal Order following proceedings) • The child should not be accommodated (S.20), though may have been ‘looked after’ in the past, or may be in receipt of regular respite as part of a Child in Need Plan. (Referrals will be accepted for children returning home from being accommodated (S.20) where neglect remains an ongoing concern) • The child should ideally have a lead worker (though the absence of a professional in this role will not exclude them from the programme)
-----------------------------	--

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

Service provision

At six service sites, a choice of one of two parenting programmes was offered: Pathways Triple P and Video Interaction Guidance. The decision about which service was to be offered was made by the team manager after considering the wishes of the parent and referrer – unless it was a self-referral by the parent. In one service site, Cardiff, Pathways Triple P was the only service offered in this programme.

Theory of Change for Video Interaction Guidance within the NSPCC



Processes

- **Inputs** – these are the parents being referred into the service and the circumstances that make them eligible for inclusion
- **Activities** – these are the programmes, and are conceptualised as leading directly to the outcomes. They are the activities undertaken by practitioners during the work and also the activities undertaken by parents themselves, which can include sharing problems, seeking emotional support and learning skills.

Impacts

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

- **Primary outcomes:** the outcomes that the programme can expect to affect directly. For the parents they are changes in their understanding of the expectations placed on them, of their child's needs and of their commitment to parenting. For children it is that their emotional and physical needs are met and that their emotional and behavioural problems are reduced. These are the outcomes where the greatest impact of the programme would be expected.
- **Secondary outcome:** parents who make changes in their parenting attitudes are likely to show changes in their parenting behaviour. For the child the risk of neglect, emotional and physical harm should be reduced.
- **Tertiary outcome:** being kept safe is categorised as a tertiary outcome because there are many factors that can affect it, with the intervention being just one. 'Safe' includes social and emotional safety in developing healthy attachments as well as physical safety. Within the theory of change it is proposed that being kept safe will be influenced directly by the secondary outcomes. As a range of other factors, including the child's local environment, their peer group, the role and behaviour of other family members, and their parents' health, can affect whether a child is safe, the programme would be expected to have the least impact on this outcome.

Appendix 2: Definitions of neglect in the UK four nations

England

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

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

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

(HM government (2015) *Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children*, page 93).

Scotland

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

(Scottish Government, (2014) *The national guidance for child protection in Scotland* page 12).

Northern Ireland

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

(Department of Health, Social Services and Public Safety (DHSSPS) (2003), *Co-operating to safeguard children*. Belfast: DHSSPS. (Paragraph 2.1.))

Wales

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

(Welsh Assembly Government (2007) *Safeguarding children: working together under the Children Act 2004* (PDF) Cardiff: Welsh Assembly Government, page 6).

Appendix 3: Research instruments

Strengths and Difficulties Questionnaire

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

Child's Name

Male/Female

Date of Birth

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

Signature

Date

Parent/Teacher/Other (please specify:)

Thank you very much for your help

© 1997/2001 Goodman, 2002

The SDQ is available to download freely from <http://www.sdqinfo.com/py/sdqinfo/b0.py> in over 80 languages. The official website has much information on its development, research uses, and scoring methods. The version shown is in UK English for an adult such as a parent or teacher to complete for a child aged 4–17. The evaluation has also used a version for younger children aged 2–4, which amends ‘Often lies or cheats’ to ‘Often argumentative with adults’, ‘Steals from home, school or elsewhere’ to ‘Can be spiteful to others’ and ‘Thinks things out before acting’ to ‘Can stop and think things out before acting.’

Parenting Scale

Child's Name: _____ Today's Date: _____

Sex: Boy _____ Girl _____ Child's Birthdate: _____

Instructions:

At one time or another, all children misbehave or do things that could be harmful, that are "wrong", or that parents don't like. Example include:

<i>hitting someone</i>	<i>whining</i>	<i>not picking up toys</i>
<i>forgetting homework</i>	<i>throwing food</i>	<i>refusing to go to bed</i>
<i>having a tantrum</i>	<i>lying</i>	<i>wanting a cookie before dinner</i>
<i>running into the street</i>	<i>arguing back</i>	<i>coming home late</i>

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

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

SAMPLE ITEM:

At meal time...

I let my child decide how much to eat.	0---0---●---0---0---0---0	I decide how much my child eats.
--	---------------------------	----------------------------------

1. When my child misbehaves...

I do something right away.	0---0---0---0---0---0	I do something about it later.
----------------------------	-----------------------	--------------------------------

2. Before I do something about a problem...

I give my child several reminders or warnings.	0---0---0---0---0---0	I use only one reminder or warning.
--	-----------------------	-------------------------------------

3. When I'm upset or under stress...

I am picky and on my child's back.	0---0---0---0---0---0	I am no more picky than usual.
------------------------------------	-----------------------	--------------------------------

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

I say very little.	0---0---0---0---0---0	I say a lot.
--------------------	-----------------------	--------------

The (Child) Parenting Scale (Arnold, O'Leary, Wolff and Acker, 1993) has 30 statements and is normed for use for children aged 2–10. It produces three sub-scores:

1. Laxness, where statements are related to permissive discipline that is characterised by avoiding the use of control, giving in, allowing rules to go unenforced and providing positive consequences for misbehaviour.
2. Over-reactivity, which has statements relating to authoritarian discipline characterised by harsh punitive responses, displaying anger and irritability.

3. Verbosity, which has statements relating to parents engaging in long verbal responses that draw attention to negative behaviours and take the place of meaningful consequences.

There is also a total parenting score that uses all of the 30 statements in the measure.

The Parenting Scale (Adolescent) is recommended for use for young people aged 11 and 12 and has 13 statements and reports on laxness and over-reactivity only, together with a total parenting score. It has good internal consistency and test-retest reliability over 2 weeks (Arnold et al, 1993).

The Parent-Child Relationship Inventory

The PCRI (Gerard, 1994) gathers information on how parents view the task of parenting and how they feel about their children. It is designed for use with mothers or fathers of children aged 3–15. It gives a quantified description of the parent-child relationship and reports on seven distinct scales:

1. Parental support: the level of practical and emotional support that a parent feels they receive. Those receiving good support will be enabled to provide good care for their child.
2. Satisfaction: the level of enjoyment the parent gets from being a parent, and so the likelihood of being a good parent.
3. Involvement in the life and activities of their child: seeking out opportunities with their child and spending time with them.
4. Communication between the parent and their child: this reflects the parent's empathy with their child and being able to talk and listen to any difficulties that their child has.
5. Limit setting: the effectiveness of a parent's discipline techniques.
6. Autonomy: the willingness of the parent to promote age-appropriate development and independence of their child.
7. Role orientation: not a measure of negative and positive parenting but a measure of different approaches to parental responsibility, from equally shared to distinct gender roles.

There are also two scales for determining whether parental responses are valid, which assess the inconsistency of responses to paired questions and also any unlikely or overly positive socially desirable responses. These checks reduced the number of valid paired PCRIs to 45 for the Video Interaction Guidance programme.

The PCRI is a copyrighted scale so is not reproduced here. It is available to purchase from WPS (<http://www.wpspublish.com/store/p/2898/parent-child-relationship-inventory-pcri#sthash.vPLnLHXz.dpuf>).

Interviews with parents who have received Pathways Triple P or Video Interactive Guidance

PARENT'S TOPIC GUIDE

Note: Introduction to the topic guide

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

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

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

Improving Parenting Improving Practice (IPIP) objectives

Parents

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

Children

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

1. Introduction

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

Introduction to researcher and NSPCC evaluation department – the names we will use.

Study is part of the NSPCC approach to testing 27 services.

Explanation of the study and key aims of the research:

1. Describe how the PTP/VIG (IPIP) service has been put into practice.
2. Explore the barriers and facilitators for parents to receive the PTP/VIG service
 - Timetable of project (2011–2014).
 - Feedback on the research findings will be provided to all participants who would like this.
 - Go through the Information Sheet for Parents:
 - explain confidentiality and anonymity
 - explain interview length (up to 1 hour) and data protection issues
 - remind respondent of £10 voucher as thank you for their time and help
 - check whether they have any questions
 - go through the Consent Form to sign
 - check that they are happy to continue and turn on recorder.

2. Finding out about the NSPCC PTP / VIG service

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

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

1. *How did you come to the NSPCC's PTP / VIG service?*
Self referral / Referred by social worker / Health worker / School's worker / Other / Don't know
2. *In what ways did you find out about the IPIP service?*
Leaflet / Posters / NSPCC website / Had it explained by someone / Other / Don't know

3. *Which of these ways do you think is the best way for the NSPCC to tell parents about the PTP / VIG?*
4. *Why did you go to the NSPCC service / were they put in touch / what was the reason? Tell me about it.*

3. Experience of relationship with practitioner

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

- Length of time they have been in contact with worker
[IE RECAP]
- Nature of contact
 - Location (*Where do you meet?*) *Did you get to choose where to meet your worker?*
 - Frequency (*How often approximately?*)
 - How they came in to contact with worker
 - Understanding of worker's role:
 - *What do you think you can expect from your worker?*
 - *What is their job in relation to you?*
 - *How are they supposed to help?*
 - *How did they help you?*
 - *Have you had an NSPCC worker before? How do they compare?*
- Overall relationship with NSPCC worker
 - *How do they treat you?*
 - *What are they like?*

What is good/ isn't good:

Communication / How well did they keep in touch with you?

 - *How well do they communicate?*
 - *How clear are they?*
 - *How approachable are they?*
 - *Does your worker listen to what you have to say?*
 - *Do you feel supported by your worker?*

Trust: Do you feel safe using the PTP / VIG service?

 - *Do you trust them? Why/why not?*
 - *Has your worker explained the confidentiality policy with you?*

- *Do you know when your worker might have to break confidentiality to tell other adults? When?*
- *Has it been explained to you that you can get to see your NSPCC records?*

Flexibility and Responsiveness

- *How available are they if you need to speak to them?*

Motivation to attend appointments / maintaining contact with worker

- *Did you like having contact with your worker? Why/ why not?*

Barriers to attending / engaging

- *What stops you getting in contact with them?*

Facilitators / what would stimulate engagement

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

4. The impact of the PTP / VIG programme

Aim: to understand the way the programme has helped the **parent**

1. *In PTP / VIG programme what has worked well for you? And not so well?*
2. *How has PTP / VIG helped you to understand the needs of your child?*
3. *How has PTP / VIG helped you to meet the expectations that there are of your parenting?*
4. *How has PTP / VIG helped you to engage / relate to your child?*
5. *How has PTP / VIG helped you to be sensitive to the needs of your child?*
6. *How has PTP / VIG helped you to show commitment to your child?*

How could they help more – specific examples

- *Can you think of any specific examples of things in the PTP / VIG programme that would help?*
- *Can you think of any specific examples of things in the PTP / VIG programme that were barriers to helping you?*

Aim: to understand the way the programme has helped the **child**

1. *In PTP / VIG what has worked well for your child? And not so well?*
2. *How has PTP / VIG programme helped the behaviour of your child?*
3. *Do you manage the behaviour of your child differently now?*
4. *Do you think your child is safer now?*
5. *Do you think that you manage the safety of the child better now?*

Worker helping them in relation to any other issues, ie different to the reason they first saw NSPCC worker

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

5. General impact of PTP / VIG programme in practice

Aim: to understand participants' views on the impact of PTP / VIG.

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

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

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

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

Priorities

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

Further suggestions

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

6. Next steps

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

- Any other areas of importance to cover?
- Any questions now for research team?
- Reassure confidentiality.
- Thank them for their time.
- Tell them that they are welcome to contact members of the research team (contact details on leaflet) to ask questions at a later date if they wish.
- Point again to Information Sheet contacts for future support.
- Hand over Love to Shop gift card and voucher, signing off that they have received it.

Paul Whalley, March 2014

Appendix 4: Ethics overview

NSPCC practitioners who deliver VIG attended evaluation training to gain an understanding of the evaluation – how it works and the key ethical considerations in carrying it out. The ethical issues of the evaluation are listed below:

Informed consent

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

Harm or upset to families

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

Respondent burden

The number of measures to be completed at three time points in the service intervention is a considerable undertaking for parents whose parenting is being considered as potentially neglectful. However, parents may welcome the use of scale measures to help them to understand more clearly the difficulties faced by their children, as they are a visual means of showing change in the process of the intervention. Also, some of the measures are being used in the practice itself.

Data security and protection

A lot of data will be passing between the evaluation team and service teams, both within and outside of the NSPCC. The data will be anonymised, reducing the risks of sensitive data being leaked in a way that will make it identifiable.

Child safety issues overlooked

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

De-briefing

Interviews will end with a discussion of how the service user found taking part in the evaluation to provide them with the opportunity to ask any questions that they may have.

Appendix 5: Statistical analysis and qualitative data management

I. Strengths and Difficulties Questionnaire data: Change in mean score, pre- and post-VIG and using the Wilcoxon Signed Ranks Test (n=52)

SDQ subscale	Mean at T1	Standard Dev. at T1	Mean at T2	Standard Dev. at T2	P Value
Emotional difficulties	4.58	2.7	3.56	2.6	0.006*
Conduct problems	5.12	2.7	3.90	2.4	0.000*
Hyperactivity	7.06	2.4	6.50	2.7	0.040*
Peer problems	3.76	2.3	3.48	2.3	0.195
Pro-social	6.04	2.4	6.96	2.3	0.019*
Total score	20.52	6.8	17.44	7.4	0.023*

* Statistically significant at p=0.05

II. Strengths and Difficulties Questionnaire data: Proportional shift in children from a clinical level of difficulty (very high need) to a normal, slightly raised or borderline level between the beginning and end of VIG. Based on an Exact McNemar's Test (n=52)

Level of difficulties	Pre programme (per cent)	Post programme (per cent)	P value
Normal range	28%	44%	0.04*
Clinical range (very high need)	72%	56%	

* Statistically significant

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

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

* Statistically significant

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

Level of difficulties	Pre programme (per cent)	Post programme (per cent)	P value
Normal range	43%	72%	0.004*
Clinical range (very high need)	57%	28%	

* Statistically significant

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

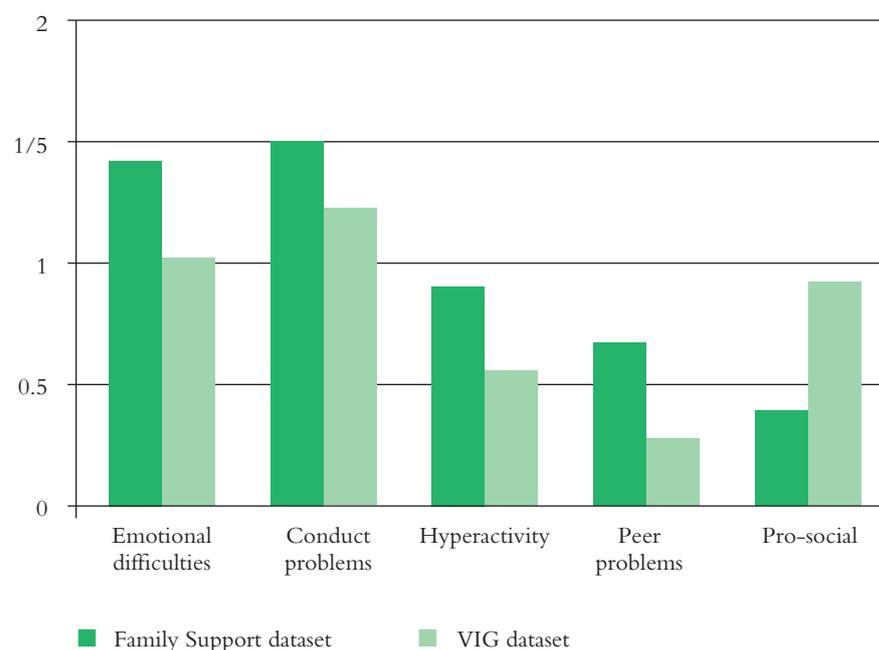
SDQ subscale	Mean differences T1 to T2 for Family Support services dataset (n=54)	Mean differences T1 to T2 for VIG dataset (n=50)	P values^a
Emotional difficulties	-1.42	-1.02	0.504
Conduct problems	-1.49	-1.22	0.514
Hyperactivity	-0.90	-0.56	0.481
Peer problems	-0.67	-0.28	0.351
Pro-social	0.39	0.92	0.256
Total score	-4.87	-3.08	0.211

^a The P value is a test of the difference between the two different means. A P value of less than 0.05 would indicate such a difference. None of the P values here are at that level.

The T1 values for the Family Support dataset have been weighted according to the T1 values of the Video Interaction Guidance dataset so that a more accurate comparison of the change from T1 to T2 mean scores can be made.

Once this is done, the differences between the two datasets indicate slightly more change for conduct problems, emotional symptoms, hyperactivity and peer problems in the Family Support services dataset than in the VIG dataset, and more change in the pro-social strengths in the VIG dataset than the Family Support dataset (see Figure 1). However, none of these changes are statistically significant, and when combined together the total overall difficulty score is still within the range of being from a similar population.

Figure 1: Comparison of mean differences on SDQ subscales between T1 and T2 for VIG programme and weighted comparison group of NSPCC historic Family Support services



VII. The Parenting Scale: Change in mean score, pre- and post-VIG, analysis based on Wilcoxon signed ranks test (n= 52)

	Mean at T1	Standard Dev. at T1	Clinical cut off	Mean at T2	Standard Dev. at T2	P Value
Laxness score	3.05	1.05	>=3.2	2.59	0.95	0.000*
Over-reactivity score	3.03	1.11	>=3.1	2.50	1.0	0.000*
Verbosity score	3.93	0.89	>=4.1	3.47	0.89	0.000*
Overall score	3.33	0.81	>=3.2	2.88	0.81	0.000*

* Statistically significant

VIII. The Parenting Scale: Proportional shift in children from a clinical level of need to a non-clinical level of need between the beginning and end of VIG. Based on an Exact McNemar's Test (n=52)

	Pre-programme	Post-programme	P Value
Laxness score	43%	29%	0.021*
Over-reactivity score	53%	31%	0.003*
Verbosity score	40%	32%	0.238
Overall score	57%	41%	0.017*

* Statistically significant

IX. PCRI: Change in mean scores, pre- and post-VIG, analysis based on the Wilcoxon Signed Ranks (n= 45)

	Mean at T1	Standard Dev. at T1	Mean at T2	Standard Dev. at T2	P Value
Parental Support	22.71	4.42	25.07	4.15	0.01*
Satisfaction with parenting	32.60	5.46	34.34	4.28	0.230
Involvement	38.57	5.58	41.68	5.59	0.000*
Communication	25.37	3.59	27.42	3.82	0.000*
Limit setting	29.53	5.38	33.13	4.96	0.000*
Autonomy	25.43	3.67	25.17	3.45	0.946

* Statistically significant

X. PCRI: Proportional shift in children from high need to a normal score between the beginning and end of VIG. Based on an Exact McNemar's Test (n=45)

	Pre-programme	Post-programme	P Value
Parental Support	22%	9%	0.016*
Satisfaction with parenting	10%	2%	0.63
Involvement	75%	55%	0.05*
Communication	54%	37%	0.035*
Limit setting	22%	5%	0.002*
Autonomy	7%	14%	0.125

* Statistically significant

Qualitative data analysis plan themes and sub-themes

Key aims of evaluation

1. What factors affected the implementation of the service?
 2. What were the barriers and facilitators to success for the service?
 3. What was the range of impacts of the service?
-
1. How families became involved in VIG and early expectations
 2. Experiences and attitudes towards VIG
 - Parents
 3. Barriers towards engagement and participation
 - Fear
 - Finding a time and a place

- The ‘corporate’ language of the values sheet
4. Parents’ description of what has changed and how things changed
 - Understanding
 - Confidence
 - Parenting
 - Family relationships
 - Child outcomes
 5. Attitudes towards VIG having finished the intervention

www.nspcc.org.uk

Registered charity numbers 216401 and SC037717.