EVALUATION REPORT

Building Positive Relationships with your Teen: Evaluating the Standard Teen Triple P Programme

Pilot trial report

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YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

The Youth Endowment Fund (YEF) is a charity with a mission that matters. We exist to prevent children and young people from becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activities.

And just as important is understanding children and young people's lives. Through our Youth Advisory Board and national network of peer researchers, we'll ensure they influence our work and that we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together, we need to look at the evidence and agree what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart, it says that we will fund good work, find what works and work for change. You can read it here.

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About the evaluator

This evaluation was conducted at the School of Education Learning and Communication Sciences at the University of Warwick and the School of Social Policy and Society at the University of Birmingham. Both the Universities of Warwick and Birmingham are among the UK's leading research universities – their academic staff have an international reputation, with their research being ranked as 'world leading or internationally excellent' in the 2021 Research Excellence Framework. The Universities of Warwick and Birmingham were ranked 7th and 13th overall, respectively, for the quality of their research outputs in the UK in this national assessment of research excellence.

Our research team has an established reputation for research across a range of topics, including youth mental health and well-being. Our research programme mainly involves the disciplines of education and psychology, with a particular focus on multidisciplinary research using a combined (mixed) method approach. We have substantial expertise in intervention development and intervention evaluation, including pilot, feasibility and large-scale randomised controlled trials. We also collaborate extensively with colleagues in other research centres and departments at Warwick, Birmingham and other universities.

We have expertise in both quantitative and qualitative methods. This allows us to take on research that requires either methodological approach or, as is often the case, studies that require both types of methods to address different aspects of the research programme, often referred to as combined mixed methods.

For more information about this evaluation, please contact the chief investigators of this study:

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Executive summary

The project

Standard Teen Triple P (STTP) aims to help parents and caregivers learn practical strategies for supporting children, managing problematic behaviour, promoting healthy development and improving the quality of the parent/caregiver–child relationship. STTP works with parents and caregivers of children up to 16 years old who are concerned about their child's development and behaviour. The programme consists of hour-long sessions delivered weekly for ten weeks. Sessions are delivered to parents on a one-to-one basis by practitioners, either in person or via video conference. Sessions cover practical ways to improve emotional regulation for families and how to support children in handling risky situations, making good decisions and developing communication and problem-solving skills. The first three sessions focus on assessment; sessions four to nine deliver the practical strategies for support before a final closing session. Practitioners use a range of methods to teach parents new skills. The intervention was developed by Professor Matthew Sanders and colleagues from the School of Psychology at the University of Queensland.

In this project, STTP was targeted at parents and caregivers of 11–15-year-olds at the edge of care (at risk of entering the care system). These children are especially vulnerable to involvement in violence, and so it was theorised that the programme could support them to improve their behaviour and, therefore, protect them from violence. STTP is also a programme typically delivered to families with complex needs, including high levels of conflict and dysfunctional discipline, which are often exhibited in families of children at the edge of care. The programme was delivered by social care practitioners within local authorities (the majority from edge-of-care teams) who were trained to deliver STTP. Social care practitioners also identified potential participants for the intervention. Six local authority sites were recruited into the evaluation: Birmingham, Cambridgeshire, Wirral, London Borough of Merton, Peterborough and Gloucestershire. Triple P UK was the delivery team responsible for the recruitment of evaluation sites, training and accreditation of social care practitioners who delivered STTP, implementation support and running of post-training clinical workshops.

This pilot study aimed to assess the feasibility of progressing to an impact evaluation of STTP; examine the implementation of STTP; ascertain its acceptability to parents/caregivers, children and wider stakeholders; and explore whether STTP leads to any adverse consequences. The evaluation piloted a two-arm randomised controlled trial. Thirty-two parents/caregivers and 12 children (from across 24 families) participated, with 12 families randomised to receive the programme and 12 to receive support as usual. Of the parents/caregivers and children who participated, 59% were White British, 11% were Asian or Asian British – Pakistani, 11% were from Mixed backgrounds (White and Black Caribbean or White and Black African), 7% were from Black backgrounds, 7% were from other White backgrounds and 5% were from any other ethnic group. A majority (72%) of parents reported that their child had special educational needs, commonly Attention deficit and hyperactivity disorder (ADHD) or autism. The evaluation collected quantitative data, including programme data on participation, participant socio-demographic data, and a range of outcome measures, including the parent-reported Strengths and Difficulties Questionnaire externalising score. Qualitative data was also collected, including semi-structured interviews with ten parents, five children, 11 practitioners and 15 professionals (site coordinators and staff) (one interview each) to understand experiences of the programme and evaluation. The pilot phase ran from July 2023 to September 2024.

Key conclusions
Proceeding to a trial of STTP is not feasible. This is due to challenges faced in recruiting families.
Recruitment to the trial was far lower than expected (less than 10% of planned numbers were successfully recruited). Challenges to recruitment included the high level of need experienced by families at the edge of care and Teen Triple P already being offered by half of the sites outside of the trial.
Programme fidelity was high, with 70–100% of sessions attended by parents/caregivers and most session components delivered by practitioners. Some barriers to delivery were identified, and attrition rates were high at the point of the six-month follow-up post-intervention (with 50% of parents/caregivers and 67% of children no longer engaged). No adverse events related to the programme were reported.

Participating parents, caregivers and children generally felt positive about the programme, but some practitioners expressed doubts about the suitability of the programme for the families they support.
The pilot provides lessons for future evaluations of interventions within social care settings, such as the need to ensure the appropriate positioning of interventions for families at the edge of care and the need for early consultation with social care practitioners regarding delivery.

Interpretation

Recruitment to the trial was far lower than expected. Less than 10% of the planned 275 participating families were recruited, and the target of recruiting 50% of parents/caregivers in the first six months was not met. Despite planning and co-designing with sites, many challenges were encountered in recruiting into the trial. Placing the trial within edge-of-care teams (that were supporting families in crisis) meant it was often not appropriate for these families to receive a parenting intervention, as they were addressing more pressing issues. Site staff suggested that the evaluation would be better placed in services with a lower level of need. Another challenge was the lack of a single definition of edge of care across local authorities. Despite consultation prior to the study commencing, the evaluation's definition of edge of care was misaligned with the definition used by some recruited local authorities; it was reported by social care practitioners as being more in line with child in need or pre-edge-of-care cases. This definitional difference contributed to the feeling of the trial being misplaced in services facing increased workloads and pressures. In one site, recruitment was impacted by the requirement for families seeking an assessment for autism and/or ADHD to undergo a parenting intervention (making them ineligible for the trial). Another site withdrew early due to a service restructure, and in three sites Teen Triple P was found to be part of the usual support offer, complicating the process of identifying eligible families.

The challenges faced in recruitment mean that proceeding to a definitive trial of STTP in the edge-of-care setting is not feasible. This is despite several mitigation strategies implemented to boost recruitment (including encouraging sites to expand the recruitment base and re-engaging families no longer in crisis).

Programme fidelity was generally high, with most sessions attended by parents/caregivers. Attendance ranged from 70% to 100%, and most session components were delivered by practitioners. However, not all session checklists and attendance logs were completed. Outcome measures and randomisation procedures were generally acceptable to families. However, there were a range of barriers to intervention delivery, including complex family circumstances and additional needs of the children, the use of videos, which some felt were outdated, and the structured nature of the programme. There was a high rate of attrition during the evaluation, with 50% of parents/caregivers and 67% of children no longer engaged at the six-month follow-up. No adverse events related to the programme were reported by practitioners, parents or children involved in the study.

Participating parents/caregivers and children generally felt positive about the programme. Some participants reported less conflict between parents/caregivers and children and improved family relationships and communication in the home. However, given the size of the evaluation, it was not possible to robustly estimate the impact of STTP on children's outcomes. Some practitioners expressed doubts about how well-suited the programme was for the families they support. They questioned the appropriateness of the content of the material delivered, suggesting that modifications were needed for it to be effective with these families.

The pilot provides lessons for future evaluations in social care settings, including the need to ensure appropriate positioning of interventions for families at the edge of care (given the high proportion who are in crisis), earlier consultation with social care practitioners involved in the delivery of interventions, further consideration given to incentives to secure participation and reduced ordinary workload to ensure practitioner buy-in.

YEF is not proceeding to an efficacy trial of STTP due to the challenges faced in recruiting families into the programme, meaning further evaluation is not feasible. This is why YEF use pilot studies: to test the feasibility of a large-scale impact study before expending significant time and resources on delivering one.

Introduction

Background

Many UK families with young people at the edge of care (i.e. young people at risk of entering the care system) experience multiple and long-standing difficulties, including mental ill-health, social deprivation, unemployment, violence, substance misuse, and relationship and behavioural difficulties [Oftsted, 2011; Bacon, 2023]). Young people are more at risk of entering the care system when experiencing social disadvantage, maltreatment, parental substance misuse or maternal depression (Simkiss et al., 2013; NICE Guideline, No.26. 2015). Drivers of adolescent out-of-home placements are associated with family stress and breakdown and adolescent behavioural problems (Percy-Smith et al., 2018). There is also a strong association between young people's special education needs (SEN) status and social care involvement (Jay and Gilbert, 2021).

The number of young people in the social care system is rising year on year, with over 400,000 young people in England reported to be in the system in 2024, representing 3% of the population of young people (Ofsted, 2024). Of these, almost 84,000 were young people placed in out-of-home care. While care placements can be beneficial for many young people, there are persisting concerns around children's social care and the placement of young people in out-of-home care, as reported in an independent review of children's social care by MacAlister (2022). Within the review, MacAlister highlighted the extreme financial pressures faced by children's social services, which are seen most acutely in areas with the highest social care needs. It was also noted that without reform to the social care system, the number of young people in out-of-home care is anticipated to continue to rise to 100,000 in the next decade – this is unsustainable, given the systemic issues in social care. A suggested means of reform by MacAlister is the establishment of family help teams, where the remit is "improving the lives of children and families, identifying risks early and preventing problems needlessly escalating for families until less dignified and more costly intervention is required later". There is demonstrably a need for an intervention to reduce care placements and address risk factors, thus changing the trajectory for young people and their families.

Evidence-based parenting intervention strategies supported by social care services can support families at the edge of care to prevent out-of-home placement (National Council of Voluntary Child Care Organisations, 2007; Ofsted, 2011; Bezeczky et al., 2020). These interventions address risk factors and promote factors to prevent the development of youth behavioural and emotional problems, as well as violence and delinquency in adolescence and adulthood; can improve social, behavioural and emotional outcomes for adolescents; can enhance positive parenting practices; can reduce family conflict; and can reduce disruptive adolescent behaviours (Wetherall, 2010; Salari et al., 2014).

By improving parenting skills and the parent–child relationship, overall family functioning and adolescent emotional and behavioural adjustment improve (Kuhn and Laird, 2014; Lanjekar et al., 2022). A key focus of all Triple P interventions is to train parents to generalise the parenting skills developed throughout the program to new problems, situations and all relevant siblings.

Five randomised controlled trials (RCTs) of Standard Teen Triple P have been reported, along with a sixth quasi-experimental study. One study looked at individual delivery of Standard Teen Triple P (Salari et al., 2014), three looked at group delivery (Chu et al., 2014; Kliem et al., 2014; Arkan et al., 2020) and one looked at self-directed delivery (Doherty et al., 2013). Although outcomes differed across studies, the RCTs reported improvements in adolescent behavioural problems, parent–adolescent relationships (reduction in conflict) and parent mental health (Chu et al., 2014; Kliem et al., 2014; Salari et al., 2014; Arkan et al., 2020). When

measured, the studies also reported improvements in parenting practices (Chu et al., 2014; Kliem et al., 2014; Salari et al., 2014). Three of the RCTs included follow-ups (three- or six-month follow-ups), reporting maintenance of improvements (Chu et al., 2014; Salari et al., 2014; Arkan et al., 2020). Sample sizes of the RCTs were similar and relatively small, ranging from totals of 46 to 84, with an approximately even split between Standard Teen Triple P and control groups. The fourth study was a quasi-experimental design, matching a sample of 103 parents who had received Standard Teen Triple P (group delivery) to a community control sample of 397 parents of adolescents (10–16 years) (Steketee et al., 2021). Similar outcomes were reported, with the Standard Teen Triple P group reporting improvements in parenting practices, parent–adolescent conflict and adolescent behavioural problems, with improvements maintained at three-to-five-month follow-up. Only one published evaluation of Standard Teen Triple P in the UK was identified, an RCT of web-based, parent-self-directed Standard Teen Triple for adolescents with Type 1 diabetes (Doherty et al., 2013). Compared to the usual care group (n=37), the treatment group (n=42) showed post treatment improvements in diabetes-related conflict. Standard Teen Triple P has been implemented as part of intensive family support models as part of edge-of-care services (Polaris Children's Services, 2025). There have been no evaluations to date of Standard Teen Triple P with adolescents at risk of out-of-home placement. While Standard Teen Triple P has promise as an intervention for this population on the edge of care, a rigorous RCT is needed.

Intervention

Standard Teen Triple P

Standard Teen Triple P is a targeted, indicated intervention for parents of adolescent children aged up to 16 years. The programme is indicated for parents who are concerned about their adolescent's development and behaviour (see trial protocol for details of the referral process).

Standard Teen Triple P involves a thorough assessment of the parent–child relationship and the application of parenting skills to a broad range of target behaviours. The programme involves parents attending 10 (one-hour) one-to-one sessions, where they learn practical strategies for how to manage problematic behaviours displayed by the child, promote healthy development and improve the quality of the parent–child relationship. Sessions are delivered face to face, either in person or via video conference. All parents in the family are invited to attend sessions.

Practitioners use a range of learning methods, including behavioural rehearsal to teach parents new skills, guided participation to discuss assessment findings, active skills training methods to facilitate the acquisition of new parenting routines and generalisation-enhancement strategies to promote parental autonomy.

In addition, parents are continuously provided with constructive feedback and are encouraged to set goals, practice strategies and complete their activity workbook and homework tasks.

Sessions 1–3 are set aside for assessment. In session 1, parents are interviewed to obtain information regarding the current problem, the adolescent's developmental history and the family history. If possible, session 2 involves an interview with the adolescent and an observation of the parent–child interaction. Then, in session 3, the practitioner shares assessment findings and assists the parent(s) in setting goals.

Sessions 4–9 are focussed on the actual intervention, whereby each session of active training (sessions 4, 6 and 8) is followed by practice sessions (sessions 5, 7 and 9). Sessions 4–5 cover promoting appropriate behaviours, sessions 6–7 are for managing problematic behaviours and sessions 8–9 are for dealing with risky behaviours.

Session 10 is the final session and covers additional skills to facilitate the generalisation and maintenance of treatment gains, an intervention review and closure.

Parents receive a Standard Teen Triple P Family Workbook to support them in using the strategies and processes taught during the programme. The Family Workbook covers each individual session, including information, practice tasks and space for taking notes/recording progress to encourage the implementation of Triple P in the family. Parents retain the workbook following the completion of the individual sessions.

Location: Standard Teen Triple P is typically delivered in the family home. Where this is not feasible, there is flexibility for delivery to occur in other locations, for example, a local authority or community premises where there is a private space to meet. There is also the option to deliver the programme remotely via video conferencing where suitable.

Frequency: Standard Teen Triple P is delivered on a weekly basis over 10 weeks. There is flexibility if parents are unable to attend a session – for example, due to illness or planned vacations – for practitioners to defer a session to accommodate such family life events.

All the parenting strategies within the Standard Teen Programme are taught by the close of Session 8, so there is a case that the completion of sessions 1–8 would be considered dose sufficient.

Logic model and theory of change

Figure 1 displays the Standard Teen Triple P logic model, and Figure 2 displays the Standard Teen Triple P theory of change.

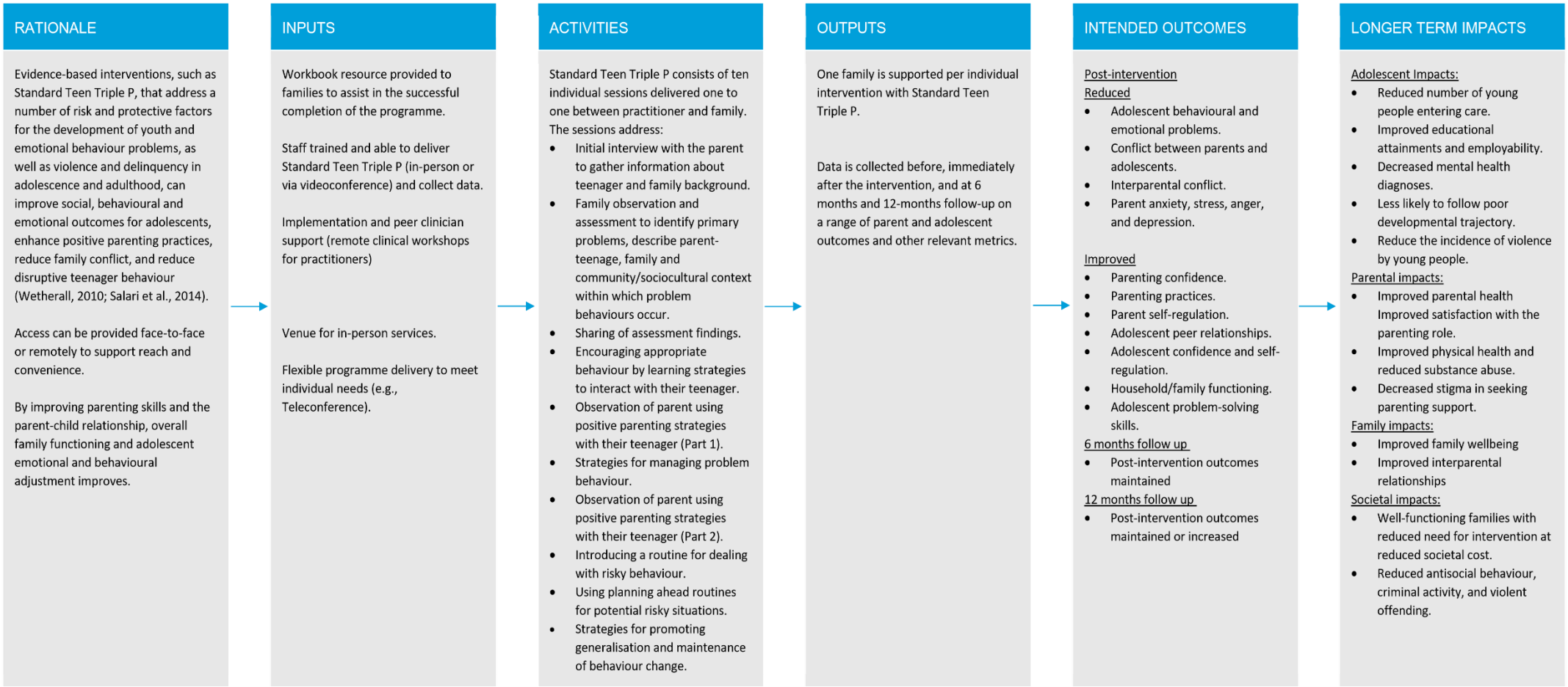
Figure 1. Standard Teen Triple P logic model

CONDITIONS: Parents of young people at the edge of care report increased alcohol and/or drug issues, childhood traumas, and mental disorders in children. Standard Teen Triple P aims to improve family functioning and increase positive outcomes for teenagers through parental promotion and the modelling of desirable behaviours. Through exposure to goal-oriented, family-focused interventions, teenager and parent emotional regulation is enhanced, parents are more engaged and their children are more likely to avoid entering the out-of-home care system. In England, the rate of children entering and remaining in care has risen steadily over the last 20 years. Among young people at the edge of care (i.e. those at risk of entering the out-of-home care system), many experience issues with school attendance, unstable housing, domestic abuse, and drug use, as well as emotional and behavioural problems. Further, parents of young people at the edge of care report increased alcohol and/or drug issues, childhood traumas and mental disorders.

PROGRAMME OBJECTIVES: This initiative aims to examine the large-scale effectiveness of Standard Teen Triple P in improving outcomes for young people aged between 11 and 15 years most at risk of entering care. This will be achieved by improving a range of outcomes across young people's well-being and behaviour and parental (biological and foster) mental health, parenting skills, self-regulation and self-efficacy, whereby parent/carer–child relationships are strengthened, and a more supportive family environment is created. The overall aim is to support families with adolescents at risk of entering the out-of-home care system and increase stability for young people on the Edge-of-Care. The primary objectives of this proposal are to:

1. Improve social, behavioural and emotional outcomes for adolescents
2. Improve practical parenting skills and parent–child relationships
3. Improve parental coping skills to reduce parenting stress, anxiety and depression to facilitate a positive family environment

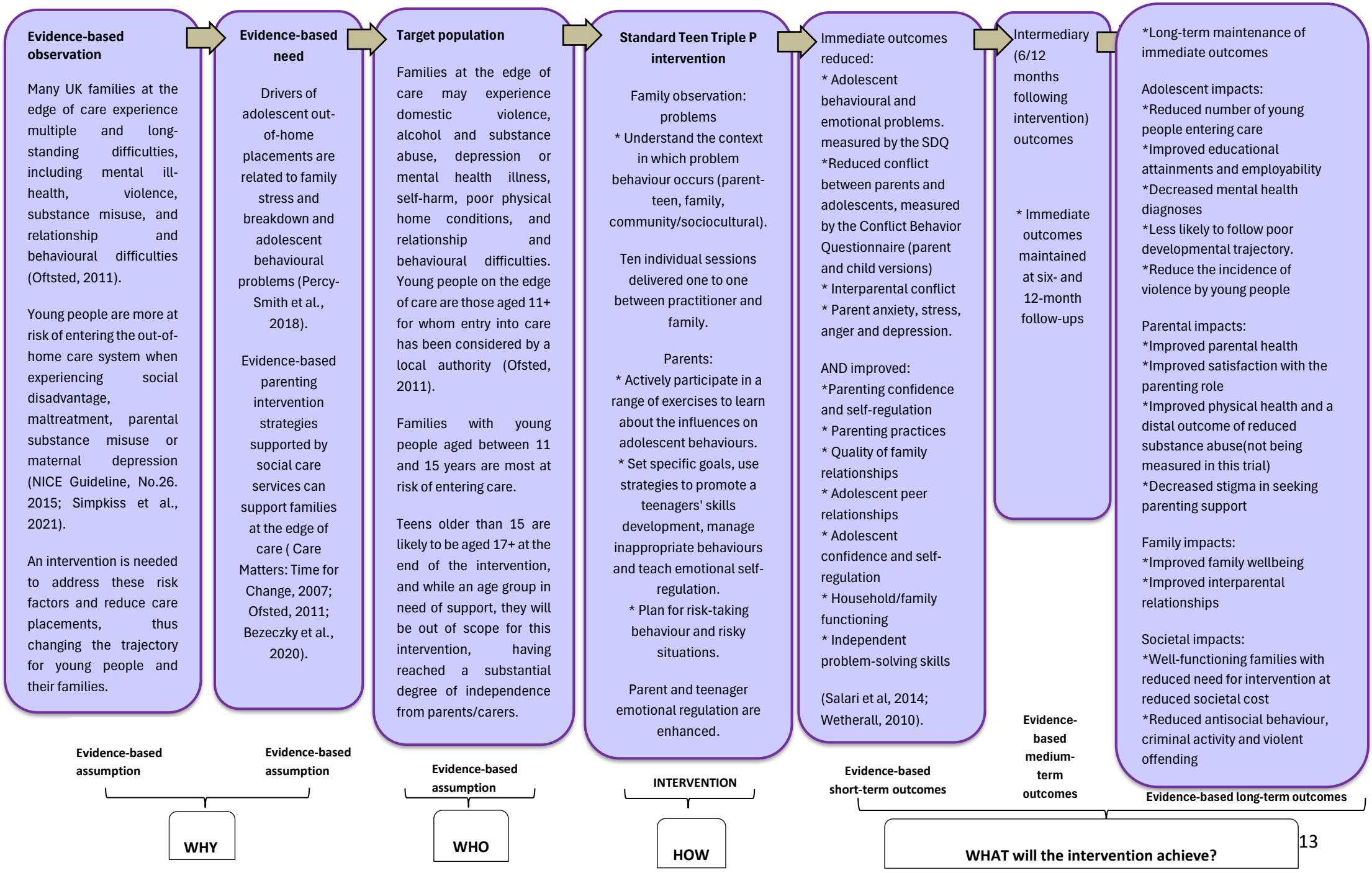
By working with caregivers, Standard Teen Triple P will seek to improve positive parenting practices and the parent–child relationship, facilitating a more positive family environment that aims to prevent adolescents from unnecessarily entering care. Focusing on parenting skills also has the added benefit of reducing child behavioural problems by teaching parents how to manage a broad range of difficult behaviours. As such, both caregivers and adolescents who are on the Edge-of-Care will benefit from Standard Teen Triple P, placing less burden on the out-of-home care system due to fewer entries into care.



Assumptions:

- Families at the edge of care will benefit from increased access to parenting skills programs.
- Practitioners deliver interventions in a sensitive and culturally appropriate manner relevant to edge-of-care practice.
- Parents will be receptive to the evidence about the impact of conflict and household functioning on their teenager/s.
- Parents report concern about the teenager or their own parenting skills or are seeking positive parenting information.
- Practitioners are available to train in and then deliver Standard Teen Triple P to parents.
- Practitioners will identify and work through disengagement, resistance, defensiveness, hostility and potential conflict from and between parents and their teenager/s.

Figure 2. Teen Triple P Theory of Change



Research questions

Primary objective

The primary objective (PO) was to determine whether there is a benefit of support as usual (SAU) plus Standard Teen Triple P over SAU alone in improving parent/carer (hereafter referred to as parents)-rated adolescent externalising behaviour problems at six-months post-randomisation in adolescents at the edge of care.

Secondary objectives (SO)

1. Complete an internal pilot (a pilot study conducted within the main study, with outcome data included in the full trial data) in the first year to inform the decision as to whether proceeding with a definitive trial is warranted and feasible.

2. Determine whether STANDARD TEEN TRIPLE P + SAU

(a) Reduces parent-reported adolescent internalising behaviour and increases prosocial behaviours at six months and 12 months post-randomisation and parent-reported adolescent externalising behaviour at 12 months post-randomisation

(b) Reduces adolescent-reported externalising and internalising behaviour problems and increases prosocial behaviours at six and 12 months post-randomisation

(c) Improves parenting practices, parent self-regulation, interparental relationships, parent–adolescent relationships and parental well-being at six and 12 months post-randomisation and decreases adolescent-reported antisocial behaviours at 12 months post-randomisation

(d) Reduces the chance of a child going into out-of-home placement over a 12-month period

3. Carry out exploratory sub-group analyses of outcomes by adolescent learning disability status and whether living with foster versus biological/adoptive parents.

4. Monitor and report adverse events related to the STANDARD TEEN TRIPLE P.

5. Complete a process evaluation using key indicators drawn from the logic model, including an evaluation of acceptability; the experiences of parents, adolescents with a broad range of ethnic and diverse backgrounds, and other key stakeholders (e.g. practitioners, delivery team); and the fidelity of delivery of the STANDARD TEEN TRIPLE P.

The pilot trial protocol is available on the YEF website (**https://youthendowmentfund.org.uk/wp-content/uploads/2023/07/Triple-P-Evaluation-protocol.pdf).**

Success criteria and/or targets

The design incorporates an internal pilot in the first year, with progression criteria (Avery et al., 2017), to examine whether moving on to complete a definitive trial is warranted. The proposed criteria are:

Recruitment

(i) Recruitment of 137 families/206 parents (50% of the final sample size) within the initial six months of the trial (green=80 to 100%, at least n=137 families/206 parents; amber=60 to 79% n=82–109 families/124–163 parents; red=<60%, n=</82 families/163 parents). Full justification of the sample size is provided on page 20.

Randomisation

(i) The proportion of recruited families then randomised (green=≥90%; amber=50-89%; red=<49%)

Fidelity and adherence (for those randomised to STANDARD TEEN TRIPLE P in the first three to four months who will have completed the intervention by the progression decision point).

(ii) Fidelity assessed according to a fidelity checklist (developed in collaboration with the delivery team prior to the internal pilot) (green=≥80 of sessions meet the criteria; amber=50–79%; red=<50%).

(iii) Adherence: session attendance, per cent of families attending at least the first eight of the ten sessions (green=≥75%; amber= 50–74%; red=<50%)

Outcomes

(i) Data completeness for the Strengths and Difficulties Questionnaire (SDQ) parent-reported young person externalising problems score at baseline for those randomised: green=≥75%; amber=50–74%; red=<50%

The final progression criterion was an assessment to confirm that the support in the intervention arm is sufficiently different to the control arm. This was an assessment based primarily on an SAU survey.

Information from the SAU survey was examined for any overlap with the content of the STANDARD TEEN TRIPLE P intervention.

Ethical review

The study received a favourable ethical opinion from London City & East NHS Research Ethics Committee and associated Health Research Authority approval on 16 June 2023 (ref: 23/LO/0435). The sponsor of this study was the University of Warwick. The trial was registered at *www.controlled-trials.com* (ISRCTN72900402).

Potential parents and adolescent participants were provided with trial information, including an information sheet, a copy of the consent/assent (detailed below) forms and contact information for the University of Warwick project evaluation team. If the parents were interested in taking part or wanted to discuss the trial further, they were able to directly contact the trial manager. Alternatively, with the consent of the parent, the local authority could provide the trial manager with the parents' contact details, and the research assistant/trial manager could contact the family.

If the parents and adolescents were interested in taking part, an appointment was arranged with a research assistant and the following was carried out:

- The trial was explained in detail, including the randomisation and consent process. Research assistants ensured that the participants had sufficient time to consider the information in the information pack.
- Eligibility was assessed.
- Consent to participate was obtained from parents for their participation and their adolescents' participation, alongside assent from adolescents.
- Baseline data was collected.

See Appendix 2 for information sheets and consent forms provided to participants.

Data protection

We abided by the data protection principles set out in GDPR (2018). Our legal basis for processing personal data was a public task (Article 6(1)(e)), and our ethical basis was informed consent. The sponsor of this study was the University of Warwick, which acted as a data controller and data processor for this study. Information sheets included our intention on behalf of YEF to transfer identifiable data to the Department for Education for anonymisation and for the YEF to subsequently become the data controller for the pseudonymised data in the archive, enabling future research with this trial cohort. See Appendix 2 for information sheets provided to participants.

Digital trial data was stored in a secure folder, accessible only to the research team, on a secure server. Paper-based trial data was stored in locked cabinets and offices for the duration of the trial. Interview data was recorded on encrypted audio recorders and stored on password-protected secure servers at the University of Warwick. Interview recordings were transcribed fully and pseudonymised for analysis using NVivo computer software. Pseudonymised digital data is being stored for 10 years. All data is confidential, and it is not possible to identify a child or any member of their family within any publication arising from this work.

Project team and stakeholders

- The intervention was delivered by practitioners at six local authority sites (Birmingham, Wirral, Merton, Cambridgeshire, Peterborough, Gloucestershire).
- The intervention was developed by Professor Matthew R. Sanders and colleagues from the School of Psychology at the University of Queensland. As the delivery team, Triple P UK was responsible for the recruitment of the local authority sites and the training and accreditation of practitioners within the local authority teams who delivered the intervention. Triple P UK also provided clinical workshops post-training on set topics.

Evaluation team

- The Chief Investigators were Professor Kylie Gray and Dr Paul Thompson from the University of Warwick/University of Birmingham.
- The Trial Manager was Dr Atiyya Nisar, and the Research Assistant was Katharina Bucher from the University of Warwick/University of Birmingham.
- The wider study team comprised:
  - Dr Samantha Flynn from the University of Warwick, who provided expertise in process evaluation
  - Professors Richard Hastings and Peter Langdon from the University of Warwick/ University of Birmingham, who provided additional expertise in conducting RCTs
  - Faye Tomlinson from the University of Warwick, who provided expertise in social care.

The research team has the following potential conflicts of interest to declare:

K. Gray and R. Hastings have a joint Economic and Social Research Council (ESRC)-funded PhD project with Triple P UK that focuses on a different population and different Triple P intervention. K. Gray was previously an investigator on a funded research study which implemented and evaluated the Stepping Stones Triple P programme in Australia. This work was funded by the National Health and Medical Research Council of Australia and included Professor Matthew Sanders (Triple P developer) as a co-investigator. Gray and Sanders have co-authored papers from this research. Gray and Hastings have not at any time been employees of Triple P UK or Triple P International, nor have they been authors of any Triple P materials, and they do not receive any royalties from Triple P UK/Triple P International. The remaining research team members have no potential conflicts of interest.

Methods

Trial design

A two-arm cluster RCT design was used, with random allocation at the family level (families as clusters). Families were randomised on a 1:1 basis to either the intervention (STANDARD TEEN TRIPLE P and SAU) or control arm (SAU only), using stratified permuted block randomisation stratified by the local authority.

Participant selection

There was one pathway for recruiting participants in each local authority (site). Practitioners in services identified potential adolescent participants in their service, with reference to the inclusion and exclusion criteria below. Potential parents and adolescent participants were provided with trial information (physically, online or by post/email), including an information sheet, a copy of the consent/assent forms and contact information for the University of Warwick project team. If the parents were interested in taking part or wanted to discuss the trial further, they could directly contact the University of Warwick research assistant/trial manager. Alternatively, with the consent of the parent, the local authority provided the University of Warwick research assistant/trial manager with the parents' contact details, and the research assistant contacted the family.

If the adolescent (and parent if appropriate) was interested in taking part, an appointment was arranged with a research assistant (via telephone) and the following was carried out:

- The trial was explained in detail, including the randomisation and consent process. Research assistants ensured that the participants had sufficient time to consider the information in the information pack.
- Eligibility to participate in the trial was assessed.
- Consent to participate was obtained from the adolescent's parent, alongside assent from the adolescents.

The appointment with the research assistant was made in one of two ways – the research assistant contacted the participant/parent to arrange the appointment (using contact details provided by the local authority), or the participants/parent got in touch directly with the research assistant to request the appointment.

Families were eligible for the trial if they met all the following inclusion criteria and none of the exclusion criteria applied.

Inclusion

• Families of young people aged 11–15 years determined as being on the edge of care

Definition of edge of care

A definition of edge of care was developed jointly by the evaluation and delivery teams and through consultation with representatives from participating local authority sites. In this trial, edge of care referred to adolescents who either:

• They had not entered into care, as they had been assessed and the local authority had chosen to support them and their families through alternative provisions/services.

Or

• They were being considered for care but had not entered into local authority care

The definition was broad in scope in order to encompass the varying thresholds for edge of care across social care services situated within different local authorities. It was refined further by the application of the exclusion criteria below to provide a clear trial definition.

Exclusion

• Families in which one or more parents had received a multi-session parenting programme covering similar content to Triple P over the preceding 12 months.

• Families in which one or more parents are currently receiving a multi-session parenting programme covering similar content to Triple P or any multi-component manualised family intervention, such as multi-systemic therapy.

Families of adolescents who were 16 or older at the time of being recruited to the trial were not eligible, as they would age out of the intervention. It is also possible that these adolescents would have moved out of the family home during the trial.

We planned to recruit a total of 412 participants (parents) at an expected rate of 34–35 per month across six authorities (approximately six per local authority site per month) over 12 months. It was expected that 206 participants would be recruited in the pilot phase and 206 in the main trial phase.

Sample size calculations

Parents within the same family were randomised to the same arm, making this a cluster RCT, given that responses within the same family were potentially highly correlated. We might have expected, based on our previous research with families, an average cluster size within families of up to a maximum of 1.5 parents and a high degree of correlation among parents from the same family, so this also allowed for an intraclass correlation of 0.5 (Davé et al., 2008). Following Teerenstra et al. (2012), we also allowed for a correlation between baseline and follow-up measures of the primary outcome of r=0.5 (this was a conservative estimate based on published SDQ test–retest correlations of 0.74–0.84; Nowak et al.,2008). The sample size was then inflated to account for 20% of families being lost to follow-up at the 12-month post-randomisation follow-up time point (Tully and Hunt, 2016).

Allowing for the above assumptions and an effect size to be detected of 0.35, with 90% power and a two-sided alpha of 0.05, a sample size of N=412 parents (N1=206, N2=206) was required.

The choice of effect size was based on meta-analytic effects from similar parenting programmes' meta-analyses (Nowak et al., 2008; Baumel et al., 2016; Schoemaker et al., 2020) and on the basis that similar Triple P programmes report large effect sizes that are typically >0.5, some as large as 0.8. On this basis, we reduced it to 0.35, given the unique nature of the population in this trial. Further evidence based on

individually delivered teen parenting programmes (ie. well-powered RCTs or meta-analyses)was quite challenging to find, so meta-analyses that were slightly outside our age range were also considered.

An efficacy trial for Standard Teen Triple P reported an effect of d=0.62 (Salari et al., 2014). In another meta-analyses, it was also generally around d=0.6. Given that we delivered this to a slightly different population, the current planned minimum detectable effect size (MDES) 0.35 was justifiably conservative (mainly as most studies have been quite small and in a very different population). Considering this in terms of what change would be clinically meaningful, d=0.35 equates to approximately a two-point change in our primary outcome; an effect smaller than this was unlikely to provide any meaningful change. With reference to sample size and secondary outcomes, the trial was powered on the basis of detecting an appropriate MDES for the primary outcome, which is standard practice in all major trials (CONSORT statement; Schulz et al., 2010).

All sites that were interested in participating in the trial were required to complete a registration form to confirm that they had adequate resources and experience to conduct the trial. The settings were social work teams(primarily edge of care) across six local authorities (Cambridgeshire, Peterborough, Birmingham, London Borough of Merton, Gloucestershire and Wirral).

Standard Teen Triple P practitioner training and implementation support

The allocation of a Triple P implementation consultant and regular Triple P implementation meetings/calls are practice as usual for services delivering Standard Teen Triple P. Services are typically supported in planning, training, implementing and maintaining Standard Teen Triple P to maximise and sustain high-quality programme delivery. In the context of this trial, implementation support was delivered with local trial site coordinators and service managers.

The trial was supported by Triple P UK ’s implementation consultant for research, using the Triple P Implementation Framework (McWilliam, Brown, Sanders and Jones, 2016). The Triple P Implementation Framework and associated tools address all the key organisational elements required to establish Triple P in service settings, including tools to support practitioner selection for training and setting up quality and fidelity organisational monitoring processes and tools for managers and supervisors to support and monitor local delivery and outcomes. The function of implementation support is to set up local organisational systems to embed and sustain the programme in services to support parents and children.

There are five phases in the Triple P Implementation Framework, corresponding to key decision-making and activity sequences in the effective implementation of Triple P. Below, we have outlined key activities that applied to this trial within each phase:

1. Set-up phase/engagement: The engagement phase of implementation aims to provide the site with a greater understanding of the Triple P system, the evidence base, the implementation process and, in this instance, an overview of the YEF trial. The intended outcome of this phase was a shared understanding of the organisation’s current interest and potential capacity to successfully engage with and deliver the YEF trial of Standard Teen Triple P.

Steps in the set-up and engagement phase:

- Initial information exchange with key/senior decision makers at each site about Standard Teen Triple P and the YEF trial, including information about the Triple P System, evidence base and implementation approach and summary of the YEF trial
- Consideration of alignment with organisational mission/vision/aims/values
- Exploration of shared desired outcomes, reach and scope for Triple P and the YEF trial
- Exploration of the local definition of edge of care and referral pathways
- Alignment with the current service delivery model and specifically the edge of care service model
- Identification of any potential referral/delivery partners
- Exploration of potential fit for the YEF Triple P trial with the organisation (including target population, workforce, organisational capacity)
- The gaining of an understanding of the organisation's interest and capacity to engage with the trial

2. Commitment and contracting (November 2022–March 2023): Due to the specification of TPUK's grant agreement with the funder, TPUK was obliged to contract each local authority individually to provide the programme and the trial particulars and to formalise the local authority's commitment through a service level agreement (SLA). SLAs were intentionally closely aligned to the funder grant agreement and clearly defined the expectations and responsibilities of both TPUK and the local authorities involved. These outlined the scope of local authority involvement, the project performance metrics, the payment schedule and the potential consequences of not meeting agreed-upon standards. The aim of these was to establish trust and accountability between TPUK, the local authorities and their contributors, ensuring that all parties were on the same page and working towards the project goals. All six required SLAs were fully executed by March 2023, and local authorities formally subscribed to the project as trial sites.

Significant elements of commitment and contracting were pre-determined by the trial parameters/requirements (e.g. target population) and had been shared and discussed with sites in the Set-up/Engagement phase, including:

- Key partners in the trial (YEF, Triple P UK and the evaluation team)
- The variant of Triple P to be delivered
- The target population for delivery
- The funding envelope

All other relevant items in the commitment and contracting section of the Triple P Implementation Workbook were included and discussed with sites.

3. Implementation planning (January–July 2023)

- Each site identified a local trial coordinator in a team leadership/senior role who met weekly with TPUK's implementation consultant for research during the implementation planning phase.
- Organisational structures were set up for trial readiness (identifying the delivery team, management, mechanisms for referrals).
- The implementation strategy was developed, and activities were identified to prepare the sites to deliver Standard Teen Triple P for the trial.

- Participating practitioners were identified at each site using the Making the Most of Your Triple P Training resource provided by TPUK and with consideration that their roles were aligned with services for the trial population and capacity was available to complete all the preparation, training and delivery requirements of the trial. To ensure nominated practitioners were adequately prepared to participate in training programme delivery, plans were developed for:
    - Preparation, training, accreditation and support (assign to the cohort dates, participant selection, resources).
    - Delivery with families
    - Communications
    - Reporting

4. Briefings, training and accreditation and clinical workshop (April–mid-July 2023)

Practitioners received materials for their Standard Teen Triple P training, comprising a Standard Teen Triple P Practitioners' Manual, Participant Notes for Standard Teen Triple P Provider Training, and a copy of the Teen Triple P Family Workbook. Also provided was access to a web-based information site, *The Triple P Provider Network,* to access downloadable resources and Triple P updates. This provision of training materials and access to web-based information is practice-as-usual for all practitioners completing Triple P training in any variant of the programme.

All Triple P training, pre-accreditation workshops and accreditation events for the trial were conducted remotely via Zoom, except for one face-to-face clinical workshop with the Wirral site.

The attendance requirements to reach accreditation in Standard Teen Triple P consisted of attendance at three days of training, followed approximately a month later by a one-day Pre-accreditation workshop to prepare for accreditation, followed by attendance at their pre-selected accreditation session.

Practitioners were required to pass the role-play-based half-day accreditation with a Triple P trainer and pass a Triple P multiple choice quiz to achieve accreditation in Standard Teen Triple P to be approved to deliver the programme. The requirement to attain a specified minimum training attendance and completion of training and accreditation are practice-as-usual to reach accredited status in any Triple P programme.

Following the accreditation process, practitioners attended a half-day trial-specific briefing (conducted via Zoom and facilitated by a Triple P trainer) entitled Triple P YEF trial – preparing for your first delivery. These briefings (six in total for 20 practitioners per session) were delivered on a site-by-site basis and held prior to the intervention phase of the trial. The briefing's purpose was to support familiarity with the specific trial processes prior to the practitioner's first delivery.

Topics for the trial-specific briefing included reiteration of the family trial inclusion criteria (previously formally agreed with TPUK and the evaluation team following consultation with trial sites) and local trial referral pathways (developed previously by local senior staff and trial site coordinators). The briefing also included preparation for Triple P intervention delivery (including the use of Standard Teen Triple P workbooks/manuals and session checklists, common Triple P implementation challenges, and opportunities to ask for clarification, refresh elements of the programme and engage in Q&A on intervention content).

5. Implementation and maintenance (August 2023 onwards)

TPUK's implementation consultant for research continued to support each site in its implementation of the programme within the trial, focusing on encouraging trial coordinators to continue to monitor and refine referral pathways, reviewing and facilitating throughput of appropriate referrals and maintaining practitioner skills delivering Standard Teen Triple P with quality and fidelity.

During this period, the implementation support needs and meeting regulatory requirements were continually assessed in collaboration with each local authority coordinator. The support provided by the implementation consultant for research to the trial coordinators continued for the remainder of the trial, with a focus on implementation problem-solving and ongoing use of Triple P implementation tools.

Key integrated elements within Triple P include the maintenance of programme quality and fidelity, engagement with parents and a focus on equity, diversity and inclusion, all of which directly correlate with positive outcomes for families. The project aimed to conduct three workshops for practitioners as part of its implementation strategy. Practitioners were scheduled to participate in three half-day clinical workshops at specific intervals (November 2023, March 2024 and September 2024), facilitated by a Triple P Trainer via Zoom. Workshops were provided on a site-by-site basis. Each workshop could accommodate a maximum of 20 participants. All clinical workshops provided an exploration of the challenges of implementing Triple P programmes with parents and practical exercises to enhance practitioners' skills.

Fidelity to programme delivery

Fidelity and flexibility in the delivery of Standard Teen Triple P was actively taught and discussed during practitioner training, and these are topics for the half-day workshops that practitioners attended during the pilot phase of the trial.

To support the maintenance of high-quality programme delivery, Triple P has developed a bespoke Peer-Assisted Supervision and Support Model (PASS), whereby practitioners can provide and receive structured feedback from each other when they are delivering the programme to families. It is practice-as-usual to encourage the use of the PASS model, which is included in Triple P training and recommended by Triple P as good practice. PASS group sessions at all trial sites were conducted in small groups of practitioners and ran for one to two hours every month to maintain the quality and fidelity of programme delivery.

Training approach

- Practitioner briefing: two hours
- Training: three days
- Pre-accreditation workshop: one day
- Accreditation workshop: one >2.5-hr session per person delivered in small groups

Triple P UK delivered all events by Triple P trainers. Trainers typically hold a minimum of a master's degree in psychology and/or education, and they receive a highly structured training programme delivered by Triple P founder Professor Matthew Sanders. An ongoing accreditation process is then followed to ensure that Triple P trainers continue to deliver high-quality training and accreditation across all levels of the Triple P system.

Each site was tasked with assigning 20 practitioners to the trial, with trial site coordinators overseeing the local practitioner selection process. The selection of practitioners for Triple P training and programme delivery is a critical factor in successful delivery with families and was a key topic during implementation calls with each site to support the successful selection of practitioners with appropriate core skills and training, capacity to deliver and commitment to deliver.

Site coordinators were supported in the staff selection process by Triple P tools, including:

- Provision of the Triple P tool Making the most of your Triple P training – a structured document supporting the suitability of the programme for the site and specifically for each nominated practitioner in terms of their role, capacity and commitment to deliver the programme. Completion of this document with each practitioner was mandatory and required sign-off by each practitioner and their manager as part of the practitioner selection process.

- Two mandatory events were held for practitioners to prepare them for training and intervention delivery within the trial:

    - **Standard teen practitioner briefing:** Preparing for Triple P Training (2 hours) prior to the Standard Teen Triple P training. These were delivered to each of the six cohorts in April and May 2023 and led to most cohorts reporting high ratings of overall preparedness for the Triple P provider training courses (note: data regarding preparedness ratings was not collected by the evaluation team).

    - **Preparing for your first delivery workshop:** These were delivered to each site in July 2023. Delivery was post-Standard Teen Triple P accreditation and prior to intervention delivery that was planned to commence in August 2023. Access to the presentation and recording of the workshop were provided to sites.

- With the support of the Triple P implementation consultant for research, site trial coordinators led local aspects of training coordination, including supporting practitioner selection, gathering the information needed for the training materials to be dispatched and inviting their staff to the events. Triple P hosted the training events and dispatched the Triple P training resources ahead of each event. Triple P monitored and provided feedback to the local coordinator regarding practitioners' attendance at training activities.

Standard Teen Triple P preparation for training webinar

For agency training, it is Triple P practice for the implementation consultant to support an agency coordinator to provide practitioners (and their managers) with a Preparation for training webinar prior to attending Triple P training. The purpose is to ensure all parties have clarity about what is required to achieve accreditation in a particular Triple P programme and the accreditation and delivery expectations (for trial purposes, trial delivery requirements were included).

Six cohorts of training were delivered between May and June 2023. Each training cohort was preceded by the two-hour preparation webinar. Triple P training consisted of three full days of training, followed four weeks later by a full-day pre-accreditation workshop. This was immediately followed by a practitioners' accreditation session in small groups with the trainer, as per Triple P typical practice.

In total, 117 practitioners were enrolled to attend training. The number of practitioners who attended training sessions and passed accreditation by site is displayed in Table 1. All except one practitioner (99.75%) passed accreditation.

Table 1. Training attendance and accreditation

Site	No. of practitioners who attended training sessions	No. of practitioners who passed accreditation
Merton	20	19
Cambridgeshire	20	20
Gloucestershire	18	18
Wirral	19	19
Birmingham	20	20
Peterborough	20	20

PASS sessions: PASS sessions were mandated on a monthly basis per site. The delivery of these started in July 2023, and sites reported consistent delivery until project close in March 2024. PASS sessions were established and monitored by local trial site coordinators. Sessions were attended by Triple P practitioners delivering in the trial and, in some instances, trial site coordinators. Attendance records were collected by trial site coordinators. Sessions were peer-led, as per the PASS model, with trial Triple P practitioners setting the agenda in advance where possible. Site trial coordinators also supported some or all sessions in person, where appropriate. Please refer to the PASS information and checklist in Appendix 1 for a description of PASS session content.

Half-day clinical workshops (during the intervention phase):

Three half-day clinical workshops on flexibility and fidelity were delivered in November 2023. Workshops were delivered by Dr Claire Halsey (Triple P UK) and attended by accredited Standard Teen Triple P practitioners from across the five participating sites (the Peterborough site had withdrawn from the trial prior to workshop delivery). The TPUK clinical workshops encompass instructional content, reflective exercises, skill demonstrations, and individual and group learning sessions, each bolstered by a comprehensive practitioner workbook containing relevant content and practical exercises. The Triple P flexibility and fidelity workshop is designed for accredited Triple P practitioners who offer any Triple P course with parents. The workshop provides a review of the challenges of providing parenting programmes that are responsive to the needs of the parents while adhering to evidence-based practice. At the end of the workshop, participants should be able to:

- Understand the importance of and rationale for delivering Triple P with fidelity
- Be better able to adapt aspects of Triple P interventions to be flexible to and suit the needs of parents and children without breaching the programme's evidence base
- More confidently use the self-regulatory framework to help parents' problem solve

Data collection

Outcome measures

Baseline measures (for parents and adolescents)

-
- Parent and adolescent date of birth (dd.mm.yyyy)
- Sex/gender (including inclusive language and a 'prefer not to say' option)
- Who the adolescent lives with
- Ethnicity
- Whether English is their first language
- SEND
- Long-term physical or mental health conditions/illnesses

The University of Warwick trial evaluation team also collected contact details, including name and address (including postcode, telephone number and email address) for the purpose of completing baseline and follow-ups. These were kept separate from the trial data. The trial team used text messages, emails and post to maintain contact with participants and remind them of upcoming appointments for data collection. The full date of birth was collected, as it was required for determining trial eligibility and funder archiving (including data linkage).

Primary outcome

The primary outcome measure was the externalising behaviour subscale total score (as indicated by the logic model) from the parent-report SDQ measure collected at six months post-randomisation. The SDQ is a robust and well-validated measure of behavioural and emotional problems (Deighton et al., 2014).

Secondary outcomes

Secondary outcome measures were:

1. Adolescent behavioural and emotional problems: The SDQ (Goodman, 1999) parent report internalising problems scale and the adolescent report externalising and internalising problems scales were used.

2. Parenting practices: Parenting Scale Adolescent version (parent completed) is a short form of the Parenting Scale (Irvine et al., 1999), which assesses dysfunctional discipline practices in parents. It is an adaptation of the Parenting Scale (Arnold et al., 1993) for parents of adolescents.

3. Adolescent prosocial behaviours: The Prosocial Behaviour subscale of the SDQ (Goodman, 1999) was used to assess adolescent prosocial behaviours. This was completed by adolescents and parents.

4. Adolescent peer relationships: The Peer Relationship Problem subscale of the SDQ (Goodman, 1999) was used to assess adolescent peer relationships. This was completed by adolescents and parents.

5. Interparental outcome: The Dyadic Adjustment Scale (DAS-7) is a seven-item measure (Sharpley and Cross, 1982; Hunsley et al., 2001) that assesses the relationship quality of couples. The DAS-7 assesses relationship satisfaction and the degree to which the couple agrees on matters of importance to the relationship. This measure was completed by parents.

6. Parent mental health: The Kessler 6 is a six-item screening tool for serious mental illness in the general population (Kessler et al., 2003). It was completed by parents.

7. Parent well-being: The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a measure of mental well-being (Tennant et al., 2007). The short (seven-item) version was completed by parents.

8. Parent-adolescent conflict: The Conflict Behavior Questionnaire (CBQ-20) (Robin and Foster, 1989) assesses adolescent–parent communication, conflict and relations. Both the adolescent and parent report versions were completed.

9. Child–parent relationship: The Closeness subscale of the Child-Parent Relationship Scale (CPRS, short form) measures (Pianta, 1995) was completed by parents.

10. Family functioning: The Family APGAR scale (adaptability, partnership, growth, affection and resolve) measures satisfaction with family functioning (Smilkstein, 1978). This five-item measure was completed by parents.

11. Parent self-regulation: The Parenting Self-Regulation Scale is a 12-item parent-completed measure of parental regulation (Tellegen et al., 2022) and was completed by parents.

12. Out-of-home placement: All instances of out-of-home placement were recorded at each follow-up time point. This includes the reason for and duration of out-of-home placement. This measure directly informs a longer-term impact from our logic model, as this can be used to evaluate whether there was a reduction in the number of people entering care post-intervention.

13. Adolescent antisocial behaviours: The Self Report Delinquency Measure is a 15-item measure of antisocial behaviours (e.g. burglary, violence) and was completed by adolescents at 12-month follow-up.

Outcome measures were selected based on psychometric properties (reliability, validity and suitability for context, including cultural context), brevity (to reduce participant burden) and affordability (with the exception of the SDQ, all measures are cost-free).

Quantitative outcome measure data was collected from parents and adolescents at two time points – baseline (pre-randomisation) and follow-up (six months post-randomisation). This data was collected by Attiya Nisar and Katharina Bucher – measures were completed online or over the telephone. Baseline data was collected between August 2023 and March 2024, with follow-up data collected between March 2024 and September 2024. Each participant received a £20 shopping voucher at baseline and £25 at follow-up as a thank-you for their participation.

At six months post-randomisation, all participants (parents and adolescents) were invited to take part in qualitative process evaluation data interviews. We invited all recruited parents to an interview with a researcher about their experiences of being involved in the trial and (where relevant) their experiences with

Standard Teen Triple P. If they agreed to participate, consent was obtained from parents and adolescents who turned 16 years of age during the trial, and assent was obtained from adolescents under 16 years of age. Interviews were conducted via Microsoft Teams by Katharina Bucher, Attiya Nisar, Kylie Gray and Samantha Flynn between April 2024 and September 2024. Each participant received a £50 shopping voucher as a thank-you for completing the interviews. Interviews with parents in the intervention group explored their experiences of the trial (e.g. randomisation, questionnaire completion) of Standard Teen Triple P and factors impacting adherence. Interviews with parents in the control group explored their experiences of being in the trial. We invited all recruited adolescents to an interview about their experiences of the trial and intervention (where relevant). Where a family was randomised to receive the intervention, interviewed adolescents were asked to reflect on what they had noticed in relation to their parent attending the intervention.

We also invited practitioners, site managers and site coordinators to interview. Practitioner interviews explored their experience of delivering Standard Teen Triple P and/or SAU, the potential systems and structures which would be needed for future implementation, and the perceived impact of Standard Teen Triple P. Site manager and site coordinator interviews explored their experiences of the trial, the fit of the trial in their service and their motivations for being involved with the trial.

Framework thematic analysis was used to analyse qualitative interview data, with the framework informed by a combination of the Medical Research Council (MRC) process evaluation guidance and the intervention logic model. Triangulation was conducted, combining the qualitative and quantitative data on recruitment, adherence, fidelity and intervention mechanisms.

Practitioners working with families in the trial were asked to complete the following implementation measures to provide data on fidelity, adherence and usual support:

- Standard Teen Triple P session checklists – which components of each Standard Teen Triple P session were delivered to the family (for practitioners delivering Triple P only)?
- Attendance logs – whether each session of Standard Teen Triple P was offered to parents, whether the session was attended or whether the session was rescheduled and which parent(s) attended the session (for practitioners delivering Triple P only)?
- SAU checklists – what support was offered to families, and were any components of Triple P or another parenting intervention offered to the families?

Session checklists, attendance logs and SAU checklists were completed by practitioners at each site. These were completed either on paper by the practitioner and inputted into a secure online database by AN/KB or directly into the database by the practitioner.

Table 2. Methods overview

Research methods	Data collection methods	Participants/data sources (type, number)	Data analysis methods	Implementation/ logic model relevance
Quantitative	Screening logs	Data collected by the delivery team and local authorities, as well as the research team	Descriptive	Useful information to understand recruitment approaches for future implementation of Standard Teen Triple P
Quantitative	Standard Teen Triple P session checklists	Practitioners delivering Standard Teen Triple P rating every delivered session	Descriptive	Fidelity critical to the success of underpinning theoretical mechanisms
Quantitative	Practitioner records	Attendance data collected by practitioners delivering Standard Teen Triple P	Descriptive	Dosage/adherence critical to the success of underpinning theoretical mechanisms
Qualitative	Interviews (semi-structured)	At least 35 parents, at least 10 adolescents and at least 15 practitioners in both the Standard Teen Triple P trial arms	Framework thematic analysis	Perceptions of stakeholders are a key component in assessing change processes

Randomisation

Following baseline assessment, families were randomised on a one-to-one basis to either the intervention (Standard Teen Triple P and SAU) or control arm (SAU only) using stratified permuted block randomisation, stratifying by local authority. The randomisation allocated families as a cluster so that parents from the same family were in the same trial arm. The randomisation list was produced in advance and used a block size of four. Outcome assessors and the research team (excluding co-PI Thompson) remained blind to allocation.

Access to the allocation sequence in the database was restricted from the researchers involved in collecting data. Therefore, the senior trial statistician (co-PI Thompson) conducted the randomisation. Randomisation was conducted using statistical software R (version 4.2.2 -2022-10-31 ucrt), using the R package blockRand. The randomisation was embedded within the study database. Departmental administration was responsible for informing site coordinators of a participant's allocation by secure file transfer.

Analysis

Quantitative analysis

Details of the full planned statistical analysis for the efficacy trial can be found in the Statistical Analysis Plan (SAP; Version 1.2, Gray and Thompson, 2023), which was published before data collection was closed. The full planned analysis was not undertaken, as the trial did not progress beyond the internal pilot.

Statistical analysis for internal pilot outcomes was primarily descriptive. Outcomes are reported as frequencies and percentages, means, and standard deviations with associated 95% confidence intervals and Hedge's g effect sizes. Hedge's g effect sizes were derived by calculating the mean differences between groups and dividing this number by the sample size weighted pooled standard deviation.

Feasibility outcomes were assessed against the prespecified progression criteria. The percentage of missing data is also reported descriptively. Missing data was not imputed, as there would not have been a meaningful difference in the findings, given the small sample sizes.

Quantitative process evaluation data (e.g. recruitment, adherence, fidelity) was descriptively analysed.

Qualitative analysis

With appropriate consent, all interviews were audio recorded, fully transcribed and anonymised for analysis. Computer software (NVivo) was used to manage the qualitative data and transcripts.

Framework thematic analysis was used to analyse the qualitative interview data, with the framework informed by a combination of the Medical Research Council Process Evaluation guidance (Moore et al., 2015) and the logic model. Triangulation was conducted, combining the qualitative and quantitative data on recruitment, adherence, fidelity and intervention mechanisms. Qualitative data was used to interpret patterning in recruitment, adherence and fidelity data, with analysis of the quantitative data, in turn, highlighting areas which should be further explored in qualitative interviews and analysis.

Process evaluation objectives were achieved through the methods outlined in Table 3. These were set out for each of the methods of data collection, including what the data was used for.

Table 3. Implementation and Process Evaluation (IPE)methods overview

Objective	Data sources/ methods	Completed by or with	Timing
Recruitment and reach			
1. What are the most effective approaches for recruiting parents/carers and adolescents to take part in this trial of Standard Teen Triple P?	Screening logs	Completed by site staff	Throughout the pilot
	Interviews by research staff	With site staff (managers, team coordinators)	April–August 2024
		With practitioners	
		With parent/carer participants	May–August 2024
		With adolescent participants	

2. What are the retention rates of parents/carers? What are the reasons for attrition?	Withdrawal data	Completed by site staff and Research Assistants	Throughout the pilot
	Interviews by Research Staff	With site staff (managers, team coordinators)	April–August 2024
		With practitioners	
3. To what extent were parents/carers from diverse backgrounds recruited to the trial?	Demographic data	Completed by/with parent/carer participants	Baseline questionnaires
Intervention fidelity, adherence and dose			
4. How well was Standard Teen Triple P implemented? Did practitioners deliver the intervention as intended, with high fidelity to the manual?	Practitioner checklists	Completed by practitioners	Throughout delivery
	Interviews by research staff	With practitioners	April–August 2024
5. What is the usual dosage/average number of sessions attended by parents/carers?	Practitioner checklists	Completed by practitioners	Throughout delivery
Intervention mechanisms			
6. What are the barriers and facilitators for good implementation?	Interviews by research staff	With practitioners	April–August 2024
		Site staff (managers, team coordinators)	
		With parent/carer participants	May–August 2024
7. How does Standard Teen Triple P differ from SAU?	SAU data	Completed by/with parent/carer participants	Baseline questionnaires
	Interviews by research staff	With practitioners	April–August 2024
		With parent/carer participants	May–August 2024
		With adolescent participants	
	Practitioner checklists	Completed by practitioners	Throughout delivery
8. What are parents'/carers' and adolescents' experiences of, attitudes towards and perceptions of Standard Teen Triple P, as well as its impact?	Interviews by research staff	With parent/carer participants	May–August 2024
		With adolescent participants	
		With practitioners	April–August 2024

Timeline

The study took place between January 2023 and February 2025. The trial ended at the pilot phase, as it was determined by the evaluator and YEF that it was not feasible to proceed to the full efficacy trial (see the evaluation feasibility section for a summary of the findings in relation to the success criteria).

Table 4. Timeline

Start date	End date	Activity	Staff responsible/ leading
		Project and evaluation set-up and mobilisation stage – pilot	
03/01/2023	31/01/2023	Recruitment of local site coordinators, implementation planning (consultant weekly meetings with each of the site coordinators, preparing for the trial) and manager briefings	Project team
01/02/2023	28/02/2023	Evaluator completes protocol	Evaluator
01/03/2023	15/03/2023	YEF to review the protocol and provide feedback. In some cases, an external peer reviewer will also provide feedback. (including reviewing progression criteria)	YEF, project team, evaluator
15/03/2023	15/04/2023	Evaluator incorporates feedback and submits the final protocol	Evaluator
01/02/2023	30/04/2023	Evaluator drafts information sheets and privacy notices	Evaluator
01/02/2023	30/04/2023	Evaluator incorporates feedback and submits final information sheets and privacy notices	Evaluator
01/02/2023	30/04/2023	Evaluator prepares an ethical application and obtains approval or provides confirmation to YEF	Evaluator
01/02/2023	15/04/2023	Project team agrees on the information sharing agreements and referral mechanism with partners/stakeholders	Project team, evaluator
01/02/2023	30/04/2023	Recruitment of evaluation team (research fellow)	Evaluator
17/04/2023	17/06/2023	Recruitment of evaluation team (research assistant)	Evaluator
16/01/2023	15/03/2023	Recruitment, vetting and DBS checks of practitioners (local authority responsible) for project intervention delivery and site management	Project team
01/05/2023	01/07/2023	Research staff training	Evaluator
17/04/2023	17/07/2023	Practitioner briefings, practitioner training, accreditation and half day clinical workshops = 120 practitioners across six sites	Project team
01/02/2023	30/04/2023	Recruit Participant Advisory Group members	Evaluator, roject team

01/02/2023	31/03/2023	Finalise information sharing agreements	Evaluator, project team, YEF
01/04/2023	30/06/2023	Building and testing database	Evaluator
19/06/2023	31/07/2023	Site initiation visits	Evaluator
01/04/2023	31/07/2023	Statistical analysis plan	Evaluator
		Project and evaluation delivery – pilot	
01/08/2023	28/02/2024	Start recruitment and eligibility assessments	Project team, evaluator
21/08/2023	23/03/2024	Deliver the intervention	Project team
01/11/2023	30/11/2023	Trainer-facilitated clinical support workshops (one per site over the pilot)	Project team
01/08/2023	28/02/2024	Baseline data collection	Evaluator
01/08/2023	28/02/2024	Randomisation	Evaluator
01/02/2024	31/08/2024	Six-month follow-up data collection	Evaluator
01/04/2024	30/04/2024	YEF make a decision on whether to progress to the efficacy trial	YEF
01/04/2025	31/05/2024	Process evaluation interviews (professionals)	Evaluator
01/04/2024	31/08/2024	Process evaluation interviews (parents and adolescents)	Evaluator
01/03/24	07/10/24	Transcription	Evaluator
01/03/24	14/09/24	Data entry and cleaning	Evaluator
01/09/24	14/09/24	Data quality control	Evaluator
15/09/24	15/10/24	Analysis	Evaluator
01/02/25	21/02/25	Submission of final peer-reviewed pilot evaluation report	Project team, Evaluator
21/02/25	28/02/25	Evaluator supports the YEF publication process	Evaluator

01/12/24	30/01/25	Data archived	Evaluator

Findings

The findings from the internal pilot phase of the efficacy study are presented in this section in the following order:

1. Participant flow through the study, including information documenting losses and exclusions

2. Demographic information about the programme participants (where available) is then provided for both parents' data and young people's data.

Participant flow, including losses and exclusions

Families were initially recruited through edge-of-care teams in six local authority sites across England – Birmingham, Wirral, London Borough of Merton, Peterborough, Gloucestershire and Cambridgeshire. This was later expanded to include other social care teams within the local authority sites. The Peterborough site withdrew from the trial in October 2023 due to restructuring within the local authority and the Director for Children's Services making Standard Teen Triple P part of their universal parenting offer. The recruitment start date varied across the trial sites due to delays in site collaboration agreements being signed off. Birmingham opened recruitment in July 2023, Cambridgeshire opened in August 2023, Wirral and Merton opened in September 2023 and Gloucestershire opened in October 2023.

The flow of participants through the trial is presented in Figure 3. Across sites, 692 adolescents were identified through screening as being potentially eligible for trial. Of these, 588 were determined not to be eligible, and a further 53 were eligible, but the families did not consent to being contacted about the study. Most families that were ineligible did not meet the inclusion and exclusion criteria. One reason for ineligibility that arose during the trial was not explicitly stated in advance. At some sites, families pursuing a diagnosis for neurodevelopmental conditions were required to have completed a parenting intervention as a prerequisite to referral, making them indirectly ineligible and ultimately reducing the number of parents available for trial participation.

51 parents agreed to be contacted regarding the study, of which four declined to participate, and 10 were not contactable. 37 parents completed the eligibility assessment, following which five were not contactable, and two did not meet the inclusion criteria. 32 parents were found eligible and consented to being involved in the study and completed the baseline survey. 15 parents were randomly allocated to receive Teen Triple P and SAU, and 17 parents were randomly allocated to receive SAU only.

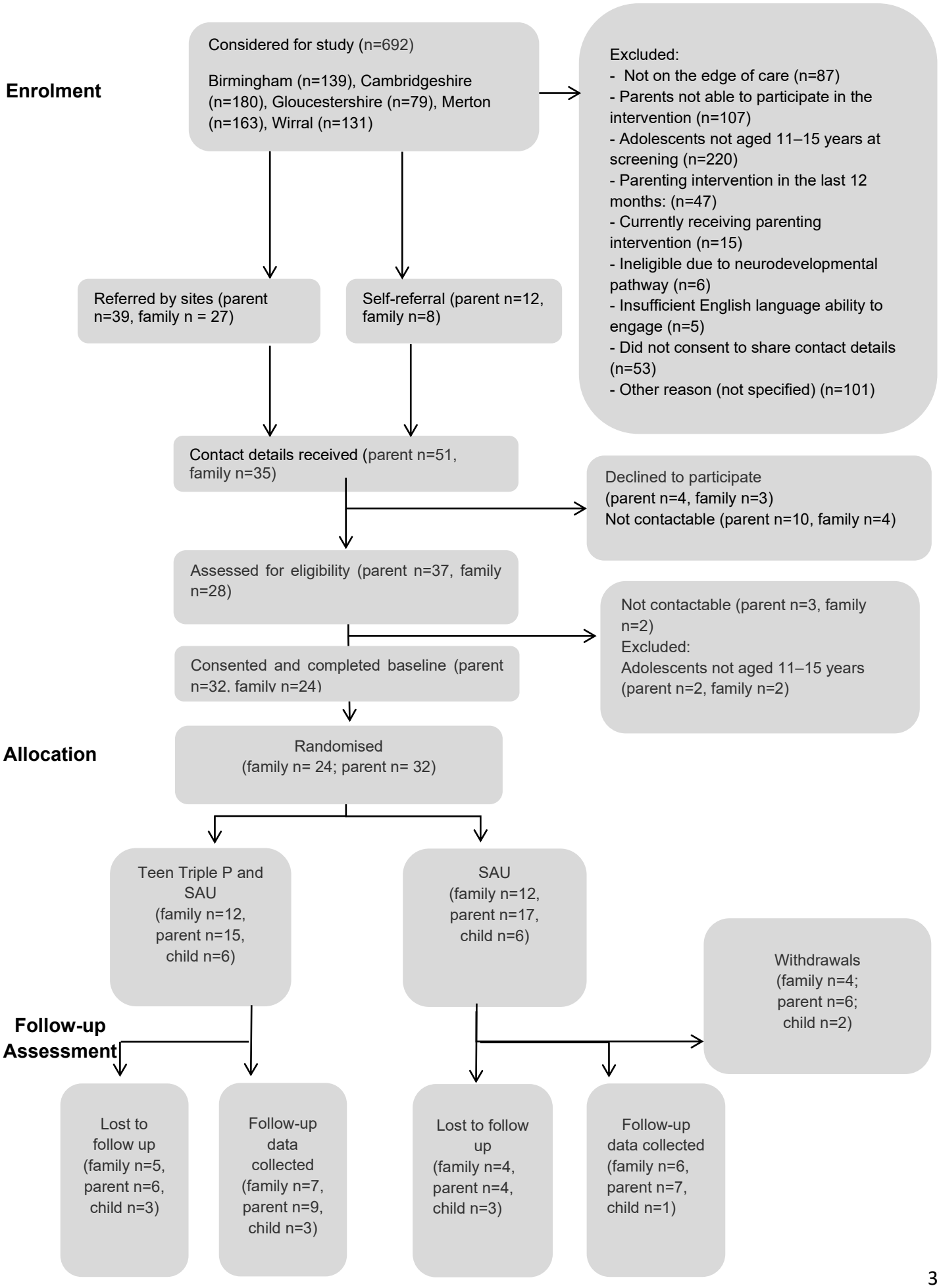
Six parents (from four families) withdrew from the trial between baseline and follow-up assessment. All withdrawals were from the SAU arm of the trial. Reasons provided for withdrawal (one per family) were 1) serious illness in the family, 2) the family being discharged from the edge-of-care team, 3) withdrawal of the Peterborough site from the trial and 4) dissatisfaction with allocation to SAU. In the Standard Teen Triple P group, seven parents completed the six-month post-randomisation follow-up survey, and in the SAU group, six parents completed the follow-up survey. The rate of attrition for parents at six-month follow-up was 50% overall, with 40% of parents lost in the Teen Triple P group and 58.8% of parents lost in the SAU group.

12 adolescents consented to being involved in the study and completed the baseline survey. Six adolescents were from families allocated to receive Teen Triple P and SAU, and six adolescents were from families allocated to SAU. Two adolescents withdrew from the trial between baseline and follow-up assessment due

to (one reason per family) the family being discharged from the edge-of-care team and the withdrawal of the Peterborough site from the trial. In the Teen Triple P group, three adolescents completed the follow-up survey, and in the SAU group, one adolescent completed the follow-up survey. The rate of attrition for adolescents at follow-up was 66.6% overall, with 50% of adolescents lost in the Teen Triple P group, and 83.3% of adolescents lost in the SAU group.

All parents and adolescents were invited to participate in process evaluation interviews. Ten parents and five adolescents from three sites (Cambridgeshire, Birmingham and Wirral) agreed to be interviewed. All 17 practitioners who were allocated to a family randomised to Teen Triple P were contacted for interviews, and 11 completed interviews. All 17 professionals at sites (site managers, site coordinators and support staff) were invited to interview, and 15 completed interviews.

Figure 3: Participant flow diagram



Descriptive summaries of outcomes

Parent baseline characteristics are presented in Table 5 for the total sample and by trial arm. The majority of parents were female (75%) and had English as a first language (84.4%). The most common ethnicity was White – British (59.4%), followed by Asian or Asian British – Pakistani (9.4%). A majority, 71.9% of parents, reported that their adolescent had SEN, with the most frequently reported SEN being Attention deficit and hyperactivity disorder (ADHD; 37.5%), followed by autism (28.1%) and behavioural problems/hyperactivity (28.1%). Adolescents' baseline characteristics are presented in Table 6 for the total sample and by trial arm. The majority of adolescents were female (58.3%) and had English as a first language (91.7%). All adolescents reported being in school, with the majority being in secondary free schools (these are schools funded by the government, which are independent of local authorities) (75.0%), and one pupil in each of a special school, pupil referral unit and home-schooled (all 8.3%). The most common ethnicity was White – British (58.3%), followed by Asian or Asian British – Pakistani (16.7%).

Table 5. Parent demographic characteristics at baseline.

Characteristic	Total N (%) n=32	Teen Triple P + SAU N (%) n=15	SAU N (%) n=17
Biological Sex			
Female	24 (75.0%)	10 (66.7%)	14 (82.4%)
Male	8 (25.0%)	5 (33.3%)	3 (17.6%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Gender (identified as)			
Female	24 (75.0%)	10 (66.7%)	14 (82.4%)
Male	8 (25.0%)	5 (33.3%)	3 (17.6%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Is English the parent's first language?			
Yes	27 (84.4%)	13 (86.7%)	14 (82.4%)
No	5 (15.6%)	2 (13.3%)	3 (17.6%)
Ethnicity			
White – British	19 (59.4%)	9 (60.0%)	10 (58.8%)
White – Irish	0 (0.0%)	0 (0.0%)	0 (0.0%)
White–any other White background	2 (6.3%)	0 (0.0%)	2 (11.8%)
Mixed – White and Black Caribbean	2 (6.3%)	1 (6.7%)	1 (5.9%)
Mixed – White and Black African	2 (6.3%)	2 (13.3%)	0 (0.0%)
Mixed – White and Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mixed – Any other Mixed background	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian or Asian British – Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian or Asian British – Pakistani	3 (9.4%)	2 (13.3%)	1 (5.9%)
Asian or Asian British – Bangladeshi	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian or Asian British – any other Asian background	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or Black British – Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or Black British – African	2 (6.3%)	1 (6.7%)	1 (5.9%)
Black or Black British – any other Black background	1 (3.1%)	0 (0.0%)	1 (5.9%)

Other Ethnic group – Chinese	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Ethnic group – any other ethnic groups	1 (3.1%)	0 (0.0%)	1 (5.9%)
Prefer not to say	0 (0.0%)	0 (0.0%)	0 (0.0%)
Does the young person have SEN?			
Yes	23 (71.9%)	11 (73.3%)	12 (70.6%)
No	9 (28.1%)	4 (26.7%)	5 (29.4%)
What is the SEN?			
Dyslexia	2 (6.3%)	0 (0.0%)	2 (11.8%)
Problems with sight	0 (0.0%)	0 (0.0%)	0 (0.0%)
English as an additional language	0 (0.0%)	0 (0.0%)	0 (0.0%)
Learning difficulties (including dyslexia and dyscalculia)	3 (9.4%)	2 (13.3%)	1 (5.9%)
Problems with hearing	0 (0.0%)	0 (0.0%)	0 (0.0%)
Young carer or sibling of a disabled child	0 (0.0%)	0 (0.0%)	0 (0.0%)
ADHD	12 (37.5%)	8 (53.3%)	4 (23.5%)
Other physical disability	0 (0.0%)	0 (0.0%)	0 (0.0%)
Bullying	1 (3.1%)	0 (0.0%)	1 (5.9%)
Autism, Asperger's syndrome or autistic spectrum disorder	9 (28.1%)	3 (20.0%)	6 (35.3%)
Medical or health problem	2 (6.3%)	0 (0.0%)	2 (11.8%)
Bereavement	0 (0.0%)	0 (0.0%)	0 (0.0%)
Behavioural problems/hyperactivity	9 (28.1%)	4 (26.7%)	5 (29.4%)
Mental illness/depression	4 (12.5%)	1 (6.7%)	3 (17.6%)
Problems with speech or language	0 (0.0%)	0 (0.0%)	0 (0.0%)
Gifted/high IQ/more able and talented/highly able	1 (3.1%)	0 (0.0%)	1 (5.9%)
Other reason[1]	1 (3.1%)	1 (6.7%)	0 (0.0%)

[1]Anger issues

Table 6. Baseline demographic characteristics for adolescents

Characteristic	Total N (%)	Teen Triple P + SAU N (%)	SAU N (%)
Biological Sex			
Female	7 (58.3%)	2 (33.3%)	5 (83.3%)
Male	5 (41.7%)	4 (66.7%)	1 (16.7%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Gender (identified as)			
Female	7 (58.3%)	2 (33.3%)	5 (83.3%)
Male	5 (41.7%)	4 (66.7%)	1 (16.7%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Is English the young person's first language?			
Yes	11 (91.7%)	5 (83.3%)	6 (100.0%)
No	1 (8.3%)	1 (16.7%)	0 (0.0%)
Is the young person in school?			
Yes	12 (100.0%)	6 (100.0%)	6 (100.0%)
No	0 (0.0%)	0 (0.0%)	0 (0.0%)
Type of school			
Private primary	0 (0.0%)	0 (0.0%)	0 (0.0%)
Private junior	0 (0.0%)	0 (0.0%)	0 (0.0%)
Private secondary	0 (0.0%)	0 (0.0%)	0 (0.0%)
Free primary	0 (0.0%)	0 (0.0%)	0 (0.0%)
Free junior	0 (0.0%)	0 (0.0%)	0 (0.0%)
Free secondary	9 (75.0%)	4 (66.7%)	5 (83.3%)
Academy	0 (0.0%)	0 (0.0%)	0 (0.0%)
Special school	1 (8.3%)	1 (16.7%)	0 (0.0%)
Boarding	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pupil referral unit	1 (8.3%)	1 (16.7%)	0 (0.0%)
Alternate provision academy	0 (0.0%)	0 (0.0%)	0 (0.0%)
Home school	1 (8.3%)	0 (0.0%)	1 (16.7%)
School year			
Year 5	0 (0.0%)	0 (0.0%)	0 (0.0%)
Year 6	0 (0.0%)	0 (0.0%)	0 (0.0%)
Year 7	1 (8.3%)	0 (0.0%)	1 (16.7%)
Year 8	3 (25.0%)	1 (16.7%)	2 (33.3%)
Year 9	1 (8.3%)	1 (16.7%)	0 (0.0%)
Year 10	5 (41.7%)	3(50%)	2 (33.3%)
Year 11	2 (16.7%)	1 (16.7%)	1 (16.7%)
Year 12	0 (0.0%)	0 (0.0%)	0 (0.0%)
Year 13	0 (0.0%)	0 (0.0%)	0 (0.0%)
Ethnicity			
White – British	7 (58.3%)	4 (66.7%)	3 (50.0%)
White – Irish	0 (0.0%)	0 (0.0%)	0 (0.0%)
White – any other White background	1 (8.3%)	0 (0.0%)	1 (16.7%)

Mixed – White and Black Caribbean	1 (8.3%)	0 (0.0%)	1 (16.7%)
Mixed – any other Mixed background	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian or Asian British – Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian or Asian British – Pakistani	2 (16.7%)	1 (16.7%)	1 (16.7%)
Asian or Asian British – Bangladeshi	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or Black British – Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or Black British – African	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or Black British – any other Black background	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other ethnic group – Chinese	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Ethnic group – any other ethnic groups	1 (8.3%)	1 (16.7%)	0 (0.0%)
Prefer not to say	0 (0.0%)	0 (0.0%)	0 (0.0%)

Descriptive data at baseline and follow-up for parents can be found in Tables 7 and 8, presented by trial arm. It is of note that there were very low levels of missingness at both time points. However, a higher percentage of missingness can be observed for the Dyadic Adjustment Scale. This is attributable to the respondent being a single parent and, therefore, not needing to complete the measure, as it pertains to relationship quality and satisfaction.

Table 7. Descriptive data at baseline for the outcome measures for parents

Measure	Teen Triple P + SAU			SAU			
	N (% missing)	M (SD)	95% CI	N (% missing)	M (SD)	95% CI	Hedges g (95% CI)
SDQ: Externalising Problems	14 (6.7%)	10.00 (2.75)	[8.41, 11.59]	17 (0%)	9.76 (6.07)	[6.65, 12.88]	0.05 [−0.68, 0.77]
SDQ: Internalising Problems	14 (6.7%)	14.64 (2.27)	[13.33, 15.96]	17 (0%)	13.47 (4.06)	[11.38, 15.56]	0.34 [−0.39, 1.07]
SDQ: Pro-social Behaviours	14 (6.7%)	4.86 (2.88)	[3.20, 6.52]	17 (0%)	5.00 (3.10)	[3.40, 6.60]	−0.05 [−0.77, 0.68]
SDQ: Peer Relationships	14 (6.7%)	4.71 (1.77)	[3.69, 5.74]	17 (0%)	4.29 (3.44)	[2.52, 6.06]	0.15 [−0.58, 0.87]
Parenting Scale	15 (0%)	51.47 (7.85)	[47.12, 55.81]	17 (0%)	53.12 (7.66)	[49.18, 57.05]	−0.21 [−0.93, 0.52]
Dyadic Adjustment Scale (DAS-7)	9 (40%)	23.89 (5.11)	[19.96, 27.82]	10 (41.2%)	24.00 (5.40)	[20.14, 27.86]	−0.02 [−0.74, 0.70]
Kessler 6	15 (0%)	14.00 (3.64)	[11.98, 16.02]	16 (5.9%)	10.38 (6.40)	[6.97, 13.78]	0.67 [−0.54, 0.91]
WEMWBS – Metric	15 (0%)	16.69 (3.74)	[14.62, 18.76]	17 (0%)	16.15 (3.05)	[14.58, 17.72]	0.16 [−0.57, 0.88]
CBQ-20	15 (0%)	12.27 (4.80)	[9.61, 14.93]	17 (0%)	14.94 (4.67)	[12.54, 17.34]	−0.55 [−1.29, 0.19]
CPRS: Closeness	15 (0%)	24.53 (6.72)	[20.81, 28.25]	17 (0%)	22.65 (6.49)	[19.31, 25.98]	0.28 [−0.45, 1.01]
Family APGAR	15 (0%)	3.20 (3.00)	[1.54, 4.86]	17 (0%)	5.06 (3.09)	[3.47, 6.65]	-0.59 [−1.33, 0.15]
Parenting Self-Regulation Scale	15 (0%)	52.73 (9.93)	[47.23, 58.23]	17 (0%)	48.82 (12.39)	[42.46, 55.19]	0.34 [−0.39, 1.07]

Table 8. Descriptive data at follow-up for the outcome measures for parents

Measure	Teen Triple P + SAU			SAU			
	N (% missing)	M (SD)	95% CI	N (% missing)	M (SD)	95% CI	Hedges g (95% CI)
SDQ: Externalising Problems	9 (0%)	11.11 (2.57)	[9.13, 13.09]	7 (0%)	13.00 (6.07)	[9.80, 16.20]	−0.60 [−1.71, 0.51]
SDQ: Internalising Problems	9 (0%)	14.00 (2.87)	[11.79, 16.21]	7 (0%)	15.71 (4.06)	[13.67, 17.76]	−0.62 [−1.73, 0.49]
SDQ: Pro-social Behaviours	9 (0%)	5.22 (2.68)	[3.16, 7.28]	7 (0%)	4.14 (3.10)	[2.59, 5.69]	0.44 [−0.65, 1.54]
SDQ: Peer Relationships	9 (0%)	4.89 (1.90)	[3.43, 6.35]	7 (0%)	5.29 (3.44)	[3.46, 7.11]	-0.19 [−1.28, 0.89]
Parenting Scale	9 (0%)	5.22 (2.68)	[3.16, 7.28]	7 (0%)	4.14 (3.10)	[2.59, 5.69]	0.44 [−1.05, 1.11]
Dyadic Adjustment Scale (DAS-7)	5 (44.4%)	11.11 (2.57)	[9.13, 13.09]	4 (42.9%)	20.75 (5.40)	[9.47, 32.03]	−0.17 [−1.25, 0.91]
Kessler 6	8 (11.1%)	17.00 (5.48)	[12.42, 21.58]	7 (0%)	10.86 (6.40)	[4.42, 17.30]	0.94 [−0.20, 2.10]
WEMWBS	9 (0%)	18.90 (1.30)	[17.91, 19.90]	7 (0%)	17.38 (3.05)	[13.20, 21.56]	0.46 [−0.64, 1.56]
Conflict Behavior Questionnaire (CBQ-20)	9 (0%)	7.89 (5.25)	[3.85, 11.93]	7 (0%)	14.71 (4.67)	[11.57, 17.86]	−1.42 [−2.64, 0.19]
CPRS: Closeness	9 (0%)	26.00 (8.25)	[19.66, 32.34]	7 (0%)	22.86 (6.49)	[16.42, 29.30]	0.38 [−0.71, 1.48]
Family APGAR	9 (0%)	4.11 (1.54)	[2.93, 5.29]	7 (0%)	6.00 (3.09)	[3.12, 8.88]	−0.76 [−1.89, 0.36]
Parenting Self-Regulation Scale	9 (0%)	61.11 (14.35)	[50.08, 72.14]	7 (0%)	51.29 (12.39)	[35.00, 67.58]	0.59 [−0.52, 1.69]

Descriptive data at baseline and follow-up for adolescents can be found in Tables 9 and 10, presented by trial arm. As with the parent data, there were low levels of missingness at both time points.

Table 9. Descriptive data at baseline for the outcome measures for adolescents

Measure	Teen Triple P + SAU			SAU			
	N (% missing)	M (SD)	95% CI	N (% missing)	M (SD)	95% CI	Hedges g (95% CI)
SDQ: Peer Relationships	6 (0%)	3.67 (1.63)	[1.95, 5.38]	6 (0%)	4.17 (2.56)	[1.48, 6.86]	−0.21 [−1.51, 1.01]
SDQ: Pro-social Behaviour	6 (0%)	5.83 (2.93)	[2.76, 8.90]	6 (0%)	7.00 (1.41)	[5.52, 8.48]	−0.47 [−1.78, 0.84]
SDQ: Externalising Problems	6 (0%)	8.67 (3.20)	[5.30, 12.03]	6 (0%)	11.33 (3.33)	[7.84, 14.82]	−0.75 [−2.10, 0.59]
SDQ: Internalising Problems	6 (0%)	14.67 (2.34)	[12.21, 17.12]	6 (0%)	14.50 (3.45)	[10.88, 18.12]	0.05 [−1.23, 1.34]
CBQ-20	5 (16.7%)	12.40 (7.47)	[3.12, 21.68]	5 (16.7%)	13.60 (4.72)	[7.74, 19.46]	−0.18 [−1.47, 1.11]
SRDM	6 (0%)	10.50 (8.29)	[1.80, 19.20]	6 (0%)	13.33 (8.82)	[4.07, 22.59]	−0.31 [−1.60, 0.98]

Table 10. Descriptive data at follow-up for the outcome measures for adolescents

	Teen Triple P + SAU			SAU			
Measure	N (% missing)	M (SD)	95% CI	N (% missing)	M (SD)	95% CI	Hedges g
SDQ: Peer Relationships	3 (0%)	2.67 (1.53)	-*	1 (0%)	6.00 (-*)	-*	-*
SDQ: Pro-social Behaviour	3 (0%)	8.33 (2.08)	-*	1 (0%)	5.00 (-*)	-*	-*
SDQ: Externalising Problems	3 (0%)	7.67 (4.51)	-*	1 (0%)	14.00 (-*)	-*	-*
SDQ: Internalising Problems	3 (0%)	12.00 (2.65)	-*	1 (0%)	11.00 (-*)	-*	-*
CBQ-20	1 (66.7)	1.00 (-*)	-*	1 (0%)	15.00 (-*)	-*	-*
SRDM	3 (0%)	3.33 (5.77)	-*	1 (0%)	12.00 (-*)	-*	-*

*SD, CI and Hedges g could not be calculated due to the limited number of observations.

Implementation and process evaluation results

Details of the full planned process evaluation for the efficacy trial can be found in the process evaluation protocol (Appendix 7). Despite not progressing to the full efficacy stage, the full process evaluation and all associated interviews were conducted to maximise learning from the trial.

Site motivations for trial involvement

Managers and coordinators who were interviewed reported that their understanding of why their services decided to get involved in the trial included:

- An existing awareness and appreciation of the evidence base for Triple P
- A desire to have their staff trained in Triple P
- A desire to have the experience of being involved in a research trial
- Having been approached directly by the Triple P team, as their service had existing familiarity with Triple P, as teams within the service were already delivering Triple P to families
- The potential to support edge-of-care families with an evidence-based approach

Most interviewed practitioners were told by managers that there was a trial at the site that they could or would be involved with, which involved training in Triple P. Some practitioners had existing familiarity with or training in Triple P.

While there was initial motivation and desire to be involved, it was reported by some interviewed managers and practitioners that this wasn't always maintained, as services were focussed on other tasks and duties rather than the trial. Managers and coordinators noted that there also wasn't enough emphasis placed on the importance of the trial within services, which were all working at or beyond capacity.

Embedding the trial within services

Some interviewed practitioners felt that the trial complemented or enhanced their usual work, while others reported that the trial did not fit neatly with their day-to-day role and that their involvement led to increased workload and pressures.

> *"I think more thought needed to have gone into the fit. Because it's lovely to say, you know, to have done another bit of training, but it's been a very stressful time … other members of my team got really, really stressed about it. And then the idea of finding a family, having to do it, seeing all these books, all these sessions, going, how do I do this as well as everything else?"* – Practitioner 5

In some cases, interviewed practitioners reported that services had to adapt their usual working timelines to ensure that all trial procedures (i.e. screening, consent, baseline questionnaires, randomisation) could be completed before the practitioners began working with families in the trial, so extensions to usual timelines were needed in some cases.

Some interviewed managers suggested that had they been involved in the trial at an earlier stage, they may have been able to work with the trial teams to support their understanding and decision-making about some of the practical aspects of trial delivery within their services.

According to interviewed managers and coordinators, there were realisations, at different points for different services, that the teams that had been selected to be involved in the trial were not always the most appropriate teams for a variety of reasons, including:

- Triple P was already being delivered as SAU.
- The families they supported were in crisis, meaning that it would not be possible to engage them in a trial.

Edge of care definitions

Many interviewed managers and coordinators reported that the definition of edge of care differed between the services and the trial, this divergence in definitions was not clear from the outset and it was sometimes not known until following the practitioner training.

> *"This service that we located Triple P in is called our edge-of-care service, so in all the initial discussions with Triple P around thresholds [and] around criteria, this seemed the most appropriate service to place this trial in, from those initial discussions. But as we learnt more, it kind of felt like the thresholds were still being defined as edge of care, but, in reality, what is our edge of care wasn't the same, almost the same definition that was being used for this trial".* – Site coordinator 1

> *"We gave our definition of [edge of care], and Triple P had a definition of that, and I think that over time they found that those two definitions weren't the same, and I think there was optimism on one side … but not really understanding … that we could do it with the families that we mainly happen to have, but it was harder to find the right families who were ready for Triple P".* – Manager 1

From the data gathered in manager and coordinator interviews, the edge of care definitions within services seemed to be largely consistent with each other and were that adolescents were on the verge of being, or could at any moment be, placed in care. The trial definition was reported as being more in line with child in need or pre–edge of care definitions within services, and this was reported by managers and coordinators as being on the lower end of the work that the edge-of-care teams were currently involved in.

Managers and site coordinators reported that there were discussions with Triple P about the definitions and that the trial definition remained unchanged, as it was linked to the wider context of the trial. The difference in the edge of care definitions was reported as being one of the biggest challenges to services' effective involvement in the trial by local authority front-line staff, who were not involved in shaping the definition, as it impacted their ability to recruit families from their service. The difficulties with the edge of care definition and recruitment led some services to identify additional teams to be involved in the trial, as many of the families who were being referred to the edge-of-care teams were currently experiencing crises. This challenge to recruitment will be expanded on in the **recruitment and reach** subsection of this report.

Site procedures

Communication with the trial teams

Some interviewed managers and coordinators indicated that they did not always fully understand the different roles of the evaluation team and the delivery team within the trial and that it was not always clear who had responsibility for different elements of the trial.

Communication from the delivery team and the evaluation team, individually, was reported by managers and coordinators as being typically responsive and helpful. Some of the information coming from the evaluation team in the briefings was too academic for some staff, and this was reported as being a barrier to their involvement and/or understanding.

The involvement of two separate teams within the trial, the evaluation team and the delivery team, sometimes felt disjointed to the interviewed managers and coordinators. In practice, it was reported by managers and coordinators that they were meeting each team separately and that some aspects of communication between the service, evaluation and delivery teams were not always effective.

> *"It's not the most important thing, but just another thing that sometimes felt a little bit disjointed and was unclear was around the roles of different organisations, so Warwick's role and Triple P's role, and sometimes, it felt like it wasn't totally clear whether that was the role for Warwick or that was the role for Triple P or whether that was their decision or whether that was their decision – whose role was that?"* – Site coordinator 1

Further, some interviewed managers and coordinators stated that there were too many meetings between the teams that were sometimes repetitive.

Paperwork and monitoring

Interviewed managers and coordinators reported that the paperwork and monitoring required for the trial by Triple P were often overly long. They did not always fit into services' usual processes or duplicated procedures within services – this was reiterated by some interviewed practitioners. Furthermore, some interviewed managers and coordinators reported that the wording on some Triple P forms was not accessible to all staff and that the purpose and importance of the forms were not always clear. It was suggested that having all paperwork sent to services at the same time prior to delivery commencing may have contributed to the confusion within services, as they were not immediately used. Interviewed practitioners echoed these concerns, indicating that they did not understand where the paperwork ultimately went and did not always understand how to complete the paperwork. Some practitioners also expressed that completion of the paperwork was a burden on top of their regular workload.

> *"Some of the stuff wasn't clear in the sense as to how we do it like, 'You have to do this, and you have to do…', like when you're filling out the forms and stuff and, like, you know recording; that got really confusing because it was like 'Oh, if it is selected, then you fill out this. If it's not…'. So it did get quite confusing, and I think that was really off-putting not just for me … because, obviously, as you can imagine, we've got caseloads obviously working with families, and this is another thing that you … because we've*

got our own paperwork to do, and then it was like, 'OK, you have to fill out this form, and this form, and this form', and it was a lot for us, and I think that's why a lot of us were quite reluctant, understandably, for it". – Practitioner 7

Submitting the contact log weekly or fortnightly was reported by site coordinators and managers as being manageable, but it was suggested by practitioners that it would have been easier for them if Warwick had handled the screening procedure.

Internal site processes

Managers and coordinators reported that some of the internal processes did not work particularly well, including the site coordinators being far removed from practitioners in terms of hierarchy in some services, limiting the ease of communication and working.

Recruitment and reach

1. What are the most effective approaches for recruiting parents/carers and adolescents to take part in this trial of Teen Triple P?

Barriers to recruitment

Some interviewed managers and coordinators stated that they believed that some practitioners were reluctant to recruit families to the trial, as they felt that it was another strain on their already heavy workload.

"Keeping practitioners motivated when they've got massive workloads. … To recruit families onto the trial that have been screened and identified as eligible. Because they knew how big a piece of work it was going to be. … And this wasn't said to me by practitioners, but [it] is my belief that some of the practitioners that didn't recruit families onto the trial were their own barrier because they probably knew how big a piece of work it would be if they were to receive the Triple P". – Site coordinator 2

Managers and coordinators also suggested having the impression that some practitioners may have hoped that the families would be allocated to receive SAU so that they did not have to deliver both Triple P and SAU. These managers and coordinators speculated that Triple P was seen by practitioners as a time-consuming addition to their usual roles. Furthermore, some interviewed managers and coordinators reported that some practitioners were sceptical about whether the families they worked with would really benefit from the intervention, as many of them were currently in crisis.

For trial sites where Triple P already formed part of the usual support offered to families supported by their services, managers and coordinators expressed that this was a challenge to recruitment, as it disincentivised families from participating in the trial.

"Because we offer Triple P, and a lot of our families know about Triple P, and they can get a referral from their GP, or schools or CAMHS [Child and Adolescent Mental Health Services] or their case worker, it's a bit like if you need the support and there's a chance that you're not gonna get it why am I gonna do this? … If there's a chance that you need support and you're not gonna get it, but then you can get a

referral to receive another Triple P programme that we offer, it's a bit like, 'I don't know if I want to be a part of the trial then'". – Manager 4

It was also suggested by one manager that practitioners having existing familiarity with Triple P made it difficult for them to provide SAU without invertedly delivering aspects of Triple P.

"And I think another kind of complicating [factor] is a lot of our practitioners are very familiar with Triple P. To then deliver support as usual, [it] is quite tricky not to involve any sort of parenting because it's our bread and butter, if you like, it's what we do every day, day in, day out. So to kind of separate that out and be conscious not to deliver any of that was quite tricky, I think". – Manager 6

There was sometimes a lengthy delay between Triple P training and families being approached to be involved in the trial, and this was sometimes due to getting site collaboration agreements and data sharing agreements in place. It was reported by managers and coordinators that recruitment procedures felt protracted in many services, with few families being identified. Sites were encouraged to use PASS sessions to refresh training in order to help mitigate difficulties caused by this delay.

Some managers and coordinators indicated that they believed that families that were recruited to the trial were not entirely representative of typical families seen by the edge-of-care teams, as most families they worked with were in crisis.

"There are times when people are so upset, heightened, 'I want this child out of here', 'I'm not willing to work with you' or the other way round, or they've gone missing because we have a lot of contextual safeguarding,[1] *so when I was looking for referrals, I was thinking of families where things would be a little bit more calmer. So, the question was, 'How were they representative of all?'' Well, there's very far and few that are like that. And then they don't remain like that when they come to us".* – Manager 1

"Because when you look at edge of care, what we were finding, a lot of those … families were coming in at crisis point… I think families didn't really want to engage in the Triple P stuff at that time. They were [too] focused on 'we've got this stuff going on' to … have the headspace to go and engage in something else". – Manager 4

As these quotes demonstrate, one of the main barriers to identifying families was that many families known to the edge-of-care teams were at a point of crisis and could not be approached about parenting work (including this trial) until their crisis was contained. This meant that there were long periods of time between recruiting families, so staff were not well-practised in completing the processes and would have to revisit ways of working every time.

[1] Contextual Safeguarding is defined as "an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse". (Firmin, 2017, p.3)

Another identified barrier to managers and coordinators recruiting families was that many families were on the neurodevelopmental pathway and had to complete a parenting intervention before their child would be assessed for autism and/or ADHD.

One practitioner reported that there was a difference in practitioners' and managers' understanding of the eligibility criteria, but they did not elaborate on this point. Another barrier, according to practitioners, was asking families to get in contact with the research team, as this was an additional step in the process that was difficult for many families that were often very busy.

Families' experiences of recruitment

No parents or young people who were interviewed reported having any existing awareness of Triple P. Interviewed parents reported getting involved in the trial for a variety of reasons, including:

- Challenges with the young person's behaviour, anger, emotional regulation and/or mental health
- The young person having difficulties at school
- The young person frequently running away
- The young person having trauma
- The young person having ADHD

One young person reported being initially hesitant about taking part in the trial, but most parents and young people were happy to take part, with some parents stating that they would have tried anything at that point to help their children and wider family.

2. What are the retention rates of parents/carers? What are the reasons for attrition?

There was a high rate of attrition, with 50% of parents lost at follow-up and 66.6% of adolescents lost at follow-up. Six of these families withdrew from the trial post-randomisation.

Interviewed practitioners reported different reasons for families withdrawing from the trial, including:

- A school intervening and stating that a parenting course was not needed for the family
- Parents not feeling the need for additional resources
- Family cases being open longer than expected due to significant delays in the recruitment process

Withdrawal processes were reported by interviewed practitioners as not always being clear.

Generally, interviewed parents and young people reported that the randomisation procedure did not impact their willingness to be part of and stay involved in the trial; however, one parent reported that because they were allocated to Triple P, this made it more likely for them to stay involved in the trial.

3. To what extent were parents/carers from diverse backgrounds recruited to the trial?

For parents recruited to the trial, the most common ethnicity was White – British (59.4%), followed by Asian or Asian British – Pakistani (9.4%) and White – other background, Mixed (White and Black Caribbean), Mixed – White and Black African, and Black or Black British – African (all 6.3%).

Trial processes

Randomisation

Service staff understanding of randomisation procedures

Generally, interviewed practitioners reported that they clearly understood the randomisation process and felt confident explaining this to families and that this was reinforced through supervision. Interviewed managers and coordinators reported that practitioners were generally comfortable with the randomisation process, but managers themselves sometimes struggled with this.

One interviewed practitioner reported that they initially believed that each member of their team would receive an equal number of allocations to either Triple P or SAU. However, when they learned that this was not the case and that all recruited families which a practitioner handled might be allocated to the Triple P arm, they were concerned about the additional workload that would be involved. One practitioner reported that they felt disappointed that a family was randomised to SAU, as they believed that the family would have benefited from the Triple P intervention.

Interviewed managers and coordinators reported that some practitioners found it ethically difficult to withhold Triple P from families they felt could benefit from it.

> "*Ethically, I found it pretty difficult. Not difficult. But a bit challenging, I guess. … At the end of the day, it's [children's] and families' lives, isn't it? So it felt a bit uncomfortable for me".* – Manager 6

Family understanding of randomisation procedures

Interviewed practitioners reported that explaining the randomisation process to families was generally manageable, though it was sometimes challenging to convey that families might not receive Triple P, leading to disappointment for some parents who were allocated to the SAU arm but who were eager to receive all additional support available. Managers and coordinators also reported that it was often difficult to explain this to families and that they thought that some families did not want to hear that they may or may not receive additional support, as all of them were in distress and wanted all available resources.

> *"It was easy to explain to them, but … introducing that this is Triple P, but there is a possibility that we might not be doing this with you, was a bit like, 'Oh, okay, so are you almost like wasting your time telling me about this?' because obviously you're spending your time telling them about this, but there's a possibility you're not going to get it, so I think it can be quite confusing for families to get that".* – Practitioner 4

Interviewed parents and young people reported generally understanding the randomisation procedure, saying that this was clearly explained to them by practitioners. However, one young person reported not being aware that their family had been randomised as part of the trial.

Family views about randomisation allocation

Parents viewed their allocation variably, with some parents saying that they were not worried about being allocated to Triple P and others saying that they were relieved to be allocated to Triple P rather than to SAU.

Problems with randomisation

One practitioner reported that they faced an issue of the wrong allocation being sent through by a site coordinator, and, as a result, a family who should have been receiving SAU only also received Triple P. It was reported that the family ended up being involved with the team longer than the standard 12 weeks as a result and that the involvement with the family became very unproductive, with the family ultimately withdrawing from receiving support from the service.

Completing consent and questionnaires

Practicalities of completing consent and questionnaires

One team leader described the trial procedures as being structured but flexible. Some interviewed practitioners reported that they worked more closely with some families who required additional support to remind them to complete various aspects of the trial (e.g. consent forms, questionnaires).

One interviewed parent reported that she preferred to be contacted and to complete consent over the telephone, as she did not check her email very frequently.

Interviewed parents and young people reported that completing the questionnaires was easy and didn't take too long.

Family reflections on questionnaire content

Many parents and young people found the questions asked within questionnaires to be interesting and/or insightful, allowing them to reflect on their current or previous circumstances when they were completing the questionnaires.

Some interviewed parents and young people reported finding some of the questions confusing or difficult to begin with, with one young person suggesting that it would have been helpful for her to have someone to support her in reading the questions (Note. This is an option that was available for all participants but may not have been communicated with sufficient clarity).

One interviewed parent reported feeling upset when she was completing the questionnaires, as she felt that the questions included were personal and made her think about things that she had not previously considered. This parent reported in her interview that she wanted to be truthful in her questionnaire but that she worried about what people would think when her answers were read by the research team. A young person wondered how honest other young people would be when they were asked about committing crimes.

Intervention fidelity, adherence and dose

4. How well was Standard Teen Triple P implemented? Did practitioners deliver the intervention as intended, with high fidelity to the manual?

Across the 10 weeks, 72 attendance logs were returned by practitioners. 72 sessions were offered to parents, of which 64 were attended. Of the eight sessions not attended, three sessions were rescheduled and five sessions were not rescheduled. Sessions were variably attended by mothers and fathers or mothers only and by the grandmother for one trial family. Six families met the adherence criteria for attending the first eight of ten sessions of Triple P. Descriptive statistics for the attendance logs can be seen in Appendix 3.

Most sessions were delivered with a high level of fidelity, with the majority of items delivered for each session. The exceptions to this were 'Item 27. Was a clinical interview conducted with the teenager's teachers?' on the Week 1 session checklist, as 70% of practitioners did not deliver this session component, and Items 5–10 on the Week 5 session checklist, which 50% of practitioners did not deliver. Descriptive statistics for the session checklists completed by practitioners and the assessment of fidelity of delivery can be seen in Appendix 4, with the percentage of completion for every individual item reported for each of the ten sessions.

Completion of checklists

Interviewed practitioners generally reported finding the checklists challenging at first, often due to the delay between initial training and recruitment. Most interviewed practitioners reported completing the checklists quickly, typically within 10–15 minutes; however, some described the process as repetitive and tedious, which affected their motivation to complete them. There was confusion about which checklists to complete and about the volume of forms to complete, leading to some practitioners falling behind with them.

Triple P training

Interviewed managers and coordinators reported that they thought that services did not understand what Triple P was in any detail until practitioners were trained. Interviewed managers and coordinators reported that the training was very structured and ran to a tight schedule, with some managers and coordinators feeling that it was too fast-paced for their staff to relate to and not as reflective as they were used to.

> *"It seemed … quite fast-paced and … a bit frantic. I didn't feel it was very reflective, and there's a lot of stuff I didn't really understand. I think a lot of assumptions were made about what some of the workers knew and understood".* – Manager 3

Some interviewed practitioners reported finding the training to be long and repetitive, making it difficult to concentrate, with some expressing a dislike for the role-play elements, feeling that they were unnecessary. Other interviewed practitioners reported that they struggled with the complexity of the training, finding it tedious and contradictory, although they felt more comfortable once they began delivering Triple P. Practical breakout sessions were seen as beneficial, but some practitioners reported that these seemed rushed. Overall, while the training was reported by interviewed practitioners as being helpful, there were

calls for it to be more concise and relevant and ideally delivered in a face-to-face format.

"It's helped really a lot actually, because … I've got a real good understanding of the programme and the background of the programme. … When I initially started and … somebody showed me Standard Teen Triple P, and I looked at videos, and … I got the principles but didn't like … but then actually to do it after doing the training, I can really understand how the programme is sort of made and delivered. Yes. Some of the videos are a little bit out of date, but actually, it's easy; I find it easy enough to explain that through to the families when I'm working with them, so that's quite good". – Practitioner 8

Suitability of Triple P to families supported by services

While many interviewed practitioners reported that they appreciated the training content and felt confident in their delivery afterwards, they noted that not all of the Triple P material was applicable to families with specific needs, such as young people with ADHD or autistic young people. The workbooks to use with families were reported by some interviewed managers and coordinators as being good to use, but other resources (e.g. mistakenly referring to "behaviour charts" but actually meaning "behaviour contracts") were reported as being inappropriate to use for some families.

Interviewed managers and coordinators reported that some practitioners were finding it difficult to connect with the scenarios, as the videos were Australian, were of families that were perceived to be affluent and were typically about very basic and seemingly trivial problems (e.g. tidying a bedroom).

> *"The only negative thing I can think of was that the videos were really dated, and it was like, … the issues that they were kind of presenting with were very, very much dated like they're not what, you know … and I think it would be more useful to have more recent what teenagers present with now; that would help".* – Practitioner 9

There were questions raised about whether these would be appropriate to show to the families they support, who were often in the depths of a crisis and needed more intense, sometimes trauma-informed, approaches.

> *"We need something short/quick … Not really too phased because we just, as a crisis team, that's just not helpful for us. And yes, something that perhaps we look more to do that with the trauma-informed lens".* – Manager 7

As illustrated above, many interviewed practitioners reported that they thought that the sessions were not in line with the complex issues faced by the families they work with, with some practitioners suggesting that there should also be sessions on mental health and basic care needs. Practitioners considered that while it may work for families without major issues, they speculated that it would be less suitable for families experiencing violent or aggressive behaviours from their adolescent, for example.

Interviewed practitioners believed that Triple P would be better suited as an intervention tool for families in less crisis-driven situations, as families in edge-of-care stages often find it overwhelming to engage.

"I think it should be a pre-intervention rather than an intervention of when they're in crisis or when they're struggling with behaviour. Because I think it could stop a lot of things from escalating from an early age. … I think when [they're] already in crisis, and there's already a lot going on for that family, that's starting from very, very basic rather than just being able to go in and deliver a parenting programme. But I do think the principles work". – Practitioner 9

Interviewed managers and coordinators expressed different views about how well Triple P fits in their services, with some saying that it was a good fit for their service and was helpful for families and others saying that it would fit better in other services (e.g. early help). One interviewed parent suggested that it would be better to deliver Triple P before behavioural problems occurred, when adolescents were much younger.

The highly structured nature of Triple P was very different to typical working models in some services, especially where there were other more pressing matters to attend to, such as parental mental health problems and substance abuse, before moving on to work on parenting.

Interviewed practitioners generally reported that while the intervention's principles were solid, it could benefit from adaptations for adolescents with special educational needs and disabilities, as well as more emphasis on mental health support. (Note: Standard Teen Triple P is not designed specifically for children with SEND or children with specific mental health difficulties. Variants of Triple P designed specifically for these populations are available, e.g. Stepping Stones Triple P is designed for children with intellectual and physical disabilities. However, this programme is not currently available for teens. Practitioners appreciated the one-to-one format but desired a more tailored approach that allowed families to select the most relevant strategies and for families to be able to receive videos in advance of sessions.

"I know because it was involved in a trial; they had to be very kind of set with [regard] to ten sessions, you know, one a week, duh, duh, duh. That's not how families work, you know. When you work with families, you will go [for] one week; they'll be able to focus on that parenting. You'll go the next week, their benefits have stopped. They've got no food, so you'll have to do a referral to a food bank. Help them to, you know, support them to ring universal credit, things like that, you know. The Triple P sessions as well, they're not one hour, ten sessions". – Site coordinator 2

Support and supervision for practitioners

According to interviewed managers and coordinators, the internal support and supervision processes, including the peer sessions, were valued by practitioners but could feel pointless when there was no Standard Teen Triple P delivery taking place.

"I think the PASS supervisions were definitely more beneficial once we'd recruited families onto the trial. So, I think, you know, actually starting … I suppose they were useful in keeping the trial at the forefront of practitioner thinking. Because workers would go over, 'Oh, actually, you know, this didn't come in as a referral for me to think about the trial. But I've been working with this family, and actually, they're ready for parenting. So we could possibly recruit them'". – Site coordinator 2

The peer supervision and support sessions were described as loose and unstructured by one practitioner, as very few families had been recruited at their site, and, therefore, most practitioners were not yet delivering Standard Teen Triple P. Informal conversations with colleagues who were also part of the trial were reported by practitioners as being helpful.

One manager reported that Triple P offered additional implementation support to a practitioner to support them in adapting the intervention for a family they were working with. Another practitioner reported that they would have appreciated this support but did not receive it.

Interviewed practitioners reported varying experiences of support and supervision. Some noted the value of monthly peer support groups led by the site coordinator, while others expressed a lack of supervision and support. One practitioner felt they were effectively leading supervision sessions themselves due to being the sole practitioner delivering Triple P in their team.

Intervention mechanisms

6. What are the barriers to and facilitators of good implementation?

Interviewed practitioners reported multiple barriers to and facilitators of parents' participation and engagement in Triple P. These have been summarised in the two subsections below.

Barriers

1. **Homework:** There was some resistance to completing homework among some families.
2. **Complex family circumstances:** As personal challenges arose, including a bereavement for one family, engagement declined for some families. For one family, the interviewed practitioner reported that the family disengaged due to delays in support, and despite the practitioner's efforts to re-engage them, the parent often cancelled or forgot appointments.
3. **Young people with additional needs:** Some interviewed practitioners reported that they faced challenges when delivering Triple P to families of adolescents with additional needs, as not all aspects were suitable

   "The family I was working with … the teenager does have autism and ADHD, and I just found that some of the things weren't necessarily going to work". – Practitioner 2

4. **Outdated videos:** The outdated videos did not resonate with many families, making it harder for parents to connect with the material.

   "A lot of like input we get from the families is that they feel that the videos are really outdated". – Practitioner 1

5. **Long sessions:** Not being able to share videos in advance extended session lengths, as the videos were lengthy (45 mins) in some cases, meaning that sessions did not always fit into an hour and had to be broken into two sessions instead.

6. **Unrealistic timescales:** It was reported by one site coordinator that Triple P takes a lot longer than 10 weeks to deliver appropriately with families at the edge of care, as there were other concerns to deal with in the sessions. This was a concern, given the limited window available for practitioners to support families at the edge of care who access their services, as there is a risk that they will not be able to complete all sessions of the programme.
7. **Family resistance:** One interviewed practitioner reported that there was initial resistance from the young person and their father, which hindered engagement, as the father did not like the Triple P methods. In one case, it was reported by an interviewed practitioner that the young person would deliberately disrupt sessions.
8. **Incomplete session materials:** It was reported that there was some missing information in resources for the first session.

Facilitators:

1. **One-to-one format:** Interviewed practitioners reported that, largely, parents were receptive and engaged, appreciating the one-to-one format for fostering honesty and open communication that might not occur in a group setting.
2. **Structure:** Some practitioners reported that the weekly structure of the sessions was helpful. "*So, sometimes families don't know what the next week's going to look like. Where with Triple P, it was very structured, and I think they like that they know what they're doing at week seven; they know what week four was going to look like. And I think it just eased some of that anxiety with a new intervention that they've never done before".* – Practitioner 6
3. **Receptiveness:** Interviewed practitioners reported that some families initially engaged well with the Triple P intervention, showing receptiveness to the information and adherence to the intervention.

Family perceptions about barriers to engagement

Parents also reported that there were barriers to their engagement in the intervention, and these included:

- Significant issues at home (being in crisis)
- Behaviour of adolescents being very difficult to manage, so they could not be engaged

"It wasn't necessarily that I think it was difficult to do; it was because of the situations that I was in at the time, like because [daughter's name] was acting up so badly; it was hard to try and get her to engage in what was needed doing. So, it wasn't able to be completed". – Parent 1

- It not being a suitable time to complete the programme
- Difficulties completing the homework tasks, as they were low priority in their lives
- Some elements of the intervention being difficult to complete, confusing or not right for them (e.g. the workbooks, behaviour charts)

"Some of it was a bit confusing. We kinda like played around with it to make it our own, to make it work for us, but other than that. Sometimes, then she'd be reading through the book as well. We'd be

reading through our book, 'Well, that doesn't make sense, so that bit's no good for us'. So some of it was a bit confusing". – Parent 4

- Some parts of the intervention not being entirely relevant for families (Note: Standard Teen Triple P teaches a range of parenting strategies which parents can select from in order to meet their children's needs. It is expected that parents will not find all strategies to be relevant to their family)
- It being hard to engage adolescents with special educational needs

"And if you're doing it with a special needs child, I think it needs to be more engaging, more play, rather than more work based". – Parent 1

- Difficulties in scheduling sessions around work or other busy family schedules
- Working night shifts
- Parents forgetting about sessions

Intervention outcomes for parents

Interviewed practitioners reported various outcomes for the parents themselves, including a greater awareness of risky behaviours and what these can look like, the implementation of family meetings, improved communication and consistency between parents, and greater confidence in setting boundaries with their children. Further to these practitioner reports, interviewed parents and young people reported outcomes for the parents, including being calmer, less stressed, more consistent and confident with their parenting, and better parental coping. However, some interviewed parents reported that they did not see any changes in their feelings about being a parent.

Intervention outcomes for young people

Interviewed parents and young people reported outcomes for the young people, including having improved friendships and fewer bad influences, experiencing fewer emotional and behavioural problems, and being more understanding and open. Some interviewed parents reported that they did not see any changes in young people's friendships.

Intervention outcomes for the wider family

Interviewed practitioners reported that there were outcomes for the wider family, including using Triple P techniques with other adolescents and more positive family dynamics. Interviewed parents and young people corroborated these reports and reported less conflict in the family home, improved family relationships and communication, and an improved awareness of behaviour and expectations.

No adverse outcomes were reported by interviewed practitioners, parents or young people for families that received Triple P.

8. What were the parent and adolescent experiences and perceptions of Standard Teen Triple P, their attitudes toward this intervention and their understanding of its impact?

Interviewed parents discussed what they valued about the intervention, what supported them in engaging with the sessions and how helpful they perceived the intervention to be and shared their views on the intervention resources.

Flexibility of delivery

Interviewed parents reported that it was sometimes difficult to engage with Triple P due to family home issues, but having the practitioner come to the home was helpful. Some parents attended all sessions, with flexibility in scheduling (e.g. splitting sessions over two weeks) aiding engagement. Practitioners accommodating families' schedules (e.g. working around daily activities) and building positive relationships helped maintain engagement. Some parents reported being very keen, looking forward to sessions and appreciating the practitioner's efforts to accommodate their needs. Some interviewed parents thought that sessions should be split over two weeks to allow families extra time.

Family perceptions of the intervention

Many interviewed parents reported finding the intervention helpful and practical, suggesting it should be offered to more families. They appreciated writing down goals. Sessions were reported by parents as being interesting and helpful in opening up family communication. Interviewed parents appreciated face-to-face interactions.

Several interviewed parents found the workbook hard to go through alone and preferred practical learning. The videos were seen as cheesy, too long or not well-suited for adolescents with special educational needs by many interviewed parents.

> *"There's been a couple where I've struggled a little bit with the watching of the videos. The videos are so cheesy. I'm sorry, but they really are so cheesy in places".* – Parent 16

The Australian context of the Triple P videos was reported by some practitioners to be a slight barrier, as families did not think that everything worked for them in the same way (e.g. praise not being sarcastic). Families were reported by interviewed practitioners as relating a little better to the videos with an English accent.

Concerns were raised by some managers and coordinators about buy-in from parents being low at this level of need, as families could feel like they were being forced to do parenting interventions when they had other more pressing concerns to deal with.

The intervention was generally considered helpful and informative by interviewed parents, with some parents suggesting it could replace other social worker activities.

> *"Really, I just thought it was really good, and it's really useful. And I think you should roll it out further. … And I think that the other social workers' activities could be replaced with this. And I think the way it was presented to us and the meetings that we had, it's very umbrella-ed; it covers a lot of things that need to be covered by other people".* – Parent 2

The handbook was valued, with some parents reporting frequently referring to it during challenging times.

One parent reported attending most of the sessions and feeling like she got everything she could out of the sessions. One interviewed parent said that they only covered the basics, as the intervention was not a priority at the time, as she was at breaking point and just trying to get through the day.

> *"When you are at breaking point with your kids, and you're stressing out, and everything is just hitting you day in, day out. Trying to do the … even to do the diaries and stuff like that, it's, it's sort of the last thing on your mind. … You're just trying to get through that motion of getting through the day".* – Parent 1

Support as usual

7. How does Standard Teen Triple P differ from SAU?

SAU provided to families was monitored using practitioner-completed SAU checklists and is reported by trial arm (see Appendix 5). For the SAU arm, the support provided included managing parent-on-child violence, improving positive communication, supporting young people with additional needs, providing support for healthy relationships, supporting personal development, managing emotions and de-escalation (for parents and young people) and engaging in positive youth activities. During eight of the ten sessions of SAU, a component of Standard Teen Triple P was delivered for one family in the SAU arm. During week eight of SAU, a component of another parenting programme was reported to be delivered to a family in the SAU arm. No practitioners in the Standard Teen Triple P arm reported that concurrent parenting interventions were delivered to families.

According to the SAU checklists (displayed in Appendix 5 by trial arm), SAU was largely distinct from Standard Teen Triple P. However, interviewed managers and coordinators reported that Triple P is very similar to SAU in a lot of services. They described their approach to SAU as being flexible and drawing on multiple programmes and techniques, depending on the needs of the family they are working with overall and specifically at that moment in time. There is usually an element of parenting need, and they suggested that the techniques used in Triple P are not necessarily new to their services, but it is packaged differently and strictly manualised.

> *"Umm, I wouldn't say that there's anything on Triple P that they don't normally do. So they do things around like, you know, like having a parental agreement type of thing. So, things that we agree to do as parents and things that you agree to do as a teenager, look at de-escalation strategies. … And I think Triple P as a package probably calls it something different to what we call it. But really, in practice, they are very similar techniques and strategies".* – Manager 3

Interviewed managers and coordinators reported that some practitioners struggled to deliver their SAU, as this would mean inadvertently delivering aspects that were similar to Triple P (e.g. structured parenting support techniques) to families.

> *"And yeah, one of the things of Triple P trial, I recall this, was the fact that you couldn't use certain tools from other things if you were using Triple P. And that was a bit mind-boggling for people and also like, 'Oh! I can't do that now', and 'Maybe that would have been appropriate here'". – Manager 2*

Interviewed practitioners reported that their typical and varied SAU offer was delivered over a 12-week period, in line with usual edge-of-care cases, and included:

- Signposting families to other services (e.g. financial services, housing support)
- Supporting liaising with schools
- Supporting routines, life skills and finances
- Safeguarding (child protection)
- Working on building positive family relationships
- Setting goals
- De-escalating

This was in line with the usual support that practitioners reported providing on the SAU checklists.

Some interviewed practitioners reported that it was difficult to deliver both Triple P and SAU to families, as Triple P was very structured, and it was a lot of work to complete both in one week. It was suggested by interviewed practitioners that families should instead receive SAU or Triple P. One interviewed parent suggested that it would have been helpful to have had SAU and Triple P delivered by different practitioners so that they were more separate.

While the randomisation procedure was well understood at some sites, there was concern that families who needed Triple P the most were not allocated to it, and there were mixed feelings about the fairness and effectiveness of the process. Managers and coordinators reported that there was frustration about many families being allocated to SAU instead of Triple P, leading to doubts about the study's value within the site.

> *"But I think every family that we put through were allocated business as usual. None of the practitioners got to deliver any of the Triple P information because every time we put a family through, we got business as usual. And it was a bit frustrating in the end, to be honest, because they were like, we just wanna get started and deliver it, but they couldn't".* – Site coordinator 3

Interviewed parents and young people did not report any negatives about being allocated to SAU. Some parents and young people found SAU to be helpful, leading to positive outcomes, with practitioners knowing how to help them.

Ending the trial

Interviewed managers and coordinators reported that the trial ended before services could really get to grips with procedures and before momentum built up, and most stated that they were disappointed that it had ended, as so much work had gone into it.

> *"Do you know, truthfully, gutted. Because we'd worked so hard trying to find alternatives, … and I felt like just as [we were] trying to gain momentum. Because as a local authority, this is the first time for edge of care that we've gone through anything like that, a trial of that lens, you know, and that. … It's a real shame. Even if it was to sort of, say, look, this is not suitable to the edge-of-care population because of X, Y and Z. It's a shame. I felt really gutted that we didn't get to finish".* – Manager 7

This feeling of disappointment was shared by some interviewed practitioners.

> *"Yeah, that's the … the finishing of it seemed very abrupt. It seemed like, okay, well, you know, by the way, we're not doing it anymore anyway. And I think for me and the other colleague in our team that really tried to make it work; it was a bit of a smack in the mouth because it was like, 'Alright then, see you later'".* – Practitioner 5

A longer lead-in time was suggested by interviewed managers and coordinators, as they felt that there was not enough time to embed the new processes within complex teams.

Interviewed practitioners reported that they felt frustrated or disappointed that the trial ended at the pilot phase, as they would have liked to have seen the impact of the trial, and they felt that other families they worked with could have benefited. One interviewed practitioner reported that it was frustrating not to have any families who met the trial eligibility criteria and that they felt like they put a lot into the trial.

> "*We'd had all this training; we [weren't] using it, and there was a worry that we're going to lose it. … We had the practitioners' book, which I just read all the time. I was just like, oh, I'm going to keep ahead of this because when I get a family, I need to know what I'm doing. And so, that was the only worry, really. But it was just it was frustrating that we couldn't get families identified for the level that it was at".* – Practitioner 6

Benefits of being involved in the trial

Interviewed managers and coordinators reported that it was great that practitioners have been upskilled and can now use the techniques with other families. Interviewed managers and coordinators reported that some practitioners had continued to use techniques from their Triple P training with families, and some services had continued with their peer support sessions.

> *"All these new tools and learning and skills we've got which are another tool to add to our toolbox. We still refer to them; so, when we're in group supervision and we're talking and workers come in and say, 'I'm working with this family', somebody will say, 'Have you tried this from Triple P?' So yeah".* – Manager 1

Evaluation feasibility

The feasibility of the pilot evaluation is outlined below in relation to the success criteria to progress to the full efficacy trial.

1) Recruitment

The target of recruiting 50% of the trial parents in the first six months (n=99) was not met, as only 32 parents (24 families) were recruited, placing recruitment in the red zone of the success criteria.

Many challenges were encountered in recruiting families to the trial, which are summarised below:

a) A significant barrier, as highlighted by the process evaluation interviews, was the placement of the trial within edge-of-care teams. It was apparent from screening logs and interviews with site staff that a substantial proportion of families being supported by the edge-of-care teams were in crisis. It was not an appropriate time for them to receive a parenting intervention, as there were other, more salient issues to be addressed – therefore, this precluded many families from being able to be approached for the trial.

b) Site interviews highlighted that the trial definition of edge of care placed it at a lower end of work than edge-of-care teams are usually involved with, whereas sites conceptualised edge of care to mean that there is an immediate risk of the adolescent being placed in care. This divergence in the sites and trials definitions of edge of care contributed to the trial being misplaced in services.

c) Standard Teen Triple P was found to be part of the usual parenting support in services in three of the trial sites – the delivery team (Triple P UK) did not become aware of the programme being accessed at these sites until the recruitment of families was underway. The presence of Standard Teen Triple P at these sites impacted recruitment, as it created a risk that for families recruited to the trial, Triple P would have to be withheld from families who would have otherwise been able to access it. Site coordinators were asked to monitor and manage this risk; however, the potential for impact on recruitment persisted.

d) At one trial site, recruitment was also impacted by the requirement for all families seeking an assessment for autism and/or ADHD to undergo a parenting intervention, as this made them ineligible for the trial.

e) There were substantial delays in several of the sites opening recruitment owing to delays in signing site collaboration agreements. This not only truncated the window for recruitment but also impacted practitioners' confidence and motivation, as it resulted in long delays between training in Standard Teen Triple P and delivery to families

f) Practitioner capacity to deliver had an impact on recruitment, as for some practitioners, their caseloads became full with families who were eligible for the trial but opted not to take part. Interviews with site coordinators and managers also suggested that this contributed to a reticence for practitioners to recruit families to the trial.

g) One of the six trial sites withdrew from the trial early on in the pilot due to a restructuring of the service

h) Many site staff, including site coordinators and practitioners, went on long-term sick leave during the delivery phase of the trial. There were also multiple changes in the trial coordinator at one site, resulting in a lack of continuity of support for practitioners.

A number of mitigation strategies were implemented in December 2023 to address the recruitment challenges. These strategies included encouraging sites to consider how they could expand the recruitment base within their services to identify families meeting the edge-of-care thresholds who may not be referred into the edge-of-care teams. Sites were also advised to revisit families in crisis that were identified as eligible

for the trial if the crisis was contained and it was an appropriate juncture for them to become involved. A further mitigation strategy was to explore whether families could be screened for eligibility before being allocated to a practitioner to help alleviate issues with practitioner caseloads reaching capacity with families not eligible for the trial – this strategy began to be implemented at some sites towards the end of the pilot phase. However, these strategies did not significantly contribute to the numbers recruited to the trial.

2) Randomisation

All families recruited to the trial (i.e. completed baseline assessment) were randomised to the trial, indicating the green target for randomisation was achieved. Feedback regarding the randomisation procedures from interviews indicated that they were largely well-understood and acceptable to families and practitioners.

Some challenges incurred during randomisation were linked to the communication of random allocations to the trial arm between the site coordinator and practitioners. The evaluation team emailed site coordinators any new allocations following randomisation, but these were not always passed on correctly. The evaluation team were made aware of this occurring on three occasions across two different sites. After each incident of this occurring, we conducted retrospective retraining of site coordinators and site team leaders/managers to smooth this process and prevent further issues.

3) Fidelity and adherence

The session checklists and attendance logs completed by practitioners suggest a high level of fidelity and adherence for Standard Teen Triple P sessions (see Appendices 3 and 4). According to the session checklists, the majority of session components were delivered for all sessions of Standard Teen Triple P, and session attendance ranged from 70% to 100% across the ten weeks, with six families meeting the adherence criteria for attending eight of the first ten sessions of Triple P. However, an important caveat to this is that the session checklists and attendance logs were not completed and returned for all families allocated to the intervention arm – therefore, we cannot fully determine fidelity and adherence to Standard Teen Triple P delivery in this pilot trial.

4) Outcomes

Data completeness for the SDQ parent-reported young person externalising problems score at baseline was 96.9%, indicating the green target for data completeness on this item of the SDQ was achieved.

The low levels of missingness of outcome measures data overall indicate that the measures were acceptable to both adolescents and parents. This is supported by the process evaluation interviews, as parents and adolescents reported that they found the measures quick and easy to complete.

5) SAU

The practitioner-completed SAU checklists (Appendix 5) indicate that the support provided to families in the control arm was largely distinct from Standard Teen Triple P – however, one practitioner reported components of Standard Teen Triple P were delivered during weeks 2–8 and week 10 of SAU, as well as a component of another parenting skills programme in Week 8. This is in contradiction to interviewed

managers and site coordinators in several services, who felt that there were many similarities between Standard Teen Triple P and what was offered as SAU.

Evidence of promise

Due to the low number of families recruited into the trial, there was insufficient statistical power to conduct the planned inferential analysis. Therefore, we cannot comment on the evidence of promise for the Standard Teen Triple P programme for families of adolescents at the edge of care.

Conclusion

Table 11: Summary of pilot findings

Summary of pilot findings	
Research aims	**Finding**
Determine whether Standard Teen Triple P + SAU (a) reduces parent-reported adolescent internalising behaviour and increases prosocial behaviours at six months and 12 months post-randomisation and parent-reported adolescent externalising behaviour at 12 months post-randomisation, (b) reduces adolescent-reported externalising and internalising behaviour problems and increases prosocial behaviours at six and 12 months post-randomisation, (c) improves parenting practices, parent self-regulation, interparental relationships, parent–adolescent relationships and parental well-being at six and 12 months post-randomisation and decreases adolescent-reported antisocial behaviours at 12 months post-randomisation and (d) reduces the chance of a child going into out-of-home placement over a 12-month period.	It was not possible to determine the impact of Standard Teen Triple P + SAU on outcome measures from this pilot evaluation due to insufficient numbers of families being recruited. 12-month data collection was not undertaken due to the trial ending at the pilot.
Research objectives	**Finding**
1. Complete an internal pilot in the first year to inform the decision as to whether proceeding with a definitive trial is warranted and feasible.	An internal pilot was completed, and it was determined that it was not feasible to proceed to a definitive trial due to the challenges in recruiting families to the trial.
2. Carry out exploratory subgroup analyses of outcomes by adolescent learning disability status and whether they are living with foster versus biological/adoptive parents.	It was not possible to conduct any exploratory subgroup analyses of outcomes as part of this pilot evaluation.

3. Monitor and report any adverse events related to Standard Teen Triple P.	No adverse events in relation to Standard Teen Triple P were reported.
4. Complete a process evaluation using key indicators drawn from the logic model, including an evaluation of acceptability and the experiences of parents, adolescents with a broad range of ethnic and diverse backgrounds, and other key stakeholders (e.g. practitioners, delivery team), and fidelity of delivery of Standard Teen Triple P.	A process evaluation was conducted, which included interviews with parents, adolescents and professionals (site coordinators, managers and professionals). This provided insight into the failure of the pilot to meet the progression criteria for recruitment, which included challenges relating to the trial definition of edge of care and the high proportion of families in crisis. Site coordinators and managers identified that the trial may have been better placed in services with a lower level of need (i.e. not in crisis). Practitioners and families reflected on their experiences of delivering and receiving Standard Teen Triple P. Generally, parents and adolescents felt positive about their experience of Standard Teen Triple P and the impact of the programme on their families, which included less conflict between parents and adolescents, improved family relationships and improved communication in the home. Practitioners expressed doubts regarding how well-suited the programme was for the families they support and suggested that modifications to the material were needed for it to be effective with this population. Barriers to intervention delivery included complex family circumstances, additional needs of the adolescent and outdated resources, while facilitators included the one-to-one format and structured nature of the programme. Programme fidelity was high, with the majority of sessions attended by parents, and most of the session components were delivered by practitioners. Outcome measures, randomisation procedures and the intervention were generally acceptable to families.

Evaluator judgement of evaluation feasibility

This pilot evaluation failed to meet success criteria for recruitment despite a number of mitigation strategies being implemented to boost recruitment. On the basis of this pilot, it is not feasible for a full efficacy trial of Teen Triple P to be undertaken in edge-of-care settings following the processes adopted in the current trial for delivery and research data collection.

Interpretation

The failure of this trial to recruit sufficient numbers of families stemmed from many challenges, some of which could not have been anticipated during the planning of this trial (these challenges are detailed above, under the evaluation feasibility – recruitment section). We did not anticipate the degree to which the demand for these services would be substantially heightened during the period of time when the trial was conducted; this placed an additional burden on sites in terms of their everyday practice, which constrained their ability to engage with the trial. This additional demand on sites was due in part to the increase in the proportion of families coming into the services that were in crisis – another challenge we could not have predicted, which also limited the number of families eligible for the trial, as they were not able to engage with the trial at that point in time. The Peterborough site dropping out of the trial due to restructuring of the service and Standard Teen Triple P being added to their universal parenting offering also formed a major barrier to the success of the pilot, as we lost one-sixth of our pool for recruitment early on. The most effective mitigation to these difficulties would have been the recruitment of additional sites, as this would have both widened the recruitment pool and eased the burden on existing sites; however, this was not a feasible mitigation to implement in this trial due to funding and time constraints. Another significant issue, which future studies should be careful to avoid, was the recruitment of a number of sites to the trial, where Standard Teen Triple P was already established as part of the existing digital offer to families – this was a complicating factor for these sites in terms of how eligible families could be identified within their services, and it was a contributor to the Peterborough site withdrawing from the trial.

The challenges of this trial mirror the difficulties encountered in previous RCTs conducted in the field of social care. Dixon et al. (2013) conducted a national evaluation of Multi-dimensional Treatment Foster Care for Adolescents (MTFC-A) in England over a period of three years. They faced many challenges in recruitment, including delays in getting the intervention started, low numbers of referrals, concerns from the practitioners regarding randomisation (leading to gatekeeping of potential participants) and an insufficiently small pool from which to recruit participants. Despite the implementation of many mitigation strategies, including negotiating study extensions and modifying the RCT design, only 34 adolescents were randomised to the trial, with the initial recruitment target being 130 adolescents. Another RCT to face challenges was Forrester et al.'s (2018) evaluation of the impact of Motivational Interviewing for social workers in child protection, where worker attrition during the trial resulted in randomisation having to be suspended at times until staff numbers reached sufficient numbers to continue.

The findings of the current trial demonstrate that the challenges in undertaking RCTs in social work settings identified previously persist and suggest there is considerable work to be done to foster a culture and

develop supports in social care that are conducive to research and the development of evidence-based practice.

Future research and publications

There are a number of learnings for research undertaken in social care settings as a result of this pilot evaluation.

- There is currently a high level of need within social care – services reported increased demand during the course of this trial, with a large proportion of families supported by edge-of-care teams in crisis. Any future evaluations of interventions for the population of families at the edge of care need to be appropriately positioned within services in local authorities to ensure families being approached regarding the trial can participate in the intervention.
- Social care practitioners involved in the delivery of interventions during trials need to be consulted during the co-production stages to establish buy-in for the intervention and to ensure trial activities are a good fit with the practitioners' existing role. Buy-in from practitioners is fundamental for trial success, both in terms of the value they ascribe to research and evidence-based practice and their perceptions of interventions they are being asked to deliver as part of a trial.
- The pilot highlights the need for research infrastructure and support for trials in social care settings. In contrast to the NHS, there is no research infrastructure in social care settings, such as local authorities, which creates an additional burden and presents challenges in implementing trials. Supporting practitioners at sites to provide the time and support needed to be involved in research is also critical.
- A bedding-in period should be built into recruitment timelines to ensure there is time for social care staff to become familiar and comfortable with trial processes.
- When selecting and recruiting services, work should be undertaken to assess whether the programmes being evaluated are part of a service's routine offer to families.
- To prevent potential contamination across trial arms, the workers delivering the intervention and those delivering SAU should be different people.
- Funding should be sufficient to ensure a high volume of trial sites can be recruited, as this is necessary in order to account for the challenges recruiting from this population.
- There is a high rate of attrition at follow-up within this population, which needs to be considered when deciding on incentives for participants and preparing sample size calculations.

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Appendices:

Appendix 1: PASS Information and Checklist

Appendix 1.pdf

Appendix 2: Participant information sheets and consent forms

Participant Information forms:


PIS Parent 04-04-2023.docx


PIS CYP under 16 - 04-04-2023.docx


PIS CYP - 16 and over - 04-04-2023.do

Consent forms:


Consent form CYP 16 & over 04-04-2023.d


Consent form CYP under 16 (interviews)


Consent form Parent 04 apr 2023.docx

Appendix 3: Triple P Session Attendance Logs

	Week 1 N = 10[1]	**Week 2** N = 7[1]	**Week 3** N = 10[1]	**Week 4** N = 9[1]	**Week 5** N = 7[1]	**Week 6** N = 7[1]	**Week 7** N = 7[1]	**Week 8** N = 6[1]	**Week 9** N = 5[1]	**Week 10** N = 4[1]
Was this session offered to the parent(s)?										
Yes	10 (100%)	7 (100%)	10 (100%)	9 (100%)	7 (100%)	7 (100%)	7 (100%)	6 (100%)	5 (100%)	4 (100%)
Did the parent(s) attend the session?										
No	1 (10%)	0 (0%)	3 (30%)	0 (0%)	1 (14%)	1 (14%)	1 (14%)	0 (0%)	1 (20%)	0 (0%)
Yes	9 (90%)	7 (100%)	7 (70%)	9 (100%)	6 (86%)	6 (86%)	6 (86%)	6 (100%)	4 (80%)	4 (100%)
Missing	0	0	0	0	0	0	0	0	0	0
If the parent(s) did not attend, was the session rescheduled?										
No	1 (100%)	0 (0%)	1 (33%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)	0 (0%)
Yes	0 (0%)	0 (0%)	2 (67%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	9	7	7	9	6	6	6	6	4	4
What was the reason for re-scheduling the session?										

Alternative Commitment	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Illness	0 (0%)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other reason	0 (0%)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	10	7	8	9	7	7	7	5	5	4
Which parent(s) attended the session?										
Mother	6 (67%)	3 (60%)	2 (29%)	6 (67%)	2 (33%)	2 (33%)	3 (50%)	2 (33%)	2 (50%)	1 (25%)
Mother and Father	2 (22%)	2 (40%)	4 (57%)	2 (22%)	3 (50%)	3 (50%)	2 (33%)	4 (67%)	1 (25%)	2 (50%)
Other	1 (11%)	0 (0%)	1 (14%)	1 (11%)	1 (17%)	1 (17%)	1 (17%)	0 (0%)	1 (25%)	1 (25%)

[1] n (%)

Appendix 4: Triple P Session Checklists

Session 1

Item	N = 10[1]
1. Welcome and self-introduction	
Yes	10 (100%)
No	0 (0%)
2. Provided an overview of the session	
Yes	10 (100%)
No	0 (0%)
3. Initial Interview	
Yes	10 (100%)
No	0 (0%)
4. Keeping track of teenager's behaviour	
Yes	9 (90%)
No	1 (10%)
5. Exercise 1: Sharing information	
Yes	10 (100%)
No	0 (0%)
6. Family details	
Yes	10 (100%)
No	0 (0%)
7. Referral source	
Yes	10 (100%)
No	0 (0%)
8. Teenager behaviour	
Yes	10 (100%)
No	0 (0%)

9. Parenting skills	
Yes	10 (100%)
No	0 (0%)
10. Previous history of psychological help	
Yes	10 (100%)
No	0 (0%)
11. Factors influencing teenager's behaviour	
Yes	10 (100%)
No	0 (0%)
12. Obstacles to change	
Yes	10 (100%)
No	0 (0%)
13. Health status	
Yes	10 (100%)
No	0 (0%)
14. Parent/s' perceptions of the problem	
Yes	10 (100%)
No	0 (0%)
15. Parent/s' expectations	
Yes	10 (100%)
No	0 (0%)
16. Introduced monitoring of teenagers' behaviour	
Yes	9 (90%)
No	1 (10%)
17. Decided on the target behaviour/s to monitor	
Yes	8 (80%)

No	2 (20%)
18. Exercise 2: Choosing what to monitor	
Yes	7 (78%)
No	2 (22%)
Missing	1
19. Devised a system for keeping track of the target behaviour/s	
Yes	7 (70%)
No	3 (30%)
20. Explained the monitoring form/s chosen	
Yes	6 (60%)
No	4 (40%)
21. Exercise 3: Keeping track	
Yes	6 (67%)
No	3 (33%)
Missing	1
22. Reviewed the session	
Yes	9 (90%)
No	1 (10%)
23. Explained tasks to be completed before next session	
Yes	8 (80%)
No	2 (20%)
24. Scheduled the next appointment	
Yes	9 (90%)
No	1 (10%)
25. Closed the session	

Yes	10 (100%)
No	0 (0%)
26. Were any problem behaviours in the school setting, or academic difficulties discussed during the session?	
Yes	7 (70%)
No	3 (30%)
27. Was a clinical interview conducted with the teenager's teachers?	
Yes	3 (30%)
No	7 (70%)

[1] n (%)

Session 2

Item	**N = 10**[1]
1. Welcome and self-introduction	
Yes	10 (100%)
No	0 (0%)
2. Provided an overview of the session	
Yes	10 (100%)
No	0 (0%)
3. Initial Interview	
Yes	10 (100%)
No	0 (0%)
4. Keeping track of teenager's behaviour	
Yes	9 (90%)
No	1 (10%)
5. Exercise 1: Sharing information	
Yes	10 (100%)
No	0 (0%)
6. Family details	
Yes	10 (100%)
No	0 (0%)
7. Referral source	
Yes	10 (100%)
No	0 (0%)
8. Teenager behaviour	

Yes	10 (100%)
No	0 (0%)

9. Parenting skills

Yes	10 (100%)
No	0 (0%)

10. Previous history of psychological help

Yes	10 (100%)
No	0 (0%)

11. Factors influencing teenager's behaviour

Yes	10 (100%)
No	0 (0%)

12. Obstacles to change

Yes	10 (100%)
No	0 (0%)

13. Health status

Yes	10 (100%)
No	0 (0%)

14. Parent/s' perceptions of the problem

Yes	10 (100%)
No	0 (0%)

15. Parent/s' expectations

Yes	10 (100%)
No	0 (0%)
16. Introduced monitoring of teenagers' behaviour	
Yes	9 (90%)
No	1 (10%)
17. Decided on the target behaviour/s to monitor	
Yes	8 (80%)
No	2 (20%)
18. Exercise 2: Choosing what to monitor	
Yes	7 (78%)
No	2 (22%)
Missing	1
19. Devised a system for keeping track of the target behaviour/s	
Yes	7 (70%)
No	3 (30%)
20. Explained the monitoring form/s chosen	
Yes	6 (60%)
No	4 (40%)
21. Exercise 3: Keeping track	
Yes	6 (67%)
No	3 (33%)

Missing	1
22. Reviewed the session	
Yes	9 (90%)
No	1 (10%)
23. Explained tasks to be completed before next session	
Yes	8 (80%)
No	2 (20%)
24. Scheduled the next appointment	
Yes	9 (90%)
No	1 (10%)
25. Closed the session	
Yes	10 (100%)
No	0 (0%)
26. Were any problem behaviours in the school setting, or academic difficulties discussed during the session?	
Yes	7 (70%)
No	3 (30%)
27. Was a clinical interview conducted with the teenager's teachers?	
Yes	3 (30%)
No	7 (70%)

[1] n (%)

Session 3

Item	N = 7[1]
1. Provided an overview of the session	
Yes	7 (100%)
No	0 (0%)
2. Obtained a brief update	
Yes	7 (100%)
No	0 (0%)
3. Reviewed homework	
Yes	7 (100%)
No	0 (0%)
4. Formulated hypotheses	
Yes	6 (86%)
No	1 (14%)
5. Explained the feedback process	
Yes	6 (86%)
No	1 (14%)
6. Exercise 1: Sharing assessment findings	
Yes	6 (86%)
No	1 (14%)
7.Discussed the data from each information source	
Yes	6 (86%)
No	1 (14%)
8. Provided an integrating summary	

Yes	6 (86%)
No	1 (14%)
9. Outlined the purpose of discussing factors influencing teenagers' behaviour	
Yes	6 (86%)
No	1 (14%)
10. Introduced the factors influencing teenagers' behaviour	
Yes	6 (86%)
No	1 (14%)
11. Exercise 2: Identified factors influencing teenagers' behaviour	
Yes	6 (86%)
No	1 (14%)
12. Shared your own observations	
Yes	6 (86%)
No	1 (14%)
13. Asked the parent/s for any additional factors not listed	
Yes	6 (86%)
No	1 (14%)
14. Provided an integrating summary	
Yes	6 (86%)
No	1 (14%)
15. Exercise 3: What skills should we encourage in teenagers?	
Yes	5 (71%)
No	2 (29%)

16. Exercise 4: Set goals for change	
Yes	5 (71%)
No	2 (29%)
17. Introduced the format of Standard Teen Triple P	
Yes	5 (71%)
No	2 (29%)
18. Negotiated an intervention plan	
Yes	5 (71%)
No	2 (29%)
19. Reviewed the session	
Yes	5 (83%)
No	1 (17%)
Missing	1
20. Explained tasks to be completed before next session	
Yes	6 (86%)
No	1 (14%)
21. Scheduled the next appointment	
Yes	6 (100%)
No	0 (0%)
Missing	1
22. Closed the session	
Yes	6 (86%)
No	1 (14%)

[1] n (%)

Session 4

Characteristic	N = 6[1]
1. Provided an overview of the session	
Yes	5 (83%)
No	1 (17%)
2. Recapped main points from Session 3	
Yes	5 (83%)
No	1 (17%)
3. Obtained a brief update	
Yes	5 (83%)
No	1 (17%)
4. Reviewed homework	
Yes	5 (83%)
No	1 (17%)
5. Introduced the principles of positive parenting	
Yes	5 (83%)
No	1 (17%)
6. Exercise 1: What is positive parenting?	

Yes	4 (80%)
No	1 (20%)
Missing	1

7. Provided a rationale for strategies for encouraging appropriate behaviour

Yes	5 (83%)
No	1 (17%)

8. Provided a rationale for developing positive relationships with teenagers

Yes	6 (100%)
No	0 (0%)

9. Introduced spending time with teenagers and completed Exercise 2: Ideas for spending time with your teenager

Yes	6 (100%)
No	0 (0%)

10. Introduced talking with teenagers and completed Exercise 3: Things to talk about

Yes	6 (100%)
No	0 (0%)

11. Introduced being affectionate with teenagers and completed Exercise 4: Ways to show affection

Yes	5 (83%)
No	1 (17%)

12. Provided a rationale for increasing desirable behaviour

Yes	6 (100%)
No	0 (0%)

13. Introduced descriptive praise and completed

Exercise 5: Giving descriptive praise

Yes	6 (100%)
No	0 (0%)

14. Introduced giving attention and completed

Exercise 6: Ways to give attention

Yes	6 (100%)
No	0 (0%)

15. Introduced engaging activities and completed

Exercise 7: Ideas for engaging activities

Yes	6 (100%)
No	0 (0%)

16. Provided a rationale for teaching new skills and behaviours

Yes	6 (100%)
No	0 (0%)

17. Introduced setting a good example and completed

Exercise 8: Ways to set a good example

Yes	6 (100%)
No	0 (0%)

18. Introduced coaching problem solving and completed

Exercise 9: Coaching problem solving

Yes	6 (100%)
No	0 (0%)

19. Introduced the idea of using behaviour contracts

and completed Exercise 10: Using a behaviour contract

Yes	6 (100%)
No	0 (0%)

20. Worked through example behaviour contracts with parent/s

Yes	6 (100%)
No	0 (0%)

21. Provided a rationale for family meetings

Yes	6 (100%)
No	0 (0%)

22. Exercise 11: Planning a family meeting

Yes	6 (100%)

No	0 (0%)
23. Reviewed the session	
Yes	6 (100%)
No	0 (0%)
24. Explained tasks to be completed before next session	
Yes	6 (100%)
No	0 (0%)
25. Scheduled the next appointment	
Yes	6 (100%)
No	0 (0%)
26. Closed the session	
Yes	6 (100%)
No	0 (0%)

[1] n (%)

Session 5

Characteristic	N = 4[1]
1. Provided an overview of the session	
Yes	4 (100%)
No	0 (0%)
2. Obtained a brief update	
Yes	4 (100%)
No	0 (0%)
3. Recapped main points from Session 4	
Yes	4 (100%)
No	0 (0%)
4. Exercise 2: Review tasks set after last session	
Yes	4 (100%)
No	0 (0%)
5. Explained process of practice task	
Yes	2 (50%)
No	2 (50%)
6. Exercise 3: Set goals for the practice task	
Yes	2 (50%)
No	2 (50%)
7. Reviewed the rules	
Yes	2 (50%)
No	2 (50%)
8. Checked how the parent/s and teenager feel	
Yes	2 (50%)

No	2 (50%)
9. Prompted the parent/s to keep track of whether they meet their goals during the practice task so they can complete Exercise 4	
Yes	2 (50%)
No	2 (50%)
10.Began the practice task	
Yes	2 (50%)
No	2 (50%)
11. Set up to conduct self-evaluation and feedback	
Yes	3 (75%)
No	1 (25%)
12. Exercise 4: Reviewing the practice task	
Yes	3 (75%)
No	1 (25%)
13. Set goals for behaviour change	
Yes	4 (100%)
No	0 (0%)
14. Discussed any additional agenda items	
Yes	4 (100%)
No	0 (0%)
15. Reviewed the session	
Yes	4 (100%)
No	0 (0%)
16. Explained tasks to be completed before next session	
Yes	4 (100%)
No	0 (0%)

17. Scheduled the next appointment	
Yes	4 (100%)
No	0 (0%)
18. Closed the session	
Yes	4 (100%)
No	0 (0%)

[1] n (%)

Session 6

Characteristic	N = 4[1]
1. Provided an overview of the session	
Yes	4 (100%)
No	0 (0%)
2. Obtained a brief update	
Yes	4 (100%)
No	0 (0%)
3. Recapped main points from Session 4	
Yes	4 (100%)
No	0 (0%)
4. Exercise 2: Review tasks set after last session	
Yes	4 (100%)
No	0 (0%)
5. Explained process of practice task	
Yes	2 (50%)
No	2 (50%)
6. Exercise 3: Set goals for the practice task	
Yes	2 (50%)

No	2 (50%)
7. Reviewed the rules	
Yes	2 (50%)
No	2 (50%)
8. Checked how the parent/s and teenager feel	
Yes	2 (50%)
No	2(50%)
9. Prompted the parent/s to keep track of whether they meet their goals during the practice task so they can complete Exercise 4	
Yes	2 (50%)
No	2 (50%)
10.Began the practice task	
Yes	2 (50%)
No	2 (50%)
11. Set up to conduct self-evaluation and feedback	
Yes	3 (75%)
No	1 (25%)
12. Exercise 4: Reviewing the practice task	
Yes	3 (75%)

No	1 (25%)
13. Set goals for behaviour change	
Yes	4 (100%)
No	0 (0%)
14. Discussed any additional agenda items	
Yes	4 (100%)
No	0 (0%)
15. Reviewed the session	
Yes	4 (100%)
No	0 (0%)
16. Explained tasks to be completed before next session	
Yes	4 (100%)
No	0 (0%)
17. Scheduled the next appointment	
Yes	4 (100%)
No	0 (0%)
18. Closed the session	
Yes	4 (100%)
No	0 (0%)

[1] n (%)

Session 7

Item	N = 6[1]
1. Provided an overview of the session	
Yes	6 (100%)
No	0 (0%)
2. Obtained a brief update	
Yes	6 (100%)
No	0 (0%)
3. Recapped main points from Session 6	
Yes	6 (100%)
No	0 (0%)
4. Exercise 2: Review tasks set after last session	
Yes	6 (100%)
No	0 (0%)
5. Explained process of practice task	
Yes	6 (100%)
No	0 (0%)
6. Exercise 3: Set goals for the practice task	
Yes	5 (100%)
No	0 (0%)
Missing	1
7. Reviewed the rules	

Yes	5 (100%)
No	0 (0%)
Missing	1

8. Checked how the parent/s and teenager feel

Yes	5 (100%)
No	0 (0%)
Missing	1

9. Prompted the parent/s to keep track of whether they meet their goals during the practice task so they can complete Exercise 4

Yes	5 (100%)
No	0 (0%)
Missing	1

10.Began the practice task

Yes	5 (100%)
No	0 (0%)
Missing	1

11. Set up to conduct self-evaluation and feedback

Yes	5 (100%)
No	0 (0%)
Missing	1

12. Exercise 4: Reviewing the practice task

Yes	4 (100%)
No	0 (0%)
Missing	2

13. Set goals for behaviour change

Yes	6 (100%)
No	0 (0%)
14. Discussed any additional agenda items	
Yes	4 (100%)
No	0 (0%)
Missing	2
15. Reviewed the session	
Yes	6 (100%)
No	0 (0%)
16. Explained tasks to be completed before next session	
Yes	6 (100%)
No	0 (0%)
17. Scheduled the next appointment	
Yes	6 (100%)
No	0 (0%)
18. Closed the session	
Yes	6 (100%)
No	0 (0%)

[1] n (%)

Session 8

Item	N = 5[1]
1. Provided an overview of the session	
Yes	5 (100%)
No	0 (0%)
2. Recapped main points from Session 7	
Yes	4 (80%)
No	1 (20%)
3. Reviewed homework	
Yes	4 (80%)
No	1 (20%)
4. Exercise 1: Reviewing progress	
Yes	4 (80%)
No	1 (20%)
5. Introduced risky situations	
Yes	5 (100%)
No	0 (0%)
6. Exercise 2: Identifying risky situations	
Yes	5 (100%)
No	0 (0%)
7. Introduced the routine for dealing with risky behaviour	
Yes	5 (100%)

No	0 (0%)
8. Provided a rationale for planning ahead	
Yes	5 (100%)
No	0 (0%)
9. Introduced the steps of the planning ahead routine	
Yes	5 (100%)
No	0 (0%)
10.Discussed the use of planning ahead for practice sessions	
Yes	5 (100%)
No	0 (0%)
11. Used an example to illustrate an entire planning ahead routine	
Yes	5 (100%)
No	0 (0%)
12. Exercise 3: Developing a routine for dealing with risky behaviour	
Yes	5 (100%)
No	0 (0%)
13. Summarised the planning ahead routine	
Yes	5 (100%)
No	0 (0%)
14. Introduced family survival tips	
Yes	5 (100%)
No	0 (0%)
15. Exercise 4: Developing a parent and community network	
Yes	4 (80%)

No	1 (20%)
16.Reviewed the session	
Yes	5 (100%)
No	0 (0%)
17. Explained tasks to be completed before next session	
Yes	5 (100%)
No	0 (0%)
18. Scheduled the next appointment	
Yes	5 (100%)
No	0 (0%)
19. Closed the session	
Yes	5 (100%)
No	0 (0%)

[1] n (%)

Session 9

Characteristic	**N = 3**[1]
1. Provided an overview of the session	
Yes	3 (100%)
No	0 (0%)
2. Recapped main points from Session 8	
Yes	3 (100%)
No	0 (0%)
3. Reviewed homework	
Yes	3 (100%)
No	0 (0%)
4. Exercise 1: Reviewing your use of the planning ahead routine to deal with risky behaviour	
Yes	3 (100%)
No	0 (0%)
5. Exercise 2: Reviewing your plan	
Yes	3 (100%)
No	0 (0%)
6. Exercise 3: Planning for future risky situations	

Yes	3 (100%)
No	0 (0%)

7. Prompted the parent/s to keep track of whether they meet their goals during the practice task

Yes	3 (100%)
No	0 (0%)

8. Begin the practice task

Yes	3 (100%)
No	0 (0%)

9. Set up to conduct self-evaluation and feedback

Yes	3 (100%)
No	0 (0%)

10. Set goals for behaviour change

Yes	3 (100%)
No	0 (0%)

11. Exercise 4: Identifying future risky situations

Yes	3 (100%)
No	0 (0%)

12. Discussed any additional agenda items

Yes	3 (100%)
No	0 (0%)

13. Used minimal prompts to help the parent/s solve problems

Yes	3 (100%)
No	0 (0%)

14. Noted any additional content or major deviation from the set program

Yes	3 (100%)
No	0 (0%)

15. Reviewed the session

Yes	3 (100%)
No	0 (0%)

16. Explained tasks to be completed before next session

Yes	2 (67%)
No	1 (33%)

17. Scheduled the next appointment

Yes	3 (100%)
No	0 (0%)

18. Closed the session

Yes	3 (100%)
No	0 (0%)

[1] n (%)

Session 10

Item	N = 3[1]
1. Provided an overview of the session	
Yes	3 (100%)
No	0 (0%)
2. Recapped main points from Session 9	
Yes	2 (100%)
No	0 (0%)
Missing	1
3. Reviewed homework	
Yes	3 (100%)
No	0 (0%)
4. Exercise 1: Reviewing use of strategies and routines	
Yes	3 (100%)
No	0 (0%)
5. Review family survival tips	
Yes	3 (100%)
No	0 (0%)
6. Exercise 2: Taking care of yourself	
Yes	3 (100%)
No	0 (0%)
7. Review suggestions for phasing out the program	
Yes	3 (100%)
No	0 (0%)
8. Exercise 3: Identifying changes that have been made	

Yes	3 (100%)
No	0 (0%)
9. Provide an orienting statement	
Yes	3 (100%)
No	0 (0%)
10. Discuss obstacles to maintaining change	
Yes	3 (100%)
No	0 (0%)
11. Review guidelines for maintaining change	
Yes	3 (100%)
No	0 (0%)
12. Review planning ahead routines	
Yes	3 (100%)
No	0 (0%)
13. Exercise 4: Planning for future risky situations	
Yes	3 (100%)
No	0 (0%)
14. Exercise 5: Identifying future risky situations	
Yes	2 (100%)
No	0 (0%)
Missing	1
15. Exercise 6: Independent problem solving	
Yes	2 (67%)
No	1 (33%)
16. Exercise 7: Identifying future goals	

Yes	3 (100%)
No	0 (0%)
17. Exercise 8: Completing Assessment Booklet Two	
Yes	2 (67%)
No	1 (33%)
18. Review the session	
Yes	3 (100%)
No	0 (0%)
19. Discuss future use of materials and referral options	
Yes	3 (100%)
No	0 (0%)
20. Close the session	
Yes	3 (100%)
No	0 (0%)

[1] n (%)

Appendix 5: Support-as-Usual Checklists

Support-As-Usual Checklists for the SAU arm

	SAU									
	Week 1 N = 8[1]	**Week 2** N = 7[1]	**Week 3** N = 7[1]	**Week 4** N = 8[1]	**Week 5** N = 8[1]	**Week 6** N = 7[1]	**Week 7** N = 8[1]	**Week 8** N = 7[1]	**Week 9** N = 7[1]	**Week 10** N = 7[1]
1. Financial Support	1 (14%)	2 (33%)	1 (14%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (33%)	1 (20%)
Missing	1	1	0	2	3	1	2	2	1	2
2. Housing	0 (0%)	0 (0%)	0 (0%)	1 (17%)	1 (17%)	0 (0%)	1 (17%)	1 (20%)	1 (20%)	1 (20%)
Missing	2	2	1	2	2	1	2	2	2	2
3. Assistance accessing medical appointments	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	2	1	2	2	1	2	2	2	2
4. Prevention of child exploitation	1 (14%)	0 (0%)	0 (0%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	1	2	1	2	2	1	2	2	2	2
5. Locating missing young people	1 (14%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	1	2	1	2	2	1	2	2	2	2

6. Addressing domestic violence	1 (14%)	0 (0%)	1 (17%)	0 (0%)	1 (17%)	1 (17%)	2 (33%)	0 (0%)	1 (20%)	0 (0%)
Missing	1	2	1	2	2	1	2	2	2	2
7. Managing child-on-parent violence	3 (43%)	1 (20%)	3 (50%)	4 (50%)	3 (43%)	2 (33%)	1 (17%)	1 (20%)	0 (0%)	0 (0%)
Missing	1	2	1	0	1	1	2	2	2	2
8. Reducing parental conflict	3 (50%)	2 (33%)	1 (17%)	1 (17%)	2 (33%)	1 (17%)	2 (33%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	1	2	2	1	2	2	2	3
9. Improving positive communication	4 (57%)	2 (40%)	3 (50%)	4 (67%)	5 (71%)	4 (67%)	5 (71%)	3 (60%)	1 (20%)	3 (50%)
Missing	1	2	1	2	1	1	1	2	2	1
10. Liaison with school	2 (33%)	3 (50%)	1 (17%)	2 (33%)	2 (33%)	2 (29%)	0 (0%)	4 (67%)	2 (33%)	2 (33%)
Missing	2	1	1	2	2	0	2	1	1	1
11. Support for parents with additional needs (e.g., ADHD, autism)	1 (17%)	1 (20%)	2 (33%)	1 (17%)	2 (33%)	2 (33%)	0 (0%)	2 (33%)	0 (0%)	0 (0%)
Missing	2	2	1	2	2	1	2	1	2	2
12. Support for young people with additional	4 (57%)	3 (50%)	2 (33%)	2 (33%)	4 (67%)	4 (67%)	1 (17%)	3 (60%)	2 (33%)	2 (40%)

needs (e.g., ADHD, autism)										
Missing	1	1	1	2	2	1	2	2	1	2
13. Substance Misuse services (for parents)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	2	1	2	2	1	2	2	2	2
14. Substance Misuse services (for young people)	1 (14%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	1	2	1	2	2	1	2	2	2	2
15. Daily Routine planning	2 (29%)	1 (20%)	2 (33%)	4 (67%)	3 (50%)	3 (50%)	2 (33%)	3 (60%)	2 (40%)	2 (40%)
Missing	1	2	1	2	2	1	2	2	2	2
16. Managing emotions and de-escalation (for parents)	2 (33%)	2 (40%)	2 (33%)	3 (50%)	3 (50%)	2 (33%)	3 (50%)	3 (60%)	2 (40%)	1 (17%)
Missing	2	2	1	2	2	1	2	2	2	1
17. Managing emotions and de-escalation (for the young person)	1 (17%)	3 (60%)	4 (67%)	4 (67%)	5 (71%)	3 (50%)	4 (57%)	3 (60%)	2 (40%)	3 (50%)
Missing	2	2	1	2	1	1	1	2	2	1

18. Referral to CAMHS (or other mental health support for the young person)	0 (0%)	0 (0%)	1 (17%)	1 (17%)	1 (14%)	1 (17%)	1 (17%)	1 (17%)	0 (0%)	0 (0%)
Missing	2	2	1	2	1	1	2	1	2	2
19. Referral to mental health support for the parent(s)	0 (0%)	0 (0%)	1 (17%)	1 (17%)	1 (17%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	2	1	2	2	1	2	2	2	2
20. Personal Development (e.g., building self-esteem and resilience)	3 (43%)	2 (40%)	3 (50%)	2 (33%)	3 (50%)	2 (33%)	2 (33%)	3 (50%)	2 (33%)	2 (33%)
Missing	1	2	1	2	2	1	2	1	1	1
21. Healthy Relationships	3 (38%)	1 (20%)	2 (33%)	1 (17%)	4 (67%)	3 (50%)	3 (50%)	2 (33%)	1 (20%)	2 (40%)
Missing	0	2	1	2	2	1	2	1	2	2
22. Physical Health (e.g., Healthy Eating)	1 (14%)	0 (0%)	1 (17%)	1 (20%)	1 (14%)	3 (43%)	1 (14%)	0 (0%)	0 (0%)	1 (20%)
Missing	1	2	1	3	1	0	1	2	2	2
23. Engagement in positive youth activities (e.g., youth	1 (17%)	1 (20%)	1 (17%)	3 (50%)	4 (57%)	2 (33%)	3 (43%)	2 (33%)	2 (33%)	1 (17%)

clubs, sports, arts and crafts)										
Missing	2	2	1	2	1	1	1	1	1	1
24. Parenting an infant	1 (14%)	1 (20%)	1 (17%)	1 (17%)	0 (0%)	0 (0%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)
Missing	1	2	1	2	2	1	2	2	2	2
Was any other support not listed offered to families?	1 (13%)	1 (14%)	1 (14%)	1 (13%)	0 (0%)	1 (14%)	0 (0%)	1 (14%)	2 (29%)	1 (14%)
Missing	0	0	0	0	0	0	0	0	0	0
Have any components of the Triple P programme been delivered to families receiving support as usual only?	0 (0%)	1 (14%)	1 (14%)	1 (13%)	1 (13%)	1 (14%)	1 (13%)	1 (17%)	0 (0%)	1 (14%)
Missing	0	0	0	0	0	0	0	1	0	0
Have components of any other parenting skills programmes been delivered to families receiving support as usual only?	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (14%)	0 (0%)	0 (0%)
Missing	0	0	0	0	0	0	0	0	0	0

[1] n (%)

Support-As-Usual Checklists for the Teen Triple P + SAU arm

	Teen Triple P + SAU									
Type of Support	**Week 1** N = 8[1]	**Week 2** N = 7[1]	**Week 3** N = 7[1]	**Week 4** N = 8[1]	**Week 5** N = 8[1]	**Week 6** N = 7[1]	**Week 7** N = 8[1]	**Week 8** N = 7[1]	**Week 9** N = 7[1]	**Week 10** N = 7[1]

1. Financial Support	2 (22%)	1 (20%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	1 (50%
Missing	1	1	2	1	0	0	0	1	1	0
2. Housing	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	0	1	1	0
3. Assistance accessing medical appointments	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
4. Prevention of child exploitation	1 (13%)	0 (0%)	0 (0%)	2 (50%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)	1 (50%
Missing	2	1	2	1	0	0	1	1	1	0
5. Locating missing young people	0 (0%)	1 (13%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
6. Addressing domestic violence	0 (0%)	1 (13%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
7. Managing child-on-parent violence	0 (0%)	1 (13%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0

8. Reducing parental conflict	0 (0%)	2 (25%)	1 (20%)	1 (20%)	2 (40%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
9. Improving positive communication	3 (50%)	4 (50%)	3 (60%)	1 (20%)	3 (75%)	1 (25%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
10. Liaison with school	2 (33%)	6 (75%)	1 (20%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
11. Support for parents with additional needs (e.g., ADHD, autism)	0 (0%)	2 (25%)	2 (33%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
Missing	2	0	2	1	0	0	1	1	1	0
12. Support for young people with additional needs (e.g., ADHD, autism)	3 (33%)	1 (20%)	1 (17%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)	1 (50%)
Missing	1	1	1	1	0	0	1	1	1	0
13. Substance Misuse services (for parents)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0

14. Substance Misuse services (for young people)	1 (13%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
15. Daily Routine planning	3 (38%)	2 (40%)	2 (40%)	3 (75%)	1 (25%)	0 (0%)	1 (25%)	0 (0%)	2 (67%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
16. Managing emotions and de-escalation (for parents)	2 (25%)	1 (25%)	1 (20%)	3 (60%)	1 (25%)	1 (33%)	3 (75%)	0 (0%)	1 (33%)	0 (0%)
Missing	2	2	2	0	0	0	1	1	1	0
17. Managing emotions and de-escalation (for the young person)	5 (63%)	2 (50%)	3 (60%)	2 (50%)	3 (75%)	1 (33%)	3 (75%)	0 (0%)	2 (67%)	1 (50%)
Missing	2	1	2	1	0	0	1	1	1	0
18. Referral to CAMHS (or other mental health support for the young person)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0

19. Referral to mental health support for the parent(s)	1 (11%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)	0 (0%)
Missing	1	1	2	1	0	0	1	1	1	0
20. Personal Development (e.g., building self-esteem and resilience)	2 (25%)	1 (20%)	1 (20%)	1 (25%)	1 (25%)	1 (33%)	1 (25%)	1 (33%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
21. Healthy Relationships	2 (25%)	1 (20%)	1 (20%)	3 (75%)	1 (25%)	1 (33%)	0 (0%)	1 (33%)	1 (33%)	1 (50%)
Missing	2	1	2	1	0	0	1	1	1	0
22. Physical Health (e.g., Healthy Eating)	1 (13%)	0 (0%)	1 (20%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
23. Engagement in positive youth activities (e.g., youth clubs, sports, arts and crafts)	1 (13%)	1 (20%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
24. Parenting an infant	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0

Was any other support not listed offered to families?	2 (20%)	2 (33%)	2 (29%)	2 (40%)	0 (0%)	0 (0%)	1 (25%)	1 (33%)	0 (0%)	0 (0%)
Missing	2	1	2	1	0	0	1	1	1	0
Have components of any other parenting skills programmes (e.g., Incredible Years, Solihull Approach) been delivered to families?	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Missing	1	0	0	0	0	0	1	1	0	0

[1] n (%)

Appendix 6: Implementation tools

The implementation tools shared with trial co-ordinators throughout the trial are as follows:

- Information Sheet - Standard Teen Triple P YEF Research Trial Brief overview of YEF Trial and trial requirements
- Triple P Implementation Workbook - Presents the components and value of implementation science
- Organisational Readiness Checklist - self assessment tool for organisational capacity to implement Triple P
- Local Lead Implementation Functions - Planning tool around role and responsibilities of implementation lead
- Local Co-ordination Functions - Breakdown of activities/tasks of Local co-ordinator/lead
- Making the most of your Triple P Training - Supporting selection of practitioners for Triple P training
- Quality Assurance Considerations (Triple P) - Considerations to support high quality programme delivery
- Triple P Quality and Fidelity Monitoring Process - Process to support quality and fidelity
- Quality and Fidelity Core Components - Checklists to support self-evaluation
- PASS Session Guide - Supporting Peer Assisted Supervision and Support Sessions)
- Peer Assisted Supervision and Support (PASS) - PASS information sheet

Appendix 7: Process Evaluation Protocol

1 Teen Triple P Trial Process Evaluation Objectives

The aim of the process evaluation is to aid interpretation of the pilot trial findings by describing and assessing implementation of Teen Triple P and its mechanisms of action. To achieve this, the process evaluation has the following objectives:

Recruitment and reach

1. What are the most effective approaches for recruiting parents/carers and adolescents to take part in this trial of Teen Triple P?
2. What are the retention rates of parents/carers? What are the reasons for attrition?
3. To what extent were parents/carers from diverse backgrounds recruited to the trial?

Intervention fidelity, adherence and dosage

4. How well was Teen Triple P implemented? Did practitioners deliver the intervention as intended, with high fidelity to the manual?
5. What is the usual dosage/average number of sessions attended by parents/carers?

Intervention mechanisms

6. What are the barriers and facilitators for good implementation?
7. How does Teen Triple P differ from support as usual (SAU)?
8. What are parents'/carers' and adolescents' experiences of, attitudes towards, and perceptions of Teen Triple P, as well as its impact?

2 Research Design

2.1 Methods and data collection

A mixed methods approach will be adopted, using the Medical Research Council (MRC) guidance (Moore et al., 2015) on process evaluations as a framework.

Quantitative methods will be used to assess intervention fidelity, recruitment and reach of families, and to understand what SAU was offered to families.

Qualitative methods will examine implementation processes, operation of intervention mechanisms, the role of contextual factors, and interrogate patterns in the quantitative data. Interviews with parents and CYP will be conducted post-6 month follow-up data being collected from families. Interviews with practitioners and other site staff will be conducted throughout the same period of time.

Specifically, the aforementioned process evaluation objectives will be achieved through the methods outlined in Table 1 and in more detail below. These are set out for each of the methods of data collection, including what the data will be used for.

Table 1: Summary of data collection methods to address objectives

Objective	**Method/Documents**	**Completed by or with**	**Timing**
Recruitment and reach			
1. What are the most effective approaches for recruiting parents/carers and adolescents to take part in this trial of Teen Triple P?	Screening logs	Completed by site staff	Throughout the pilot
	Interviews	With site staff (managers, team co-ordinators)	Spring/Summer 2024
		With practitioners	
		With parent/carer participants	Spring-Autumn 2024
		With adolescent participants	
2. What are the retention rates of parents/carers? What are the reasons for attrition?	Withdrawal data	Completed by site staff and RAs	Throughout the pilot
	Interviews	With site staff (managers, team co-ordinators)	Spring/Summer 2024
		With practitioners	
3. To what extent were parents/carers from diverse backgrounds recruited to the trial? What proportion of adolescents had Special Educational Needs and Disabilities (SEND)?	Demographic data	Completed by/with parent/carer participants	Baseline questionnaires

Intervention fidelity, adherence and dose			
4. How well was Teen Triple P implemented? Did practitioners deliver the intervention as intended, with high fidelity to the manual?	Practitioner checklists	Completed by practitioners	Throughout delivery
	Interviews	With practitioners	Spring/Summer 2024
5. What is the usual dosage/average number of sessions attended by parents/carers?	Practitioner checklists	Completed by practitioners	Throughout delivery
Intervention mechanisms			
6. What are the barriers and facilitators for good implementation?	Interviews	With practitioners	Spring/Summer 2024
		Site staff (managers, team co-ordinators)	
		With parent/carer participants	Spring-Autumn 2024
7. How does Teen Triple P differ from support as usual (SAU)?	SAU data	Completed by/with parent/carer participants	Baseline questionnaires
	Interviews	With practitioners	Spring/Summer 2024
		With parent/carer participants	Spring-Autumn 2024
		With adolescent participants	
	Practitioner checklists	Completed by practitioners	Throughout delivery
8. What are parents'/carers' and adolescents' experiences	Interviews	With parent/carer participants	Spring-Autumn 2024

of, attitudes towards, and perceptions of Teen Triple P, as well as its impact?		With adolescent participants	
		With practitioners	Spring/Summer 2024

2.1.1 Recruitment and reach

Demographic and baseline data will be used to describe the numbers of parents/carers and adolescents approached to participate in the trial, and the proportion who agree to do so. In addition, we will also collect participant demographic information on ethnicity, sex and SEND status.

Screening logs and withdrawal data will be used to record how many parents/carers and adolescents were approached, recruited, retained at all stages, and reasons for attrition (if given).

Interviews are planned with all site co-ordinators, team managers, and managers (n=18), all practitioners who have completed Teen Triple P sessions with families in the trial (n=18), all recruited parent/carers (n=29), and all recruited adolescents (n=12). Interviews will include questions about the recruitment and retention of participants to the trial to provide context to the descriptive quantitative findings.

2.1.2 Implementation fidelity, adherence, and dosage data

Triple P have treatment fidelity checklists for each session, which practitioners are encouraged to use. These were revised by the trial team in collaboration with the delivery team, to ensure delivery of all core components of each Triple P session is checked, and an overall fidelity score will be generated for each family's receipt of Teen Triple P. The revised checklists detail each component of the session and ask the practitioner to select if this was completed in the session. The fidelity score is the average proportion of sessions content delivered. Fidelity items will be scored 0 or 1. Total fidelity session score will be dependent on the session.

Teen Triple P attendance data will be recorded by practitioners, including start date of parents/carers and adolescent engagement with the intervention; number of sessions completed. Teen Triple P attendance data will be recorded by practitioners, as well as if the session took place as planned, and any implementation challenges. Adherence will be defined as at least one parent carer from the family completing up to and including session 8 of the programme.

Interviews with practitioners will include questions about implementation, adherence, and fidelity to the manual to provide necessary context to the descriptive quantitative data from the practitioner checklists.

2.1.3 Intervention mechanisms

Qualitative interviews with adolescents and parents will explore perceived benefits and mechanisms of the interventions.

We will invite all recruited parents/carers to an interview with a researcher about their experiences of being involved in the trial and (where relevant) their experiences of Teen Triple P. Interviews with parents/carers in the intervention group will establish their experiences of the trial (e.g., randomisation, questionnaire completion), of Teen Triple P, and factors impacting adherence. Interviews with parents/carers in the control group will establish their experiences of being in the trial.

We will invite all recruited adolescents to an interview with a researcher about their experiences of the trial and intervention (where relevant). Where a family was randomised to receive the intervention, interviewed adolescents will be asked to reflect on what they have noticed in relation to their parent attending the intervention.

We will invite all practitioners to an interview with a researcher to explore their experience of delivering Teen Triple P, the potential systems and structures which would be needed for future implementation, unintended effects and key components of Teen Triple P. These data will enable us to explore the extent to which key intervention mechanisms appear to be working as intended, variation across context (e.g., by practitioner, local authority, family context), and any unintended mechanisms or barriers to participation.

We will ask families in the post-intervention questionnaire whether they have received Triple P or any other parenting programmes, as well as the names of any parenting programmes that they have received. We will quantitatively describe these data. Interviews with practitioners, parent/carers, and adolescents will include questions about SAU to provide further context to the quantitative data.

2.2 Lone working procedures

Process evaluation data collection will follow the steps laid out in the overall study's lone working procedures.

2.3 Data Analysis

With appropriate consent, all interviews will be audio-recorded, transcribed fully, and anonymised for analysis. Computer software (NVivo) will be used to manage the qualitative data and transcripts.

Framework Thematic Analysis will be used to analyse qualitative interview data, with the framework informed by a combination of the MRC Process Evaluation guidance and the logic model. Triangulation will be conducted, combining the qualitative and quantitative data on recruitment, adherence, fidelity and intervention mechanisms. Qualitative data will be used to interpret patterning

in recruitment, adherence and fidelity data, with analysis of quantitative data in turn highlighting areas which should be further explored in qualitative interviews and analysis.

Quantitative process evaluation data (e.g., recruitment, adherence, fidelity) will be descriptively analysed.

2.4 Ethics

Policies and procedures for ensuring the ethical conduct of the research, including the provision of information for participants and the seeking of consent are described in the main trial protocol, and at all times the process evaluation will align with these. During data collection – particularly when conducting qualitative interviews, there is the possibility that participants may disclose information which indicates a potential risk of harm (either to the participant or another person). It is also possible that participants may seek advice or support from the interviewer on a matter which has been discussed during the interview (e.g., something related to the support being offered at site). Before commencing data collection, all research staff conducting interviews should be familiar with trial procedures for a) dealing with requests for help/support; b) disclosures of potential harm including trial procedures for dealing with such disclosures; and c) disclosures of potential harm where there is an immediate risk to the wellbeing of an individual (e.g., someone describing suicidal thoughts).

2.5 Dissemination

All journal articles and other dissemination activities will be discussed with and approved by the Teen Triple P Trial Management Group and will be included in the trial's publication plan.

References

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D., & Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *BMJ (Clinical research ed.), 350*, h1258. https://doi.org/10.1136/bmj.h1258