Integrating "Triple P" into Parent Link Centres | Alberta, Canada

Supported Parenting

Family and Disability Studies
University of Alberta

2010

David McConnell • Rhonda Breitkreuz
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This research was supported by a grant from the Alberta Centre for Child, Family and Community Research

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Integrating "Triple P" into Parent Link Centres

an independent evaluation

2010

David McConnell, PhD
Professor and Director, Family and Disability Studies Initiative, University of Alberta

Rhonda Breitkreuz, PhD
Assistant Professor, Human Ecology, University of Alberta

Amber Savage, MSc (OT)
Research Coordinator, Family and Disability Studies Initiative, University of Alberta

Alec Hamilton, M.Psych
Graduate Research Assistant, Family and Disability Studies Initiative, University of Alberta

Project commenced: March, 2009
Project completed: April, 2010

This research was supported by a grant from the
Alberta Centre for Child, Family and Community Research

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ISBN: 978-1-55195-268-0

What parents are saying about Parent Link and 'Triple P'

"My PLC basically saved my sanity. I had just moved from another province to a place where I knew no one. I was told about the Parent Link Center and began to meet many other mothers whom I now consider friends. It was a great support to my family when I was experiencing post-partum depression with my second child. They informed me of the many resources that were available and allowed me to just talk about my feelings. Without the PLC I would have never made it. I'm very fortunate to have such a program in our town. I feel at home here thanks to them."

"The Triple P program has really changed our whole interaction for the better. I feel that we are now much better equipped to deal with our children. The program really helped us to "change" our household for the better. Other factors may have helped as I have a less stressful job now. But the majority of the positive change came from the program teaching us- the parents - to behave and communicate with a "goal" in mind. They helped us to analyze the situation and correct it properly. It really was extremely helpful to us!"

"Overall I have had an amazing experience with my Parent Link group. It is so comforting knowing that other moms have the same questions, concerns, troubles, doubts and wonderful times with their children. Without the Parent Link Centres, becoming a new mom would have been a little more scary and I would have had trouble finding other new moms to develop friendships with. The Parent Link Centres and its programs are an excellent resource for new families!"

"The Parent Link Centre helped my family by teaching us how to deal with anger in a proper manner. It has helped me to become a more confident parent and to believe in myself. I have also learned more effective discipline techniques that work a lot better than what I had been using. We now know how to successfully deal with our child's tantrums. After completing the Triple P program parenting has become a lot less stressful and more enjoyable for the children and I. I really enjoy every minute with my children now and they listen so much better. The ongoing support from the Parent Link Centre is wonderful and I am grateful they were able to help my family."

"I first started bringing my children to the Parent Link Centre simply to get out of the house. I did it reluctantly as I imagined it to be one of those places that bored moms hang out at just to fill up their days - like a shopping mall. I quickly realized it was not the case. More than anything the Parent Link Centre has become a place of refuge for me and a constant source of emotional support - both employees and other moms being the source of support. Feeling I can't always confide in someone at home, the PLC has become a place where I can do just that...and be myself. In terms of my children it has given us a place for them to socialize. I have learned a great deal about my children by watching them interact with others. My husband enjoys taking our kids to playroom as there are often fathers there. He also uses it as a meeting place when planning with other fathers. Overall the PLC has provided us with a greater sense of community."

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Executive Summary

The focus of this study was on the question of whether, and if so how, the dissemination of the Positive Parenting Program ("Triple P") (levels 2 and 3)[1] is strengthening the capacity of Parent Link Centres (PLCs) to support parents and families in Alberta, Canada. This study had three aims. The first aim was to examine the process of integrating Triple P (levels 2 and 3) into PLCs including barriers and facilitators to implementation (see Chapter 2). The second aim was to determine whether Triple P enhances parent, child and family outcomes compared to PLC services-as-usual (see Chapter 3). The third aim was to investigate factors that may contribute to or moderate the effects of parent training and support (see Chapter 4).

Mixed methods were employed. Individual interviews were conducted with PLC directors and group interviews were completed with a total of 62 PLC practitioners from 10 of 19 Triple P pilot sites in Alberta. Participating PLCs were selected to ensure representation of urban and rural areas, and PLCs serving aboriginal and immigrant families. A survey incorporating primary and secondary outcome measures was then administered to a sample of 1296 parents who had utilised PLC services in the 3 months prior. A total of 923 parents responded to the survey, including 172 parents who had received a Triple P intervention.

What factors are influencing the integration and implementation of Triple P?[2]

Six key factors were identified that influenced the integration, implementation, and potentially, the sustained use of Triple P. First, the organizational or workplace context was a factor. More established and stable PLCs are finding it easier to integrate Triple P into the services they offer. Second, the fit between practitioner's theoretical orientation or preferred approach and the theory and approach of Triple P was identified as a factor affecting implementation. Specifically, some practitioners prefer a more relationship-based approach and perceive Triple P as too behavioural. A third factor is practitioners' perceptions of the adaptability of the program. Depending on the training they received, some practitioners perceived the program as adaptable while others perceived the program as rigid and inflexible.

The fourth factor relates to access to Triple P resources. Non-accredited staff indicate that not having access to Triple P resources limits their ability to offer the highest quality service to clients. Fifth, the perceived suitability/unsuitability of Triple P (levels 2 and 3) for some groups influenced the implementation of Triple P. In particular, practitioners raised concerns about whether these levels of Triple P were appropriate for immigrant families, or families with multiple or more complex needs.[3] Finally, factors related to ongoing training are identified as barriers to the sustainability of Triple P. Specifically, practitioners raised concerns about how PLCs will be able to continue offering Triple P as staff turnover can be high and Triple P training is not frequently offered.

[1] Levels 2 and 3 of the Triple P system are designed to assist parents with common, discrete child behaviour problems and challenging child developmental transitions. Level 2 (Selected Triple P) includes provision of parenting tip sheets and/or a group seminar. Level 3 (Primary Care Triple P) includes one-to-one, narrow-focus, active skills training.

[2] These findings are presented in Chapter 2.

[3] There are two issues here. One is that Triple is designed as a tiered system of parent training and support, and levels 2 and 3 are not designed to meet the learning and support needs of families with children who have more entrenched or severe behaviour problems. The dissemination of Triple P levels 4 and 5 may help to redress this issue. The second issue is that Triple P, levels 2 and 3, is perceived my some practitioners as less accessible for some families, including some immigrant families or parents with lower literacy, who do not necessarily need a more intensive intervention, but may need levels 2 and 3 of Triple P to be presented in plain English or in their first language.

Is Triple P (levels 2 and 3) enhancing outcomes for PLC clients?[4]

No difference was found between Triple P and PLC services-as-usual groups on measures of parenting stress, family functioning, positive parenting practices, and total child difficulties. A small effect was found for Triple P on parent reported need satisfaction, but this was contingent on parent participation in a group-based parent education program (i.e., a Triple P group seminar or service-as-usual group activity). Without the element of 'group-work', Triple P (levels 2 and 3) offered no advantages above those obtained by services-as-usual.

Although Triple P does not appear to be measurably enhancing outcomes for parents, children and families, *that is by comparison with PLC services-as-usual*, the program appears to be adding value to PLC services in other ways.[5] Practitioners highlight efficiency gains. Having high quality educational resources in-hand is time-saving, and the systematic nature of the program ensures that time is used effectively. Practitioners also highlight credibility gains and, in turn, improved relationships with other service providers. They perceive that their credibility is enhanced by the Triple P evidence-base and the accreditation process for Triple P trainers.

What are the outcomes for PLC clients overall?[6]

The data suggests that Parent Link Centres are making a profound and positive difference in the lives of many parents and families in Alberta. One important way that PLCs are supporting parents is by creating opportunities for them to connect and support one another. In doing so, parents experience a sense of community belonging. Another way that PLCs are supporting parents and children is through parent education and training. Equipped with effective parenting strategies, parents report feeling more confident and less stressed by the everyday demands of parenting.

Most parents reported high levels of need satisfaction (i.e., the extent to which PLC services met their support and learning needs). Higher levels of need satisfaction were linked to lower levels of parenting stress and more positive parenting. In turn, lower levels of parenting stress and more positive parenting practices were associated with more positive family functioning and fewer child behaviour problems.

What program and client characteristics predict PLC service outcomes?[7]

More positive parent, child and family outcomes were associated with several service/program characteristics. Participation in group-based parent education, and support with personal issues such as loneliness and depression, were among the strongest predictors of parent need satisfaction. Further, a strong association was found between parent utilization of a PLC drop-in playgroup and more positive parenting practices.

However, the data suggests that PLC services are not equally efficacious for all parents and families who are utilising PLC services. PLC services appear to be less effective in meeting the learning and support needs of (i) parents experiencing socioeconomic disadvantage and/or financial hardship; (ii) parents for whom English is a second language; (iii) parents with a disability or chronic health condition; (iv) parents caring for a child with a disability or chronic health condition; and, (v) parents who have an older child with more challenging behaviours.[8]

[4] These findings are presented in Chapter 3.
[5] These findings are presented in Chapter 2.
[6] These findings are reported in Chapter 4.
[7] See footnote 6
[8] Many of these families may need more support or different support than what PLCs, as primary care providers, are equipped and designed to offer.

RECOMMENDATIONS

If Alberta Children and Youth Services remains committed to the dissemination and implementation of Triple P (levels 2 and 3), they might consider the following recommendations:

To support the integration, implementation and sustained use of Triple P:

1. Ensure that PLC directors are consulted about the implementation of Triple P before Triple P training is offered, and ensure that each PLC has an adequately resourced plan in place to integrate Triple P into their parent education programming.
2. Provide orientation sessions for PLC directors and staff so that they may be fully informed about the theoretical model underpinning Triple P, the scope and commitment involved in the Triple P training and accreditation process, and how Triple P can complement other PLC supports and services.
3. *Because there is no Triple P train-the-trainer model in place*, schedule frequent and regular Triple P training events throughout the year to address the problem that arises due to staff turnover.
4. Create opportunities for Triple P trained practitioners to support and 'supervise' one another. Regular Triple P network meetings could be scheduled, and practitioners could be connected, for example, via an on-line discussion forum.
5. In consultation with Triple P trained practitioners in Alberta, develop a series of informative case studies illustrating how the program may be creatively adapted for use in a variety of settings and for different client groups.

In addition, Triple P International might consider:

6. Investigating whether Triple P accreditation is necessary for practitioners in primary care settings to effectively utilize the Triple P Parenting Tip Sheets, *and if not*, consider issuing 'unrestricted licenses' at an appropriate cost, so that all licensed primary care professionals may disseminate the Triple P Parenting Tip Sheets.
7. Developing and disseminating a 'Triple P train-the-trainer' model, so that Triple P dissemination sites may become more self sufficient and not have to rely on trainers always coming in 'from the outside.'

To improve parent training and support for parents, including but not limited to those for whom English is a second language and those with more complex needs, *Alberta Children and Youth Services might consider:*

8. Negotiating with Triple P International to have the Triple P Parenting Tip sheets translated into the languages of major immigrant groups to Alberta.
9. Equipping PLCs with Triple P (Level 4 Group) and offering further training opportunities across Alberta to increase capacity to deliver levels 4 and 5 of the Triple P system, *or* a compatible evidence-supported program that is designed for parents and families who want additional information and/or have more complex needs.
10. In consultation with PLC Directors, reviewing PLC services (e.g., information provided) to ensure that they are accessible to parents for whom English is a second language, and to parents with low literacy and/or learning difficulties.

1
Background

SUMMARY

- Meta-analytic studies suggest that parent training and support programs produce meaningful effects on a range of outcomes: parenting knowledge, stress and behaviours, and child social-emotional development. Further research is needed to improve understanding of what works, for whom and under what circumstances.
- Behaviour-based approaches to parent training and support are among the most widespread and most frequently researched. The Triple P program is one of the most widely disseminated 'brands' of behaviour-based parent training. Triple P comprises a multi-level system with universal, primary care and targeted programs.
- Levels 2 and 3 of the Triple P system are designed to assist parents with common, discrete child behaviour problems and challenging child developmental transitions. Level 2 (Selected Triple P) provides early anticipatory developmental guidance to parents with the aid of tip sheets and videotapes. Information may be presented in one-to-one or group seminar formats. Level 3 (Primary Care Triple P) is a four-session intervention designed for parents who have children with mild to moderate behaviour problems and includes one-to-one active skills training.
- Meta-analytic syntheses of Triple P outcome data suggest that Triple P is as effective as other tested parent training and support programs. However, most studies of Triple P have focused on the more intensive levels of Triple P, and few studies have compared Triple P to active services-as-usual groups. Studies of Triple P in primary care settings have produced promising but mixed results.
- The focus of this evaluation is on the question of whether, and if so how, the dissemination of Triple P (levels 2 and 3) is strengthening the capacity of Parent Link Centres (PLCs) in Alberta to support parents and families. The study employed mixed methods. PLC practitioners were interviewed and a total of 923 parents completed a survey that incorporated measures of parent, child and family outcomes.

Supporting parents is arguably the most effective way of supporting children. Parents can be their children's primary source of support and/or their primary source of vulnerability. Experiences of parental love (e.g., warmth and responsiveness) and surety (i.e., safety and stability) are the building blocks of healthy development; and, parental investments (e.g., learning materials, extra-curricula activities) potentially create an opportunity structure that further enhances a child's life chances (Conger & Donnellan, 2007; Sameroff, 2010; Shonkoff, 2010). However, when parents have limited adaptive resources, including limited social supports, stress may become toxic, relationships conflict-prone, and parenting practices harmful (Adamakos et al., 1986; Guralnick, Hammond, Neville & Connor, 2008; McCurdy, 2005). There is an unequivocal relationship between negative, harsh and inconsistent parenting and poor child development outcomes: physical (Bell & Belsky, 2008), cognitive (Jeynes, 2005; 2007), emotional (McLeod, Weisz & Wood, 2007; McLeod, Wood, & Weisz, 2007), and behavioural (Hoeve et al., 2009; Karreman, van Tuijl, van Aken & Dekovic, 2006).

As parents, we all need support.[9] At any point in time some parents may need more support than others, and over time any parent will need more or less support depending on their circumstances. Historically, parents' support and learning needs have generally been met by family, friends and neighbours, and through ordinary, everyday, and often chance social interactions. Through informal social interactions (e.g., with neighbours and friends, in the local park or recreation centre, over coffee or a barbeque) parent identity is formed, parents' experiences are normalized, parenting norms are perpetuated and parenting ideas are shared (Fowler, 2002; Goodnow & Collins, 1995; Llewellyn, 1997). However, with ever longer hours of paid work, parents today have less time to meet and be together with other parents (Cox, 1995; Costa & Kahn, 2001; Putnam, 2000; Zolotor & Runyan, 2006) (see Box 1). The support and learning that once occurred informally and incidentally, increasingly has to be actively sought after. Parents are searching the internet; watching television programs such as "Supernanny"; purchasing pop-parenting books; and, turning to their family doctor and/or community-based parenting support agencies for guidance and validation (Carter, 2007; Invest in Kids, 2002; Rikhy, 2010).

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To address parent support and learning needs, community-based, primary care parenting and family support agencies offer a range of services. Parent education and training is typically 'core-business' (Layzer, et al., 2001). Other services include, but are not limited to, family support (e.g., collective kitchen, clothing exchange, toy library, social activities for parents) and drop-in playgroup activities for young children. A number of manualized and non-manualized parent training programs are in use. These programs are heterogeneous, varying in theoretical approach (e.g., cognitive and behaviour-based, attachment and relationship based); training modality (e.g., centre and home-based, group and one-to-one instruction); intervention scope (e.g., parent-mediated or multi-systemic); and, training intensity (e.g., brief and more intensive interventions). Over the last three decades there has been a proliferation of studies investigating the efficacy of a wide range of parent training and support programs. Meta-analytic syntheses have produced remarkably consistent findings (see Table 1). These suggest that on average, behavioural *and* non-behavioural parent training and support programs produce small (i.e., when based on independent clinical observation) to moderate (i.e., when based on parent self-report measures), but arguably meaningful effects on a range of outcomes: parenting knowledge, stress and behaviours, and child social-emotional development.[10,11]

[9] "he who has no need because he is sufficient for himself, must be either a beast or a god" (Aristotle, *Politics)*

[10] Unweighted (i.e., by the inverse of the variances and quality indices) effect sizes tend to be larger.

[11] Direct-to-child services (e.g., quality child care/preschool) appear to have larger positive effects on the cognitive development and school readiness of high-risk children than parent-mediated interventions.

Box 1. The commodification of time

Striking the balance between paid work and family has been described as "*the* topic of the 21st Century for families, employers and governments" (Human Rights and Equal Opportunity Commission, 2007, p. xi). At a time of unprecedented economic prosperity, many parents feel time-poor and are struggling to eke out the time and energy they want and need to invest in relationships, particularly relationships with their children (Duxbury & Higgins, 1998; Lamert, 1990). There are, no doubt, many social, cultural and historical factors that have contributed to this peculiarly 'modern' form of poverty. Here we highlight just three.

One factor is the differentiation of life spheres. In pre-industrial societies, the boundaries between work, family and community life were more permeable. People worked, cared for dependents, and 'played' together: production and socialisation were undifferentiated. Today, our lives have been compartmentalised: we work, we care, and if there is any time and energy leftover, we play.[12] This differentiation may have created a more productive workforce, but there is now less time for informal social interactions and consequently the 'social fabric' of society (social relationships characterised by cohesion, trust and mutual support) is becoming threadbare (Putnam, 2000; McPherson, Brashears, & Smith-Lovin, 2006).

An inter-related factor is the commodification of time. Today, 'time is money', and we never seem to have enough of it. We 'spend' time, 'invest' time, 'manage' time, 'save' time, 'waste' time, and unfortunately possess very little 'free' time. As a valuable commodity, we are obliged to display good stewardship of time: time is scarce and must be used rationally. And in our individualist western culture, where emphasis is placed more on achievement than affiliation, to be rational is to do nothing with our time unless we stand to gain from it. *Unless we recognise the value of affiliation, 'spending' time with others on an informal basis could be seen as wasteful.*

A third factor is gender inequality in the division of unpaid labour. Women, including those who are mothers, are not only participating more in the workforce,[13] they also continue to do the lion's share of unpaid work: child care, elder care, house-work. Women are working a 'double-shift', leaving little time for informal social relationships, much less rest. The implication is that as the demands on women's time and energy have increased, opportunities for informal support and learning have decreased.

"A truly prosperous society is one that values time as well as money, whether this is time spent with children or other relatives in leisure activities, time spent working voluntarily within community or time spent meeting day-to-day care needs" (HREOC, 2007, p.43). *To create a truly prosperous society, there has to be support for men and women with family and carer responsibilities. This includes support for family-friendly workplaces, support for early childhood education and care, and support for a society which values shared work and shared care.*

Less research attention has focused on moderators of parent education and training programs: Further research is needed to improve understanding of what works, for whom and under what circumstances. Individual studies have produced some inconsistent data. Notwithstanding, the overall pattern, gauged by meta-analytic reviews, suggests that the efficacy (or degree of effectiveness) of parent training and support programs may depend, at least in part, on the interaction of at least three key variables. These are (1) whether the program is universal (non-targeted) or targeted to families with children with significant behaviour problems; (2) whether parents receive one-to-one and/or group instruction; and, (3) whether parents are

[12] Although unfortunately, with ever increasing options for individual leisure, we often 'play' alone.
[13] Note that the double-income family is rarely a choice these days, it is rather a financial necessity.

Table 1. ***Meta-analytic findings (effect size[i]) for targeted and non-targeted (behavioural and non-behavioural) parent training programs***

	Non-Targeted			Targeted		
	Child behaviour	**Parenting**	**Parent wellbeing**	**Child behaviour**	**Parenting**	**Parent wellbeing**
Dretzke et al. (2009) - 24 studies				0.6(z)		
Wyatt Kaminski et al. (2008) - 77 studies				0.30	0.43	
Singer, Ethridge, Aldana (2007) - 17 studies(a)						0.29
Barlow, Coren & Stewart-Brown (2007) - 20 studies						0.40(b) 0.26(c)
Lundahl, Risser, Lovejoy (2006) - 63 studies				0.42	0.47	0.53
McCart, Priestner, Davies, Azen (2006) - 30 studies(d)				0.38		0.33(e)
Maughan et al. (2005) - 79 studies				0.30		
Curtis, Ronan, Borduin (2004) - 11 studies(f)				0.43	0.76	0.33
Barlow & Parsons (2003) - 5 studies(g)				0.29		
Layzer, Goodson, Bernstein, Price (2001) - 351 studies	0.22	0.39		0.39	1.08	
Serketich & Dumas (1996) - 26 studies(d)				0.86(z)		0.44

i. unless otherwise specified, weighted (by inverse of the variances and quality indices) effect sizes (SMD) are reported based on parent report post-test

(z) appears to be unweighted SMD, (a) targeting parents of children with DD only, (b) depression, (c) anxiety/stress, (d) behaviour parent training only, (e) parent adjustment/distress, (f) multisystemic treatments only, (g) group training only.

dealing with multiple stressors, such as serious financial hardship, that is in addition to child problem behaviour. Specifically, it appears that

- non-targeted parent education and training (i.e., service availability is not based on pre-defined eligibility criteria) usually produces smaller effects than targeted training[14] (e.g., Chamberlain, Price, Reid & Landsverk, 2008; Nowak & Heinrichs, 2008; Layzer et al., 2001);
- non-targeted parent education and training that involves group instruction may be more effective than non-targeted parent education and training that does not (e.g., Layzer et al., 2001);
- conversely, targeted parent training (i.e., for parents of children displaying significant behaviour problems) appears to work best when it involves one-to-one instruction (Lundahl, Nimer & Parsons, 2006; Maughan, Christiansen, Jenson, Olympia & Clark, 2005);
- targeted parent training is usually less effective for parents and families with multiple stressors and/or more limited adaptive resources, including low income (Lundahl, Risser & Lovejoy, 2006; Moran, Ghate & van de Merwe, 2004; Reyno & McGrath, 2005);[15] and,
- multi-level and multi-faceted interventions, incorporating but not limited to parent-mediated interventions, appear to work best for multiple-risk parents and children (Curtis, Ronan & Borduin, 2004; Shonkoff, 2003).

Triple P- Positive Parenting Program

Social learning based (i.e., behavioural) approaches to parent training and support are among the most widespread and most frequently researched. And the Triple P – Positive Parenting Program, is one of the most widely disseminated 'brands' of behaviour-based parent training and support. Other well known and well researched brands include Parent Management Training (Kazdin, 2005), Incredible Years (Webster-Stratton & Reid, 2010), and Parent-Child Interaction Therapy (Zisser & Eyberg, 2001).

A compelling number of studies have found that Triple P is efficacious. A table with information about each of 60 studies evaluating Triple P is included as Appendix A. Meta-analytic syntheses of Triple P outcome data suggest that, in general, Triple P outcomes are commensurate with other parent training and support programs, including other behaviour-based programs (see Table 2). Notwithstanding, Thomas and Zimmer-Gembach (2007) suggest that more independent evaluations are needed to confirm the efficacy of Triple P. This recommendation is supported by Eisner (2009) who observes that independent studies of Triple P, although few in number, have generally found smaller effects, that is by comparison with developer-led studies.

The unique appeal of Triple P appears to lie in its universal scope, from multi-media strategies aimed at improving parent access to high-quality parenting information, through to active, multi-modal parent training with enhancements for high risk families; its multiple levels of intervention (levels 1 to 5) which facilitate the matching of intervention type and intensity to parent support and learning needs; and, its well structured and systematic dissemination strategy, including practitioner-training and accreditation processes (Sanders, 2008). A description of each level of Triple P is provided in Table 3.

To date, most studies of Triple P have focused on outcomes from levels 4 and 5, which is the targeted end of the Triple P service spectrum (see Table 3 for a description of each level of Triple P). However, some promising data on levels 1 to 3 (universal and primary care Triple P) is now emerging. The findings from meta-analytic studies of Triple P are congruent with the findings from meta-analytic studies of parent training and support programs in general (see tables 1 and 2). In particular, the data suggests that targeted Triple P (levels 4-5) produces larger effects on parent and child outcomes than non-targeted Triple P (levels 2-3): parents and children with initially greater need, and parents who receive more intensive training appear

[14] Layzer et al. (2001) notes that family support philosophy emphasizes the desirability of non-targeted, universal services, but these show the weakest effects on both parent and child outcomes.

[15] This finding is one of the most consistent in the literature. Low socio-economic, multiple-risk families are more difficult to engage, more likely to drop-out, and less likely to benefit from parent training per se.

Table 2. ***Meta-analytic findings (effect size) for Triple P: Parent report measures***

	Non-Targeted (Levels 2&3)			Targeted (Levels 4 &5)		
	Child behaviour	**Parenting**	**Parent wellbeing**	**Child behaviour**	**Parenting**	**Parent wellbeing**
Nowak & Heinrichs (2008) - 55 trials of Triple P	0.21	0.38	0.19	0.34[(a)] 0.56[(b)]	0.36[(a)] 0.49[(b)]	0.16[(a)] 0.20[(b)]
De Graaf et al. (2008a) - 8 trials of Triple P				0.37[(c)]		
De Graaf et al. (2008b) - 13 trials of Triple P					0.54[(c)(d)] 0.57[(c)(e)]	
Thomas & Zimmer-Gembach (2007) - 11 trials of Triple P				0.73	0.70	

(a) Level 4 Triple P, (b) Level 5 Triple P, (c) outliers excluded (d) parenting style, (e) parenting competencies

Table 3. ***The Triple P Model of Parenting and Family Support***

Level of intervention	Target population	Intervention methods	Practitioners
Level 1 Media-based parent information campaign Universal Triple P	All parents interested in information about parenting and promoting their child's development.	Coordinated media and health promotion campaign raising awareness of parent issues and encouraging participation in parenting programs. May involve electronic and print media.	Typically coordinated by area media liaison officers or mental health or welfare staff.
Level 2 Health promotion strategy/ brief selective intervention Selected Triple P Selected Teen Triple P	Parents interested in parenting education or with specific concerns about their child's development or behaviour.	Health promotion information or specific advice for a discrete developmental issue or minor child behaviour problem. May involve a group seminar process or brief (up to 20 min) telephone or face-to face clinician contact	Parent support during routine well-child health care (e.g., child and community health, education, allied health, and child care staff).
Level 3 Narrow-focus parent training Triple P Primary Care Teen Triple P	Parents with specific concerns (as above) who require consultations or active skills training.	Brief program (about 80 min over 4 sessions) combining advice, rehearsal, and self evaluation to teach parents to manage a discrete child problem behaviour. May involve telephone or face to-face clinician contact or group sessions.	Same as for Level 2.
Level 4 Broad-focus parent training Standard Triple P Group Triple P, Group Teen Triple P Self-Directed Triple P Self-Directed Teen Triple P	Parents who want intensive training in positive parenting skills. Typically, parents of children with behaviour problems, such as aggressive or oppositional behaviour.	Broad-focus program (about 10 hr over 8–10 sessions) focusing on parent–child interaction and the application of parenting skills to a broad range of target behaviours. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions.	Intensive parenting interventions (e.g., mental health and welfare staff, and other allied health and education professionals who regularly consult with parents about child behaviour).
Stepping Stones Triple P	Families of preschool children with disabilities who have or are at risk of developing behavioural or emotional disorders.	A parallel 10-session individually tailored program with a focus on disabilities. Sessions typically last 60–90 min (with the exception of 3 practice sessions, which last 40 min)	Same as above.
Level 5 Intensive family intervention modules Enhanced Triple P	Parents of children with behaviour problems and concurrent family dysfunction (e.g., parental depression or stress) or conflict between partners.	Intensive individually tailored program with modules (sessions last 60–90 min) including practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills.	Intensive family intervention work (e.g., mental health and welfare staff).
Pathways Triple P	Parents at risk of maltreating their children. Program targets anger management problems and other factors associated with abuse.	Modules include attribution retraining and anger management.	Same as above.

Note. Adapted from Sanders, M.R. (2008). Triple P-Positive Parenting Program as a Public Health Approach to Strengthening Parenting. *Journal of Family Psychology, 22*(3), 506–517.

to derive the most benefit. This finding may reflect floor (i.e., 'the only way is up') and ceiling (i.e., 'the only way is down') effects (Turner & Sanders, 2006a): interventions are less likely to result in a substantial, measurable reduction in, for example, parenting stress or child problem behaviour, if levels were low to begin with.

Triple P (levels 2 and 3)

Levels 2 and 3 of Triple P are designed for use in primary care settings with parents who are seeking professional guidance and support to deal with common, discrete child behaviour problems (e.g., tantrums, whining) and challenging (but typical) child developmental transitions (e.g., toilet training). Selected Triple P (i.e., level 2) is available in two formats. The first is a brief, one to two session intervention providing early anticipatory developmental guidance to parents of children with mild behavioural difficulties or developmental issues with the aid of tip sheets and videotapes that demonstrate specific parenting skills. Additionally Selected Triple P can be offered as a seminar series, including three specific positive parenting topics. The seminars are used to promote awareness of Triple P and as brief and informative sessions for any parent. Each seminar includes a presentation, a question and answer period, distribution of a parenting tip sheet, and availability of practitioners at the end of the session to deal with individual inquiries and requests for further assistance. Primary Care Triple P (i.e., level 3) is a four-session intervention designed for children with mild to moderate behaviour problems and includes active skills training for parents.

Four English language, peer reviewed and published evaluations of Triple P (level 3 only) report promising but mixed results (Boyle et al., 2010; Crisante, 2003; de Graaf, Onrust, Haverman & Janssens, 2009; Turner & Sanders, 2006b). Turner and Sanders (2006b) employed an experimental pre-test post-test design, with random assignment of a total of 30 participants to Triple P (level 3) and waitlist control conditions. Outcomes were mixed. At post-test and follow-up, meaningful Triple P treatment effects were found on a limited subset of outcomes measures, including some dimensions of self-reported dysfunctional parenting, parent confidence and adjustment. However, no significant effect was found on observational measures of parent and child behaviours. The study findings suggest that Triple P (level 3) may be helpful to many parents and families, but the study did not address the question of utmost interest to policy makers and practitioners, that is, *is Triple P (level 3) any more effective than existing programs and practices?*

More recently, de Graaf, Onrust, Haverman and Janssens (2009) compared outcomes of Triple P (level 3) with existing primary care parenting support services in the Netherlands. Like Triple P, existing services in the Netherlands are often based on social learning theory, and may also focus on parent-child communication and conflict resolution, and involve the use of video home training. A quasi-experimental, pre-test post-test design with follow-up was employed. The sample included 87 parents (at baseline) who received Triple P (level 3), and a matched comparison group of 42 parents (at baseline) who received care-as-usual. Both parent training conditions resulted in small to moderate effects observed at post-test and follow-up: on average, parents in both groups reported a significant decrease in child problem behaviours and dysfunctional parenting. No significant difference between conditions was found on post-test and follow-up measures of child behaviours. However, small but significant differences, in favour of Triple P (level 3), were found on measures of parenting style and parent self-efficacy. De Graaf et al. (2009) conclude that Triple P (level 3) may become the program of choice, but further research is needed.

Triple P (levels 2 and 3): process and outcomes in Alberta

Building on the now substantial body of Triple P outcomes research, the focus of this evaluation was on the question of whether, and if so how, the dissemination of Triple P *(levels 2 and 3, hereafter referred to simply as Triple P)* is strengthening the capacity of primary care providers in Alberta, specifically Parent Link Centres (PLCs),[16] to support parents and

[16] See Box 2.

Box 2. Parent Link Centres in Alberta, Canada

Parent Link Centres (PLCs) began in 2004, and by 2007, all of the 46 currently operating PLCs were providing services. PLCs are non-government organisations offering a wide range of professional supports and services for parents with young children in the communities they serve. Parent Link Centres are staffed by a variety of professionals although training in early childhood development is common. PLCs provide five core services of parent education, early learning and care, developmental screening, family support, and information and referral through non-targeted, community-centered programming.

In 2007, Alberta Children and Youth Services (ACYS) implemented a pilot of levels 2 and 3 of the Triple P program in 19 PLCs in three Child and Family Services Authorities (CFSAs): Calgary and Area, Edmonton and Area, and North Central Alberta. ACYS limited training in the pilot to levels 2 and 3 of the Triple P system as these were seen to provide the levels of intervention that would be most appropriate in the non-targeted setting of PLCs. PLCs are expected to integrate Triple P programming into the parent education services they provide as a replacement for programs that address similar issues but which are perceived by ACYS to be non evidence-based.

Triple P International Pty Ltd. was contracted to provide training and accreditation for 60 PLC Staff in level 2 (provision of parenting advice through seminars and brief consultations with parents) and level 3 (narrow-focus parent skills training) in 2007-2008. Staff from the PLCs participating in this evaluation received Triple P training and accreditation in two waves. The first cohort was trained in Fall, 2007, and the second cohort was trained in Fall, 2008. Staff participated in four consecutive days of training in Triple P levels 2 and 3, followed by an accreditation session six weeks following training.

families. The first aim was to investigate the process of integrating Triple P into Parent Link Centre services. The second aim was to determine whether Triple P enhances client outcomes compared to Parent Link Centre services-as-usual. The third aim was to identify moderators of parent training and support outcomes. Mixed methods were employed. These are described briefly below and more fully in chapters 2 and 3.

Questions

- How are practitioners utilising Triple P (training and resources)?
- What are the perceived strengths and limitations of Triple P?
- What are the barriers and facilitators to integrating Triple P into PLCs?
- Does Triple P enhance outcomes compared to PLC services-as-usual?
- What client and program characteristics predict parent training and support outcomes?

Interviews with PLC directors and practitioners

In the period of May-July, 2009, one-to-one interviews were conducted with PLC directors, and group-interviews were conducted with practitioners (including Triple P accredited and non-accredited staff) at 10 Triple P pilot sites. A total of 72 practitioners (including 10 PLC directors) took part in the interviews. All interviews were conducted on-site by Alec Hamilton, a doctoral student and experienced practicing psychologist with demonstrated interviewing and group facilitation skills. Each interview took approximately 60 to 90 minutes to complete.

With participant consent, each interview was digitally recorded, transcribed verbatim, and then transcripts were checked for accuracy. The interviewer then reviewed the transcripts and identified key themes in the data. These themes were summarized in a report submitted to the Principal Investigators. Rhonda Breitkreuz then conducted a secondary thematic analysis (Miles & Huberman, 1994) of the group interview data in order to familiarize herself with the data,

ensure the rigour of the preliminary analysis, and refine and expand on recurring themes.

The findings from the interviews are documented in Chapter 2. The findings are instructive and point to some of the key benefits and challenges of disseminating and implementing a standardized program such as Triple P in a wide range of PLC sites where variability of existing programs, staff qualifications, staff retention rates, and location was considerable.

Survey of PLC clients: parent, child and family outcomes

The Supported Parenting Survey (see Appendix B), incorporating well validated outcome measures, was administered to a sample of parents drawn from 20 PLCs, including the 10 Triple P pilot sites, and 10 PLCs that were matched to them, using census-tract data, on a range of socio-demographic variables. To identify potential participants, parents who received a service from their PLC during a one month period (April-May, 2009) at each of these 20 sites were invited to record their name and contact details in a PLC Visitor's Book. A total of 1296 parents recorded their name and contact details, and these parents received a copy of the Supported Parenting Survey in the mail some 8 to 12 weeks later (June-July, 2009). A total of 923 parents completed the survey, a 'response rate' of 71%. Of these, 172 reported receiving a Triple P intervention. Details of the sampling and survey method are provided in Chapter 3.

The primary outcome measure was Parent Reported Need Satisfaction, that is, parent's own assessment of the impact of PLC services. This was based on four items, each scored on a seven-point scale. The items were (1) did you get the type of help you wanted from your Parent Link Centre?; (2) to what extent did the Parent Link Centre meet your needs as a parent?; (3) did your Parent Link Centre help you to deal more effectively with your child's behaviour?; and, (4) did your Parent Link Centre help you to deal more effectively with problems that arise in your family? The internal consistency of these four items was high so a total/composite score was created by summing item scores together.

Secondary outcome measures included the Parenting Stress Index-Short Form (Abidin, 1995), the National Longitudinal Survey of Children and Youth (NLSCY, Cycle 7) Parenting scales (i.e., positive interaction, ineffective, consistent and rational parenting) (Human Resources and Social Development Canada [HRSDC], 2007a), the NLSCY family functioning scale (HRSDC, 2007a), and the Child Strengths and Difficulties Questionnaire (Goodman et al., 2000). The Supported Parenting Survey also incorporated previously validated measures of financial hardship and social support, and an open-ended question inviting parents to describe how their Parent Link Centre has helped them and their family.

The data was analysed in PASW (SPSS) v. 18. Before data analysis commenced, a rigorous check was undertaken to ensure the survey data was entered accurately. The data was then screened: data was plotted and visually inspected, and the internal consistency reliability of each scale and sub-scale was determined. Descriptive statistics were then computed and a sample profile developed.[17]

Chapter 3 addresses the question of whether Triple P enhanced parent, child and family outcomes compared to Parent Link Centre services-as-usual. Multiple regression was employed to control statistically for potentially confounding variables. In Chapter 4, the relationships between primary and secondary outcome measures was examined, and multiple regression was employed to investigate 'predictors' of primary and secondary outcomes. One question is whether higher levels of Parent Reported Need Satisfaction are associated with lower levels of parenting stress and child problem behaviours, and more positive parenting and family functioning.

Parent testimonies of PLC impact, documented in Chapter 4, highlight the important function of PLCs in strengthening parents' social relationships. The final chapter focuses a spotlight on social relationships. Risk factors for low social support and low social integration are

[17] The overall sample profile is presented in Chapter 4

explored. Then the relationship between social support and parent, family and child outcomes is examined. Specifically we examine the main, mediating and moderating effects of social support on parenting stress, family functioning, parenting practices and child behaviour problems.

2

Integrating Triple P into Parent Link Centre services

Aim:

- To investigate the process of integrating Triple P (levels 2 and 3) into Parent Link Centres in Alberta through identifying the key barriers and facilitators of program uptake and implementation.

Method:

- Across 10 Triple P pilot sites, individual interviews were conducted with PLC directors, and group interviews involving a total of 62 PLC practitioners were completed. All interviews were transcribed verbatim and analyzed to identify key themes in the data.

Main Findings:

- Overall, staff at the Triple P pilot sites indicated that although it was still "early days," the experience of implementing Triple P into their PLCs had been positive.
- Triple P added value to PLC centres by offering high-quality resources, providing a structured and systematic program, enhancing efficiency of parenting programming, increasing the credibility of the work of PLCs, and enhancing linkages with other services providers.
- Facilitators and barriers to integrating Triple P (levels 2 and 3) included: (1) the level of development of pre-existing PLC services; (2) the degree of "fit" between the Triple P program approach and the working philosophy of PLC practitioners; (3) practitioner perceptions of program adaptability; (4) rules about who can and who cannot use Triple P resources; (5) the perceived suitability/unsuitability of Triple P for some client groups; and (6) training and sustainability issues.

Triple P is an evidence supported parent education and training program which could potentially strengthen the capacity (i.e., commitment, knowledge and skills, and educational resources) of human service agencies to address parent learning needs. In this study, we investigated the process of integrating Triple P (levels 2 and 3) into Parent Link Centres in Alberta. Our aim was to identify influences, including barriers and facilitators to program uptake; and, to explore how the program is being utilised, including any adaptations that have been made by PLC practitioners.

BACKGROUND

Social and behavioural science research suggests that there are multiple influences on the process of knowledge translation and the spread of innovation, including but not limited to the uptake of evidence supported programs. Evidence of efficacy is typically not enough to ensure adoption. Organisational support is usually requisite (Seng et al., 2006). Management has to be open to the innovation and willing to invest in the change process, including but not limited to practitioner training and program resources (Addis, 2002). For this to occur, there usually has to be some perceived or demonstrated cost-advantage (Linney, 1990). However, evidence of efficacy and 'top-down' support are still not sufficient conditions for the successful dissemination of research products and utilisation of evidence supported interventions (Schinke et al., 1991).

One key determinant of successful dissemination activity, in terms of program uptake, is the compatibility or 'fit' of the program with the beliefs and values of the potential adopter, where the potential adopter could be an organisation and/or individual practitioner. When a good fit exists, programs are more likely to be accepted and integrated into practice. 'Mis-fit' occurs, for example, when the implementation of pre-packaged manualized programs are perceived, rightly or wrongly, as detracting from the therapeutic relationship or as antithetical to 'client-centered' practice: turning professionals into technicians rather than caring human beings (Addis, 2002; Addis & Krasnow, 2000).

Another key influence on the uptake of evidence supported programs is the perceived simplicity (ease of adoption) and adaptability of the program. Dissemination is more likely to succeed when the program is simple, flexible, and adaptable to different adoption settings. This includes but is not limited to the perceived adaptability of the program for different client groups and particular client needs. Local adaptation of evidence supported programs is however controversial. Proponents of strict program fidelity point to evidence suggesting that 'tailoring' may reduce program efficacy (e.g., Kumpfer, Alvarado, Smith & Bellany, 2002; Shaw et al., 1999). Diffusion research however shows that any insistence on rigid adherence may be a barrier to successful dissemination: programs (and other innovations) that are successfully disseminated are almost always adapted in some way (Berwick, 2003).[18] Skilful competence appears to be a more realistic goal than rigid, technical adherence (Addis & Krasnow, 2000).

Successful dissemination of evidence supported programs also depends on the perceived need for and perceived advantage of the program over existing or alternative approaches. To spread quickly, a change must resonate with currently felt needs (Berwick, 2008; Landry et al., 2006). Research trials that compare new programs to no-treatment controls may produce evidence of efficacy, but they do not address this important question of *relative* effectiveness: Research trials with active service-as-usual comparison groups are needed to generate data that supports dissemination efforts. However, diffusion research suggests that practitioners may need to 'trial' the program and observe the benefits for themselves, that is, before an evidence supported program or innovation is fully integrated into their helping repertoire (Rogers, 1995). Positive client-feedback may be the single most important determinant of whether a program is

[18] "…innovations are more robust to modification than their inventors think, and local adaptation, which often involves simplification, is nearly a universal property of successful dissemination. In a successful diffusion process, the original innovation itself mutates into many different but related innovations." (Berwick, 2003, p.1971)

fully adopted and sustained (Sanders, Prinz & Shapiro, 2009).

The experience of being trained in the use of a new evidence supported program and in turn, practitioner confidence in their implementation skills, have also been identified as important determinants of program uptake and sustained use. For example, in the child welfare context, Aarons and Palinkas (2007) found that practitioners were more likely to "buy in" to a new program if the rationale for implementation was clear; if the trainers demonstrated respect for the practitioner's experience and were responsive to their concerns; and, if the trainer was perceived as experienced and expert by the practitioners. Addis (2002) also notes that learning a new program often requires practitioners to step out of their comfort zone, so opportunities to try out new interventions and to receive support from colleagues is often vital for practitioners to develop confidence in their implementation skills.

Dissemination of Triple P – Positive Parenting Program

The Triple P – Positive Parenting Program has been widely disseminated. Developed in Australia, this program is now being implemented in many other countries. Sanders and Turner (2005) attribute this success to a variety of factors, including but not limited to (1) the quality of the intervention; (2) the flexibility of the Triple P system, which allows practitioners to match intervention level to parent needs and preferences (i.e., adaptability); (3) strategic alliances with organisations, including the identification and support of an internal advocate, to ensure that program adoption is supported by management; (4) a 'just right' (i.e., not too onerous) approach to practitioner training that includes active skills training; (5) development of peer support and supervision networks; and, (6) built-in evaluation mechanisms or 'feed-back loops' to reinforce success and foster continuous quality improvement.

To date however, the adoption, implementation and sustained use of Triple P has received little research attention. Only one study that we are aware of has examined these issues in detail. Sanders et al. (2009) surveyed practitioners in a southeast region of the United States 6-months after they completed Triple P training. A total of 611 practitioners completed the survey. Of these, approximately three quarters were trained in Triple P (levels 2 and 3), with the remainder trained in level 4 or levels 4 and 5. The survey found that just 63% of Triple P trained practitioners actually initiated utilization of the program. However, of those who did so, 93% were continuing to use Triple P.

Sanders et al. (2009) found that level of Triple P use was predicted by a number of organizational, practitioner and client variables. High use was strongly associated with being a counselling professional (i.e., rather than a health, education or other professional); receiving level 4 (Group Triple P) training; integrating Triple P ideas or principles into their work in general; and, positive client feedback. Low usage was associated with perceived mis-fit between practitioner's theoretical approach and the theory underpinning Triple P; appropriateness of Triple P level with respect to client needs; professed lack of knowledge and skills in behavioural family intervention, and in turn, lack of confidence in implementing Triple P; and, low workplace support, including lack of peer consultation and supervision.

Dissemination of Triple P in Alberta

In 2007, Alberta Children and Youth Services (ACYS) implemented a pilot of Levels 2 and 3 of the Triple P program in 19 PLCs in three Child and Family Services Authorities (CFSAs): Calgary and Area, Edmonton and Area, and North Central Alberta. ACYS limited training in the pilot to levels 2 and 3 of the Triple P system as these were seen to provide the levels of intervention that would be most appropriate in the non-targeted setting of PLCs. PLCs are expected to integrate Triple P programming into the parent education services they provide as a replacement for any 'non-evidence based' programs that address similar issues.

Triple P International Pty Ltd. was contracted to provide training and accreditation for 60 PLC

Staff in Level 2 (provision of parenting advice through seminars and brief consultations with parents) and Level 3 (narrow-focus parent skills training) in 2007-2008. Staff from the PLCs participating in this evaluation received Triple P training and accreditation in two waves. The first cohort was trained in Fall, 2007, and the second cohort was trained in Fall, 2008. Staff participated in four consecutive days of training in Triple P Levels 2 and 3, followed by an accreditation session six weeks following training.

METHODS

Building on the study by Sanders et al. (2009), we investigated the process of integrating Triple P *(levels 2 and 3, hereafter referred to simply as Triple P)* into Parent Link Centre programming in Alberta, including influences on program uptake and utilisation. Like Sanders et al. (2007), this study was informed by diffusion theory and research (Rogers, 1995). However, an interpretive (qualitative) rather than analytical (quantitative) approach was taken. Interpretive methods were employed to obtain in-depth understanding, grounded in practitioners' experiences and captured in their own words: The open, flexible nature of interpretive methods allows for unexpected results to emerge from the data (Mayan, 2009). The questions were:

- *How is Triple P being used and adapted by PLC practitioners?*
- *What are the perceived strengths and limitations of Triple P?*
- *What are the barriers and facilitators of program uptake and implementation?*

One-to-one interviews were conducted with 10 Parent Link Centre directors and group interviews were conducted with practitioners (including Triple P accredited and non-accredited staff) at each of 10 Triple P 'pilot' sites. Participation was voluntary and written informed consent was obtained. A total of 62 practitioners took part in the group interviews, with the number of practitioners in each group ranging from 3 to 9. Each interview took from 60 to 90 minutes to complete. The interviews were responsive: A set of interview topics/questions was developed, but this was used more as an *aide memoire* than a rigid interview protocol. The *aide memoire* was adapted over the course of the interviews as the concurrent data analysis revealed data collection needs (e.g., divergent findings or emerging themes that required further exploration). Issues and emerging insights garnered from earlier interviews were also brought-up in later interviews for verification. Examples of questions/topics explored include, "*Can you tell me about…*"

- *"the local community and the parents accessing the service?"*
- *"the centre, its mission and the range of services you provide?"*
- *"how you are utilizing Triple P (training and resources) in your service/s?"*
- *"the strengths and limitations of the Triple P program and resources?"*
- *"any challenges involved in implementing Triple P?"*
- *"the impact of Triple P on the PLC in general (e.g., 'spill-over effects')?"*

Detailed field notes were made by the interviewer. Further, and with participant consent, each interview was digitally recorded and then transcribed verbatim. Transcripts were checked for accuracy. The interviewer then completed the preliminary analysis, identifying any recurring themes (Miles & Huberman, 1994). These themes were summarized in a report submitted to the Principal Investigators. Rhonda Breitkreuz then conducted a secondary thematic analysis of the interview data, searching for and analysing 'the negative case' (i.e. any inconsistencies) and in turn, refining, developing and expanding on the study findings.

FINDINGS

Overall, staff at the Triple P pilot sites indicated that although it was still "early days," the experience of implementing Triple P into their PLCs had been positive. The general consensus was that Triple P is enabling staff to 'do what they do' more efficiently *and* more effectively. The following quotes from PLC directors and practitioners are illustrative.

"I love the essence of it. I really enjoy this program. I think I come in weekly and tell my boss, I really like this. You know. I enjoy this program a lot. I don't want to lose -- I don't want to lose any part of the program."

"I have had a few really great experiences with it -- very very positive. Like I had a family whose little guy wasn't sleeping at all. So hence the rest of the family wasn't sleeping, you know, and it was off/on. Within four weeks… it was changed dramatically. And they filled out the satisfaction survey, and they were just so happy with the way things were going because, you know, they got some new strategies, and they were able to implement them in other areas."

"Our [Triple P group] seminars have been hugely, hugely attended, more successful probably than any of the [other] parenting courses [that we have run]."

"I think Triple P is hugely effective. I think we have found it hugely effective in our area, especially the tip sheets, that type of thing."

Staff at the Triple P pilot sites indicated that although it was still "early days," the experience of implementing Triple P into their PLCs had been positive.

Generally, staff found the **tip sheets** very useful to start conversations with parents and to provide simple and straightforward information to address specific parenting concerns. Tip sheets were also used as an "entry level" form of parent engagement. The **one-on-one sessions** were also being utilized. Most PLC practitioners indicated that the individualized aspect of Triple P one-on-one sessions is a key strength of the program. The primary benefit, according to participants, was that parents could get specific and immediate assistance rather than wait to enroll into a facilitated seminar. Triple P **group seminars** were also incorporated into the programming of many Triple P pilot sites. Most staff perceived these seminars to be very useful for parents, but some found the lecture style difficult. This was due to two key issues: their own personal fears of public speaking, and their general disagreement with holding a lecture-type seminar as compared to a more process-oriented workshop style of group work. This theme will be elaborated upon more in a later section.

Triple P (levels 2 and 3): Adding value to Parent Link Centre services

Interview participants generally indicated that Triple P is not a radical departure from pre-existing services: The parenting strategies that Triple P promotes were not new. Yet participants described a number of ways that Triple P was enhancing existing services. First, the high quality Triple P resources, and the structured and systematic nature of the program, were optimizing teaching time and effectiveness.

"Triple P has packed good parenting well…Once upon a time we had this filing cabinet full of resources. And so I'd have a client come and then I'd have to go back to my filing cabinet, and I knew something on toilet training was in there and I'd get it out. And there's five things on toilet training that would work for it. And I would write up that sheet and then I'd give it to them. Whereas now, I can go straight to Triple P toilet training."

"With Triple P you're the expert coming in saying, okay…this is what you need to do. We don't have a lot of time for small talk. We're not going to talk about that…With home visitation you can be messing around for a very long time to get that same solution. It's efficient. It's effective. It's fast, but it's not that warm and fuzzy…"

Second, although Triple P had not necessarily changed *what* PLC practitioners do, for at least some practitioners, it had transformed *how* they did it: Triple P was enhancing efficiency by way of a systematized process of support and service delivery. As one participant explained:

> "There was nothing new, nothing I had not seen before, nothing I hadn't come across before at all. I think it's in how the Triple P provider approaches as systematically as you do with the forms and the tracking – that makes that program unique."

Another participant summed-up Triple P as "a great little package that is easy to deliver." Triple P was also described as well structured and simple to implement. One participant explained how Triple P made problem-solving easy to negotiate:

> "…It's outlined like steps, if this doesn't work, do this. And if this doesn't work, do this. Then move to step two…I think it's laid out well that way."

Third, practitioners perceived that the accreditation process, and the Triple P emphasis on evidence-based practices, gave them more credibility. Having a "structured," "defined," "research-based" program meant that staff could draw on a larger body of evidence to demonstrate that these techniques worked. As one participant said, "this isn't just something airy-fairy...the key is to stay evidence-based."

> "What's different about this program, and I appreciate this a lot, is that I am not spending an hour talking at the parent. I am spending an hour working with the parent. I am hearing where they're at, what's working for them, what's not working for them. What's not working for them, we're going to tweak it a little bit and try to give them some strategies that will work. Then I am not just sending them off with these strategies and saying, I hope it works out for you. I am sending them off, and then they are coming back and we can work at it a little more. So it's much more interactive. It's much more focused on the parent. It's their program. It's about them, where they're at, and meeting them where they're at. I just guide them through it."

> "It was excellent because you could say, you know, we have been trained in this. This is an evidence-based program and these are the things that if we follow with, it will work. You know, we have to stick to it."

Although Triple P had not necessarily changed *what* PLC practitioners do, for at least some practitioners, it had transformed *how* they did it.

Fourth, a number of directors and practitioners reported that Triple P was enhancing linkages with other agencies. One interview participant indicated that they were receiving referrals because "word of mouth is we are doing a good job." Similarly, another indicated that the health unit had been a very positive source of referrals "because they heard that we are making a difference in those clients' lives." PLC staff also observed that their relationship with child and youth protection services had never been more positive. As one participant indicated, "We haven't had, I don't believe, as much of a relationship with Social Services as we have now." Evidence of this enhanced relationship and increased referrals was described by one PLC director:

> "What we are finding is that we seem to be getting a lot of parents that are being referred from Child Welfare to do the Triple P as well."

Facilitators and barriers to integrating Triple P (levels 2 and 3) into PLC services

There is variability in the way and extent to which Triple P is being integrated into Parent Link Centre services. Six key factors impacting the integration process emerged from the group interviews. These are: (1) level of development of pre-existing PLC services; (2) the degree of "fit" between the Triple P program approach and the working philosophy of PLC practitioners (e.g., certain elements of the Triple P message were contentious for some practitioners, such as the use of time-out and cry-out strategies); (3) practitioner perceptions of the adaptability of the program, or rather, how free they were to adapt the program; (4) rules about who can and who cannot use Triple P resources; (5) the perceived suitability/unsuitability of Triple P for some client groups; and (6) training and sustainability issues.

Level of development of PLC

One factor that seemed particularly salient in the implementation of Triple P was the pre-existing level of service/program development before Triple P was introduced. If the pre-existing PLC was already conducting a variety of quality programs, Triple P seemed to be more readily accepted and implemented as another 'tool in the tool box' of resources.

> "You know how they say how you build something and it has that concept of if you put the big rocks in first and then the smaller rocks and then the gravel and then the sand and then the water. So we already had the big rocks and probably some of the smaller rocks. I think we are probably at the point where Triple P adds the gravel."

Notably, a few group interview participants pointed out that the existing skills of PLC staff contributed greatly to the success of Triple P implementation. As one staff member stated: "without the skills and the experience level that the staff bring to Triple P, we would not have the success that we have." Furthermore, with a well-established PLC, staff already had pre-existing relationships with parents, and were therefore able to 'market' Triple P to parents more effectively. This point is described by participants in the following quotes:

> "So that relationship is important and then it makes them kind of able to participate… so we are getting the parents who have already built a relationship with [staff] and love them. And so if [staff] are any indication of what the rest of the Parent Link staff are like, then, you know, we are really open to come to the workshops and the seminars."

> "It's through the relationships that we have established with our families. You know, you are not coming here because you're having parenting difficulties or because you're isolated or because you're in a difficult relationship. You are coming here to play with your child. And because they have a relationship with all of us, if these things come up, they are more willing to talk to us. You know, there is not a stigma of coming here."

"Without the skills and the experience level that the staff bring to Triple P, we would not have the success that we have."

As illustrated in the quote above, staff believed that it was important that relationships developed between parents and PLC staff occurred within a 'normalized' context in order for the mandate of PLCs to be fulfilled. Programs such as playgroups served as a 'foot in the door' so that parenting concerns could then be addressed in a non-threatening manner. Participants thus saw the approach they took to their PLC programming overall as key to legitimizing Triple P: Through offering programs that were not stigmatizing or threatening, parents would be open to additional programs such as Triple P.

> "It would be humiliating to go and say 'oh, I don't really know how to do this. I think you need to tell me some special way to do that'….It's that idea that maybe if I am just hanging around this place and seeing these people talk to people and getting a little big of 'oh, is that what that's about'?...You know, maybe talking to friends who had come and spoken to them or seeing it in the newspaper more or whatever. Normalizing getting help." "And I think that with the offering of the different programs and the relationship that our parents have outside of parenting programs, like just our 'stay and play' drop-ins, they are more open to coming to you and approaching you within say that 'stay and play' setting because they are comfortable with those people, and they realize that, you know, everybody is going through these things."

If, on the other hand, the PLC was still in the process of 'getting traction' in its overall programming, it appeared that Triple P was more difficult to implement, due to lack of sufficient infrastructure, insufficient staffing, and inability to coordinate yet another program in an already struggling organization. Not surprisingly, implementing Triple P in a PLC site that is struggling to survive is difficult at best. This appeared to be the biggest struggle in PLCs where there was a hub with various satellite sites in remote locations.

> "We have never established our centre really closely out there. We hired one staff, she stayed for almost a year before she went on – and then we've had staff short, you know, and then no – now I shouldn't say nobody…What [staff] has done has then kept one program running all the time. So they know the centre is still there. It's not been five days a week that we hope but at least one of two."

In short, having a well-established PLC program with pre-existing rapport with parents enhanced the likelihood of successful implementation and uptake of Triple P.

Degree of "fit" between Triple P and current PLC practices

Some PLC practitioners expressed discomfort with the underlying theory of Triple P: Behavioural Family Intervention (BFI). They indicated that this behaviour modification approach ran counter to their training in early childhood development and attachment theory. One participant said that she is "still struggling with how attachment [fits] in Triple P." Other participants indicated discomfort with the use of "time out" and "cry out" sessions. As one participant said, "I am not in love with some of the cry time and time out stuff." Others indicated that these techniques were far too prevalent in the Triple P materials, stating that "on every single tip sheet it gets back to the time-outs and the quiet times."[19]

> "I found the behaviour modification stuff, the rewards and time outs, that kind of stuff was too prevalent in it for me – I did not feel comfortable with it. And I finished the training and I went back to my employer and said, I don't really like this program. I can't see myself using it -- I will use parts of it. There is a lot of stuff I will use but the few things in it that I didn't like I really don't like and I feel strongly about."

> "I struggle with time outs…I don't necessarily believe in them. And for me it was a bit of a hard – it's a hard sell… and I also don't think it works with every child although Triple P would absolutely disagree with me. I think that's pigeon-holing people and I think you need to find out what works…so that's my struggle. And I had a hard time presenting that."

[19] Time-out and cry-out strategies are included in the Triple P program as back-up strategies or strategies of last resort.

> "And there is one piece in that video, and it seems to me it's the crying it out. And then you leave and you just let them cry.…But I remember saying 'ladies, I'm not even going to really play this for you…' So that's a part about how I cannot promote something I am completely against."

There were also concerns raised about the clinical nature of the seminar approach versus a more process-oriented workshop style of facilitation.

> "When I first did the seminar I found it very hard to follow…how would I put it? Because I was starting with my workshops to be more workshop based and to facilitate and have people participating, and then all of a sudden have to switch back to seminars, it was like, I don't want to be doing this. I want to continue with the flow of doing workshops and not have to resort back to seminars. Because I found the validity of doing workshop based programs compared to seminar based, it appeared to me that the participants got more out of it compared to a seminar."

> "I think if we just gave the information and stuff, I don't know if we'd ever see it as successful or not. Because you spend the whole time just giving information. You'd never have a chance to see how it works."

In sum, a number of participants raised concerns about the behavioural modification philosophy and the information focused seminars used in Triple P.

'Permission' to adapt Triple P

The way in which Triple P staff were trained influenced the practitioners' perceptions of how adaptable Triple P was to meet the specific needs of the parents. Practitioners who had participated in the first wave of Triple P training were more likely to use words like "rigid" and "inflexible" to describe the program. Conversely, practitioners who had participated in the second wave of training viewed Triple P as a flexible and adaptable program. Although some PLCs described adapting some of the actual material, most adaptations pertained to how the material was delivered. The following quotes give examples of the kinds of adaptations that appear to be common.

> "For example, last week we were doing promoting positive behaviour, and there is a couple of break-out sessions where you are supposed to brainstorm, provide a descriptive praise. I just get the whole [group to discuss], because it's just way faster to do it as a group."

> "I just want to make sure that I am delivering it in a way that my clients can hear it. And sometimes that means you have to change the wording a bit. Sometimes it means you have to go over it three or four times. You have to add some extra examples."

> "So I just gathered some information when I was here, put a package together for them and fired it off. And there was some Triple P and there was some Active Parenting in it, put it all together. Because if I have information that's what they are looking for, I am doing them a disservice not to pass it on. So I turned a blind eye…"

Concerns related to the perceived adaptability of the program were closely related to understanding about who could or could not utilize Triple P resources.

Rules about who can use Triple P resources

A number of practitioners described frustration with "the rules" about who could use the tips sheets and other Triple P resources. This sentiment is well-captured by one participant: "Thou shalt not give out a tip sheet unless you are an accredited Triple P facilitator.…" Another participant suggested that it would be helpful to post the tip sheets on their wall instead of keeping them locked away, where they can only be accessed by Triple P accredited staff.

> "Thinking about the 'Triple P police' is stuff like tip sheets… [they] are fabulous and wonderful -- they are so well laid out -- but no one can give them out unless you have been accredited. I thought -- it's too bad because we have all these people, the staff working in the Parent Link -- who could really give them out and it would be really beneficial to parents, but they can't."

> "If your tip sheets are all hidden in this metal cupboard—and you need a swipe card and a key to get into it right, and then show your accreditation pass and put your thumb print in, and it opens—then it makes it seem like scary and something that's unapproachable…whereas if it's up on our wall and parents are reading it and they're interested and are asking questions, it will get utilized, and it will just become a normal part of what we are, what we do, what we offer."

Practitioners described frustration with "the rules" about who could use the tips sheets and other Triple P resources.

Although practitioners were concerned about breaking the rules of Triple P, it was sometimes difficult to resist the temptation to use the high quality Triple P resources. One non-accredited practitioner described how she "cheated" by using a video from Triple P, although as she explained, she didn't call it Triple P because she would "get into trouble:"

> "I cheated a little with the video. There was a group that already exists that does a parent topic once a month. And you know, they wanted positive parenting. So I just brought the "Every Parent's Survival Guide" video. And we just played it. And I paused it at good spots and we discussed it, and played a little bit more and we discussed it. And it was actually really successful. We only got through about a quarter of it because there was so much discussion and it was only an hour and a half slot. But they want me to come back and do more. I didn't use the power point. I didn't use the work books. I just used the video and discussion. But they really liked it. It was quite successful… And they really liked it."

Similarly, one director indicated that at her PLC, staff creatively incorporated tip sheets into their general programming in addition to giving them out to select parents. This way, the information could be more broadly utilized. She explains.

> "So we use the Triple P tip sheets. And especially we use the group seminar sheets. And what we do is we just cut them up and do like little blurts and blow them up and laminate them so parents can read what they are about and get a taste… We can't afford to just give them out…"

The suitability/unsuitability of Triple P (levels 2 and 3) for some client groups

Some of the PLC practitioners reported that Triple P did not work well for English as second language (ESL) families and was not appropriate for their clients with multiple or more complex needs.[20] One participant who worked in a PLC that served many immigrant families explained that because ESL families are struggling with language, the Triple P material, although good, "needed to be simplified." Another participant indicated that it was a "big challenge" to get through the seminar material with an ESL group. A number of participants also recognized that Triple P was not suitable for many of their clients who had more complex needs.[21] They indicated that if they screened a family and

[20] This includes families typically served by Parent Link Centres as well as families with more entrenched or severe problems who would in theory be referred on for more appropriate and intensive support.

[21] See table 3 for a description of Triple P levels and the needs that these are designed to address.

found that they had more than one or two issues, Triple P (levels 2 and 3) would not be appropriate. One participant said:

> "So they need to be at a place where they feel they can focus on that, whereas if there is too much other stuff going on in their life, they likely don't have time to track things and make a chart and -- you know."

Training and sustainability

Participants described the training as "interesting" and "worthwhile" while at the same time indicating that it was "intense," "stressful," "overwhelming," and "difficult." While some said it was the process of training that was difficult, others described the anticipation of the accreditation process as the pressure point. All were positive in their statements, however, that despite how challenging the processes of training and accreditation were, the end result was beneficial. One participant summed up the sentiment well in her comparison of the training experience to child birth:

> "It's like being pregnant, right? You give birth to the baby. You really don't want to do that again but you like the end result."

Perhaps a more salient issue around training was concern about the sustainability of Triple P due to staff turn over. A number of PLCs had lost a Triple P trained worker, and these workers had not been replaced. There were concerns about how they would be able to continue offering Triple P because training was not offered very frequently, and participants were aware that training was a costly process. Staff suggested that a train-the-trainer model would help to ensure the continuity of the program.

> "But you know, like for example, if [staff member] was to leave, or if [staff member] was to leave….then we have lost that piece of the program, because there is nobody else…again, it's just that whole turnover…..I think there should be a training trainer. So that even if there was one or two people from each Parent Link that were trained as trainers…there might be somebody in another PLC that could still come in and train the staff."

Concerns were also raised about the expense of the program, and how much time and energy it took from staff to implement Triple P. When asked about whether or not Triple P has added to the PLC site, one director said:

> "It absolutely added. I wouldn't argue that. But at the same time, you know, you are using the staff you have. And so if you are adding programs to their list then you have to subtract programs somewhere else, right? So you know, in that sense, it's a bit of a balancing act to just weave it in with what we do and make sure everybody has a balanced piece of the program…I think we have actually been working far beyond our capacity. We have been doing more programs than we can actually really do if you want to kind of sustain [programs]. So we are trying to scale back. And that means we have cut some other programs. So for example, one of our most popular programs is not running right now… And normally we would be running it 3-4 times a week in different locations – we are not running it again until September because [staff members] need a breather. They need to catch up."

DISCUSSION

Participating PLC practitioners were generally familiar with the principles and processes of behavioural family intervention before Triple P was disseminated. Therefore the process and content of the Triple P program was not particularly new. Nevertheless, PLC practitioners identified a number of ways in which Triple P is adding value to PLC services. Practitioners highlighted 'efficiency gains.' Having high quality educational resources in-hand is time-saving, and the systematic nature of the intervention

ensures that time is used effectively. Practitioners also highlighted 'credibility gains.' Practitioners perceived that their credibility, in the eyes of clients and other service providers, is enhanced by the evidence-base for Triple P and the accreditation process. The reported result is increased inter-agency cooperation, client referrals and client engagement.

Workplace, practitioner, and program characteristics influencing the integration, implementation and potentially, the sustained use of Triple P were identified. The findings are consistent with extant theory and past research on knowledge translation and the diffusion of innovation (e.g., Rogers, 1995). One key factor is the organizational or workplace context. More established (e.g., in terms of programming and community presence) and stable (e.g., in terms of staffing) PLCs are finding it easier to integrate Triple P into the services they offer. Another key factor is the fit or mis-fit between practitioner's theoretical orientation or preferred approach and the theory and approach of Triple P. Specifically, some practitioners prefer a more relationship-based approach and perceive that Triple P is 'too behavioural' and/or 'too problem-focused.'

A third key factor influencing the uptake and implementation of Triple P is the perceived adaptability of the program. Some practitioners perceive the program to be rigid while others perceive it to be flexible and adaptable. The perception of Triple P as rigid or flexible appears to be a training effect. Practitioners who participated in the second wave of training and accreditation tended to perceive the program as more flexible. However, whether the program was perceived as rigid or flexible, a number of practitioners found it difficult to fit the program to some clients' needs. The program was perceived by some as unsuitable or rather inaccessible for ESL clients due to language barriers. Many also recognised that Triple P (levels 2 and 3) was not suitable for their clients with multiple or more complex needs.

The sustainability or continued use of Triple P is a major concern for PLC directors and practitioners generally and more so for those working in environments in which there is high staff turnover. The Triple P training and accreditation model, which involves 'bringing a trainer in from the outside,' is viewed as a significant threat to program sustainability. Several participants suggested that a train-the-trainer model would be more responsive to PLC needs, and promote program sustainability.

CONCLUSION

In sum, there were both benefits and challenges experienced by PLC staff in the implementation of Triple P in the pilot sites. Perceived benefits included having new resources, being accredited and in turn having increased credibility in the service community, having a program with one-to-one training components, and experiencing the renewed energy of having a new, fresh program to offer. Challenges included perceived program rigidity, concerns about the behavioural approach to intervention, limited accessibility of Triple P materials for some families, and concerns about the lack of a train-the-trainer model to ensure program sustainability.

3
Triple P v. PLC Services-as-Usual

Aim

- To explore whether Triple P (levels 2 and 3) enhances parent, child and family outcomes compared to Parent Link Centre services-as-usual.

Method

- A survey incorporating measures of parent, child and family outcomes was administered to a sample of 1296 parents who had utilised PLC services in the prior three months. A total of 923 parents responded to the survey, including 172 parents who had received a Triple P intervention. Multiple regression analysis was employed to determine whether Triple P enhanced outcomes with support and service variables, and parent, child and family characteristics held constant.

Main findings

- Parents who participated in a group activity/program *and* received a Triple P intervention (e.g., tip sheets) reported higher levels of need satisfaction than parents who participated in a group activity/program but did not receive a Triple P intervention.
- Triple P did not enhance outcomes for parents who had not participated in a group activity/program, that is compared with PLC services-as-usual.
- Parents who participated in a PLC group-based parent education activity / program *(be it Triple P or services-as-usual)* reported higher levels of need satisfaction than parents who received only individual support *(be it Triple P or services-as-usual)*.
- No significant association was found between Triple P and any secondary outcome, including parenting stress, family functioning, positive parent-child interaction and child behaviours.

Most parents do the best they can, with the adaptive resources (personal, social, material) they have, to meet their children's developmental needs for preservation, nurturance and socialisation. The problem is that no one is born with parenting know-how: Parenting skills have to be learned and natural learning opportunities for parents are increasingly limited. There is certainly no shortage of parenting information available. Parents are saturated with information from the mass media (e.g., television programs, periodicals and pop-parenting books). However the quality of this information is questionable and many parents are looking for information and support that is tailored to their particular situation and concerns.

To disseminate effective parenting strategies and meet parent demand for individualised guidance and support, Sanders and colleagues at the University of Queensland, Australia, developed the Triple P - Positive Parenting Program *and* a strategy to disseminate this program internationally. Triple P is a behaviour-based, multi-level system of parent training and support (see Table 3 in Chapter 1). At one end of the Triple P spectrum are multi-media strategies aimed at improving parent access to high-quality parenting information. At the other, Triple P comprises active, multi-modal parent training with enhancements for high risk families.

In this chapter we present findings from an evaluation of Triple P (levels 2 and 3), which is being piloted by Parent Link Centres in Alberta, Canada. Levels 2 and 3 of Triple P are designed for use in primary care settings with parents who are seeking professional guidance and support to deal with common, discrete child behaviour problems (e.g., tantrums, whining) and challenging child developmental transitions (e.g., toilet training). Level 2 (Selected Triple P) interventions include provision of parenting tip sheets and/or a group seminar. Level 3 (Primary Care Triple P) intervention includes narrow focus 'low-dose' active skills training (e.g., 4 x 20 mins. sessions).

Few studies have empirically evaluated outcomes of Triple P (levels 2 and 3) *per se*. Four refereed English language publications report promising but mixed results (see Chapter 1 and Appendix A). Notwithstanding, the evidence in favour of behavioural family intervention in general seems incontrovertible (see Chapter 1 for brief review). The question therefore is *not* whether behavioural family intervention or more specifically, Triple P (levels 2 and 3) 'works', but rather *Does Triple P (levels 2 and 3) enhance client outcomes compared to Parent Link Centre services-as-usual?*

Conceptual framework

As Belsky (1984) and many others have described, parenting is a complex, multi-dimensional activity influenced by multiple, interacting, intra- and inter-personal factors, as well as societal, community, and cultural environments. Parenting is, in turn, a primary influence on child development:[22] Parenting behaviours influence virtually every aspect, from the developing circuitry of the brain to the emergence of language and social competence (Shonkoff, 2003). Parent education and training programs, such as Triple P, aim to promote healthy child development by targeting intra- and inter-personal determinants of parenting behaviours, including for example parent knowledge, skills and resourcefulness, parenting stress and family relationships. This logic is presented in Figure 1.

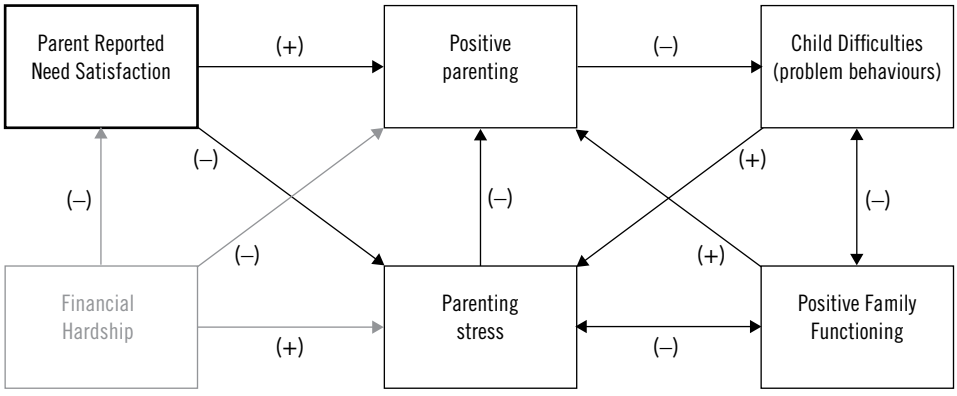
HYPOTHESES

1. Parents who receive Triple P will, on average, report greater need satisfaction compared with parents who receive only PLC services-as-usual.
2. Parent Reported Need Satisfaction is associated with parenting stress (-), positive parenting (+), family functioning (+), and child problem behaviour (-).[23]

[22] Parents are certainly not the only important influences on their child's development. Many people are involved in parenting a child, that is, in meeting a child's developmental needs: parenting is a social rather than a solo activity.

[23] Hypothesis 2 is examined in Chapter 4.

Figure 1. **Transactional model showing hypothesised links between primary and secondary outcomes**



Hypotheses

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2. Parent Reported Need Satisfaction is associated with parenting stress (-), positive parenting (+), family functioning (+), and child problem behaviour (-).

APPROACH

A minimally intrusive, quasi-experimental,[24] post-test only[25] research design was employed. This 'natural experimental' approach is fitting when interventions (and the needs they address) are as heterogeneous as Triple P and PLC services-as-usual. With this approach, the risk of selection bias is minimised by controlling statistically for potentially confounding factors.

Parent participants were recruited from ten Parent Link Centres (PLCs) which provide Triple P *(levels 2 and 3, hereafter referred to simply as Triple P)* to some parents and/or services-as-usual to others, and ten PLCs that only provide services-as-usual. Census-tract data was used to match Triple P pilot sites and services-as-usual PLCs, located in both metropolitan and rural areas, on a range of socio-demographic variables. Participants who received only 'services-as-usual' were recruited from all 20 PLC sites.

To identify potential participants, parents who received a service over a one month period, April-May, 2009, at each of the 20 PLC sites were invited to record their name and contact details in a PLC Visitor's Book, with the understanding that they may be invited to participate in a research project. Information sheets about the project were available to parents upon request at this time.

DATA COLLECTION

Outcome measures were incorporated into the Supported Parenting Survey (see Appendix B). Administration of the Supported Parenting Survey followed the Dillman method (i.e., the generally accepted standard for mail surveys in the social sciences). Approximately 8-12 weeks after parents recorded their name and contact details in the PLC Visitor's Book, the Supported Parenting Survey was mailed-out with a cover letter, consent form, pencil and a return postage

[24] Although quasi-experimental designs are more vulnerable to selection threats to internal validity, meta-analyses have consistently demonstrated that the findings from well designed quasi-experimental studies are robust: outcomes from quasi-experimental studies are typically consistent with the outcomes of true-experimental studies (Ferriter & Huband, 2005; Walach, Falkenberg, Fonnebo, Lewith & Jonas, 2006).

[25] Pre-test post-test designs have more power than post-test only designs. However post-test only designs offer several advantages. One is that they are less onerous for participants. Another advantage is that they circumvent repeat-testing, attrition and regression threats to internal validity.

paid envelope. Approximately 2 weeks later a follow-up postcard was sent to all parents thanking those who had already responded and requesting a response from those who had not yet responded. Approximately two weeks after that, a new cover letter, survey and return postage paid envelope was sent to those who had not yet responded. All respondents received an honorarium of $30.00 to acknowledge and provide some reimbursement for the time they had invested.

Supported Parenting Survey

The Supported Parenting Survey incorporated previously validated scales and items. The selection of scales and items was based on three principal considerations: predictive validity, demonstrated reliability, and parsimony. Reliability data for scales included in the Supported Parenting Survey is presented in tables 4-7. In addition, the survey included an open-ended question inviting parents to describe how their Parent Link Centre had helped them and their family.[26]

Primary outcome measure

The primary outcome measure was Parent Reported Need Satisfaction.[27] This proxy pre-post measure was based on four items (Q8-Q11, Appendix B), each scored on a seven-point scale. The items were (1) did you get the type of help you wanted from your Parent Link Centre?; (2) to what extent did the Parent Link Centre meet your needs as a parent?; (3) did your Parent Link Centre help you to deal more effectively with your child's behaviour?; and, (4) did your Parent Link Centre help you to deal more effectively with problems that arise in your family? The internal consistency of these four items was high ($\alpha = 0.861$). A total score for Parent Reported Need Satisfaction was therefore created by summing item scores together.

In addition (see Q7a-Q7h), a 'checklist' of potential parent concerns and support received was developed based on the list of topics covered by the Triple P parenting tip sheets. Parents indicated whether they had received any support from their PLC with issues to do with their (i) relationship with their partner; (ii) baby/infant; (iii) toddler; (iv) pre-school age child; (v) elementary school age child; (vi) teenager; and/or, (vii) personal wellbeing. Then, within each of these seven categories parents identified specific issues or concerns with which they had received support (e.g., sleep patterns of a baby/infant, toilet training a toddler, bed-wetting by an elementary school age child).

Secondary outcomes measures[28]

The **Parenting Stress** Index-Short Form (PSISF) (Abidin, 1990) was employed to measure stress related to the parenting role (Q81-Q116). This widely used and well-validated scale consists of 36 items comprising two subscales: personal distress and childrearing stress (Haskett et al. 2006). Combining these two sub-scales gives a total score for parenting stress (PSISF Total).

The National Longitudinal Survey of Children and Youth (NLSCY-Cycle 7) **Parenting Scales**

[26] This qualitative data is discussed in Chapter 4.

[27] It is important to keep in mind that Triple P is a flexible program: Matching interventions to individual parent and family needs does not only occur across levels, but also within levels. Further, Triple P is designed to assist parents with discrete child behaviour problems and a range of common child development issues. The individual goals, support needs and service profiles of Triple P recipients, and the recipients of pre-existing PLC services in general, are naturally diverse. Using a summative parent evaluation, where the yardstick is parent progress toward achieving their goal/s, or the extent to which a service met their needs, is one way of dealing with this heterogeneity. The alternative is to employ multiple single system design and/or make direct observations. However withholding intervention for the time required to establish a stable baseline would be unethical, and the number of direct observations that would have to be made to obtain a valid assessment is simply impracticable.

[28] Although the survey incorporated these secondary outcome measures, we did not hypothesise large and statistically significant effect sizes for either services-as-usual or Triple P conditions. The reason for this is that Triple P and Parent Link Centre services are prevention-oriented, working mostly with normal-risk parents and families. These parents, by definition, are unlikely to report high levels of, for example, parenting stress or child problem behaviour, at the outset. Consequently, floor (i.e., 'the only way is up') or ceiling (i.e., 'the only way is down') effects may come into play.

(Q46-Q80) were employed to obtain measures of 2 dimension of parenting 0-1 year olds (i.e., positive interaction, ineffective parenting), 4 dimensions of parenting 2-11 year olds (i.e., positive interaction, ineffective parenting, consistent parenting; and rational parenting), and one dimension of parenting 12-15 year olds (i.e., conflict resolution). Parents with more than one child completed these scales with regard to the child they were most concerned about (i.e., the nominated child).

Family functioning was measured by the NLSCY Family Functioning Scale (NLSCY-Cycle 7). This scale comprises 12 items (Q151-Q162) which tap various aspects of family functioning including problem solving, communication, roles, affective involvement, affective responsiveness and behaviour control. A total family functioning score was created by reverse scoring several items with a negative loading and then summing item scores together. Higher scores represent more positive family functioning.

Child behaviour for children 3 years and older was measured using the Child Strengths and Difficulties Questionnaire (Goodman, et al., 2000). This scale consists of 25 items (Q17-Q41) comprising 5 sub-scales: emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial. A 'total difficulties' score is created by summing the scores from all of the scales except the prosocial scale. Parents with more than one child completed these scales for the child they were most concerned about (i.e., the nominated child).

Support and service, parent and family characteristics

Survey items were developed to collect data on **service variables**, including history (Q3), frequency (Q4) and type (Q2); **child variables**, including age (Q13) and health status (Q16); **parent variables**, including age (Q117), gender (Q118), language spoken at home (Q121), Aboriginality (Q122), educational attainment (Q123), special support with learning at school (Q124), employment (Q127) and health/disability (Q129); and, **household/family variables** including total number of persons living in the household (Q143), number of persons < 6 years living in the household (Q144), household type (Q150) and household income (Q168).

ANALYSIS

The data was analysed using PASW (SPSS) v. 18. Before data analysis commenced, a rigorous check was undertaken to ensure the survey data was entered accurately. The data was then screened: data was plotted and visually inspected, and the internal consistency reliability of each scale and sub-scale was examined.

Triple P pilot sites v. non-Triple P PLCs

The demographic and service profiles for Triple P pilot sites and the matched non-Triple P PLCs were then compared. A series of logistic regression analyses were conducted, with pilot v. non-pilot site as the dependent variable, to determine whether the sites were equivalent with respect to (i) parent concerns/support received, (ii) service variables, (iii) parent and child characteristics and (iv) household/family characteristics.

Outcomes for parents receiving support from Triple P pilot sites were then compared with outcomes for parents receiving support from non-Triple P PLCs. *It is important to note that 172 of 420 (41%) parents in the sample who were served by Triple P pilot sites received a Triple P intervention with the remainder receiving services-as-usual.* The relationship between site (*Triple P v. non-Triple P PLC*), Parent Reported Need Satisfaction, and selected secondary outcomes was then examined with GLM-MANOVA.

Receipt of Triple P v. services-as-usual

The next level of analysis compared outcomes for parents who received a Triple P intervention and parents who received services-as-usual (from either Triple P or non-Triple P pilot sites). As above, group equivalence was first examined using a series of logistic regression analyses, and then the relationship between intervention group, Parent Reported Need Satisfaction, and each of the secondary outcomes was examined with GLM-MANOVA.

Serial multiple regression analysis was then employed to test Hypothesis 1 (i.e., receipt of Triple P is positively associated with Parent Reported Need Satisfaction), controlling statistically for potentially confounding variables (i.e.,

Table 4. ***Reliability data: Parenting Stress Index-Short Form***

	(Abidin, 1990, 1995) ***n* = 534**	(Haskett, Ahern, Ward & Allaire, 2006)[29] ***n* = 185**	(Reitman, Currier, & Stickle, 2002) ***n* = 192**	Current Study ***n* = 903**
Parental distress subscale	α=.87 Mean = 26.40 SD = 7.2	α=.78 Mean = NR SD = NR	α= 0.88 Mean = 24.67 SD = 9.13	**α= 0.87** **Mean = 26.67** **SD = 8.23**
Childrearing stress subscale		α=.91 Mean = NR SD = NR		**α= 0.91** **Mean = 45.99** **SD = 13.11**
PSISF Total Parenting Stress	α=.80 -.91 Mean = 71.0 SD = 15.4	α= 0.83 Mean = 83.90 SD = 20.40	α= 0.95 Mean = 73.44 SD = 25.56	**α= 0.92** **Mean = 72.7** **SD = 19.0**

NR= not reported

Table 5. ***Reliability data: Parenting Scales***

	NLSCY Cycle 7 (0-1 year olds)	Current Study (0-1 year olds)	NLSCY Cycle 7 (2-9 year olds)	Current Study (2-11 year olds)
Positive Interaction	*n* = 3,885 α= .70	***n* = 260** **α= .70**	*n* = 15,985 α= .69 to .72	***n* = 611** **α= .81**
Ineffective Parenting	*n* = 3,886 α= .40	***n* = 262** **α= .43**	*n* = 15,840 α= .61 to .67	***n* = 525** **α= .76**
Consistent Parenting			*n* = 15,896 α= .49 to .63	***n* = 514** **α= .75**
Rational Parenting			*n* = 15,920 α= .54 to .55	***n* = 563** **α= .65**

Note. Adapted from Human Resources and Social Development Canada [HRSDC]. (2007b). *National Longitudinal Survey of Children and Youth, Cycle 7 – User Guide.* Ottawa, ON: Statistics Canada, Special Surveys Division.

Table 6. ***Reliability data[a]: Family Functioning Scale***

Byles, Byrne, Boyle & Offord, 1988	*n* = 1869	α=.86
Epstein, Baldwin & Bishop, 1983	*n* = 503	α=.92
Peterson & Prillaman, 2000	*n* = 25	α=.86
HRSDC, 2007b	*n* = 24,155	α=.91 to .92
Current Study	***n* = 921**	**α=.92**

a. scale mean and standard deviation data was not reported in the studies listed

[29] Haskett et al. (2006) compiled data on an atypical sample of 185 parents, including 90 parents with documented histories of reported physical abuse.

Table 7. ***Reliability data: Strengths and Difficulties Questionnaire***

	Australian Norms	English Norms	Current Study
	(Mellor, 2005), n = 910	(Goodman, 2001; Meltzer, Gatward, Goodman & Ford, 2000), n = 9,998	**n = 441 (3-17 yr olds)**
Emotional Symptoms	α= 0.71 Mean = 2.1 SD = 2.0	α= 0.67 Mean = 1.9 SD = 2.0	**α= 0. 67** **Mean = 2.1** **SD = 2.1**
Conduct Problems	α= 0.67 Mean = 1.5 SD = 1.6	α= 0.63 Mean = 1.6 SD = 1.7	**α= 0. 69** **Mean = 2.4** **SD = 1.9**
Hyperactivity-Inattention	α= 0.80 Mean = 3.1 SD = 2.4	α= 0.77 Mean = 3.5 SD = 2.6	**α= 0. 78** **Mean = 4.5** **SD = 2.6**
Peer Problems	α= 0.75 Mean = 1.6 SD = 1.9	α= 0.57 Mean = 1.5 SD = 1.7	**α= 0. 63** **Mean = 2.0** **SD = 1.9**
Pro-social Behaviour	α= 0.70 Mean = 8.3 SD = 1.7	α= 0.65 Mean = 8.6 SD = 1.6	**α= 0. 75** **Mean = 7.1** **SD = 2.1**
Total Difficulties Score	α= 0.73 Mean = 8.18 SD = 6.06	α= 0.82 Mean = 8.4 SD = 5.8	**α= 0.81** **Mean = 10.9** **SD = 5.89**

Table 8. ***SDQ - Substantial Risk of Clinically Significant Problems***[30]

SDQ Score	American 4-17 year olds (n=9,878)a	British 5-15 year olds (n=10,298)a	Current study 3-17 year olds (n=441)
Total Difficulties Score: 17-40	7.3%	9.8%	**16.8%**
Emotional Symptoms Score: 5-10	7.6%	6.6%	**12.8%**
Conduct Problems Score: 4-10	10.7%	12.7%	**21.6%**
Hyperactivity Score: 7-10	9.3 %	14.7%	**23.1%**
Peer Problem Score: 4-10	10.4%	11.7%	**20.5%**
Pro-social Behaviour Score: 0-4	3.3%	2.3%	**13.5%**

a. Adapted from Goodman, R. (2005). *SDQ: Information for researchers and professionals about the Strengths and Difficulties Questionnaire.* Retrieved from http://www.sdqinfo.com/

[30] A disproportionately large number of parents in the study had a child with clinically significant behaviour problems. This data is discussed further in Chapter 4.

support and service variables, and parent, child and family characteristics). The first step in the regression series tested for interaction effects, that is, between Triple P and service variables, including type/mode, frequency of contact and whether the parent was a new or longstanding PLC client. A significant interaction was found between Triple P and participation in group-based parent education (see below). This means that the effect of Triple P on Parent Reported Need satisfaction varied depending on whether or not parents had participated in a group-based parent education program.

Separate serial regression analyses were then undertaken, first for parents who had not participated in group-based parent education and then for parents who had done so. Parent Reported Need Satisfaction was regressed on parent concerns/support received, service variables, parent, child and household/family characteristics (i.e., the full model). Non-significant 'predictors' were then dropped and the regression analysis was repeated (i.e., the revised model). No problem with multicollinearity was detected: the VIF scores for all independent variables in all regression analyses were substantially less than four.

RESULTS

A total of 1296 parents recorded their name and contact details in the PLC Visitor's book.

We do not know exactly how many parents received the invitation to record their name and contact details in the PLC Visitor's Book, and therefore we cannot accurately calculate the *'participation rate'*.31 Notwithstanding, of the 1296 parents who did record their details, a total of 923 parents completed the Supported Parenting Survey, a *'response rate'* of 71%. And of these, **172 (18.6%) reported receiving a Triple P (level 2/3) intervention.** The response rate for the 10 Triple P pilot sites and 10 services-as-usual PLCs was 70% (n=420) and 72% (n=500) respectively.32 Notably, the overall response rate from parents accessing Aboriginal PLCs was substantially lower at just 28%.33

Triple P pilot sites v. non-Triple P PLCs

The findings from the logistic regression analyses, reported in tables 9-12, show that parents who received support from a Triple P pilot site and parents who received support from a non-Triple P PLC were similar with respect to child, parent and household/family characteristics. However, having English as a second language and reporting a history of special education/support with learning at school significantly increased the odds of receiving a service from a Triple P pilot site. In other words, Triple P pilot sites were serving proportionately more parents in each of these two groups by comparison with non-Triple P PLCs.

With respect to parent concerns/support received, a significant *positive* association was found between receiving support from a Triple P pilot site and receiving support with issues to do with a toddler; and, a significant *negative* association was found between receiving support from a Triple P pilot site and receiving support with issues to do with an elementary school-age child. On service variables (including service history, type and frequency) parents who received support from a Triple P pilot site and parents who received support from a non-Triple P PLC were found to be equivalent on all variables except one, family support. Specifically, parent-clients of Triple P pilot sites were no more and no less likely than parent-clients of non-Triple P

[31] Initially parent-clients were only informed that they may be invited to participate in a research project. An information sheet prepared by the research team was available to any parent who asked for more information. Although we attempted to standardise this process, there was some variation across sites. At some sites, parent-clients 'signed-in' each time they visited or received a service from their PLC. Some parent-clients of these PLCs recorded their name and contact details five or more times. The response rate from these sites was 68%. This figure may approximate the true participation rate for the study. At other sites, parents were first informed about the study by PLC staff, and invited to record their details in the Visitor's book if they were interested in taking part. The response rate from these PLCs was > 71%.

[32] Three respondents returned surveys without the information required to identify their PLC.

[33] This is consistent with previous research showing that surveys are rarely culturally acceptable to Aboriginal groups: alternatives, such as narrative methods, tend to be more acceptable (Holmes, Stewart, Garrow, Anderson & Thorpe, 2002).

Table 9. ***Triple P pilot site regressed on parent concerns/support received***

Support with issues to do with your…	Triple P pilot site			
	% of N=920	Beta	OR	95% CI
relationship with your partner	6.0%	-.030	.970	.54 – 1.74
baby/infant	25.8%	.194	1.214	.89 – 1.65
toddler	36.3%	.307	1.359*	1.02 – 1.81
pre-school age child	16.5%	-.428	.652*	.45 - .95
elementary school age child	7.6%	-.144	.866	.51 – 1.48
teenager	1.6%	1.321	3.746*	1.16 – 12.06
personal wellbeing	24.3%	-.138	.871	.62 – 1.22

* Signifies a statistically significant odds ratio at P<.05

Note. Model $x^2 = 17.053$, df7, p<.017, Cox & Snell $R^2 = .018$, Nagelkerke $R^2 = .025$

Table 10. ***Triple P pilot site regressed on service variables***

Service variables	Triple P pilot site			
	% of N=920	Beta	OR	95% CI
new PLC client (new in last 3 months)	15.8%	-.245	.783	.54 – 1.14
service frequency (no. of contacts)		.086	1.089	.94 – 1.26
parenting information (e.g., tip sheets)	68.9%	.053	1.055	.78 – 1.43
one-to-one training	14.8%	.024	1.025	.69 – 1.52
group program	35.2%	.004	1.004	.75 – 1.35
family support (e.g., community kitchen)	18.1%	.457	1.579*	1.11 – 2.25
drop-in playgroup	85.9%	.207	1.230	.86 – 1.85

* Signifies a statistically significant odds ratio at P<.05

Note. Model $x^2 = 15.418$, df7, p<.05, Cox & Snell $R^2 = .017$, Nagelkerke $R^2 = .023$

Table 11. ***Triple P pilot site regressed on parent and child variables***

Parent and child variables	Triple P pilot site			
	% of N=920	Beta	OR	95% CI
age		.043	1.044**	1.02 – 1.07
gender – female	96.3%	-.559	.572	.26 – 1.25
aboriginal status	6.1%	.200	1.221	.68 – 2.19
English spoken at home	91.8%	-.603	.547*	.33 - .91
educational attainment		.112	1.118	.99 – 1.25
No history of special education	91.4%	-.591	.554*	.34 - .91
longstanding health condition	17.0%	.047	1.048	.73 – 1.51
employed/working	42.1%	.051	1.053	.80 – 1.39
Child age		-.060	.942	.89 – 1.00
Child longstanding health condition	14.3%	-.042	.959	.64 – 1.44

* Signifies a statistically significant odds ratio at P<.05

** Signifies a statistically significant odds ratio at P<.01

Note. Model $x^2 = 39.335$, df10, p<.001, Cox & Snell $R^2 = .043$, Nagelkerke $R^2 = .057$

Table 12. ***Triple P pilot site regressed on household/family variables***

Household/family variables	Triple P pilot site			
	% of N=920	Beta	OR	95% CI
sole parent household	3.4%	-.592	.553	.20 – 1.54
blended family	5.9%	-.452	.636	.28 – 1.44
original family	85.8%	-.342	.711	.38 – 1.34
household income		.012	1.012	.96 – 1.06
household size		-.218	.804*	.67 - .97
no. of children < 6 years		-.013	.99	.78 – 1.26

* Signifies a statistically significant odds ratio at P<.05

Note. Model $x^2 = 10.381$, df6, p=.109

Table 13. ***MANOVA: Comparison of Triple P pilot sites v. non-Triple P pilot sites***

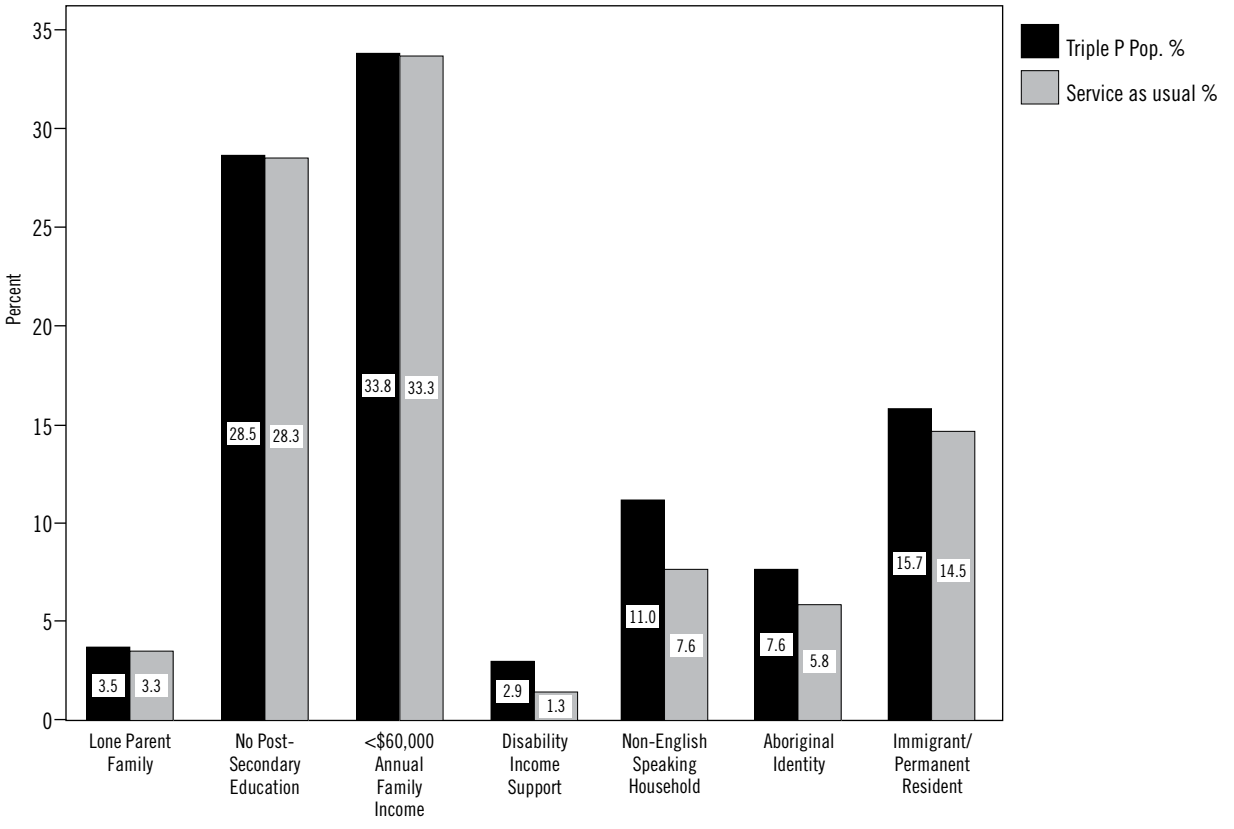
	Triple P pilot site	Non-Triple P pilot site		
MANOVA 1	Mean (SD)	Mean (SD)	F	Partial Eta Squared
Need satisfaction	20.78 (4.17)	20.44 (4.05)	1.387	.002
PSI(SF) total parenting stressa	72.51 (18.07)	72.33 (18.61)	.019	.000
PSI(SF) Personal distress	26.88 (8.22)	26.55 (8.26)	.324	.000
PSI(SF) Childrearing stress	45.63 (12.30)	45.78 (12.62)	.030	.000
Family functioning	43.31 (5.99)	43.40 (5.96)	.051	.000
Positive interaction (0-11yrs)	21.58 (2.46)	21.14 (2.76)	5.601*	.007

Wilks' Lambda F(5,824)=.990, **p = .152**

* = significant at p < .05

ns = non-significant at p < .05

Figure 2. **Demographics: Triple P and services-as-usual groups**



PLCs to receive parenting information, one-to-one and/or group-based parent education, but they were more likely to have received "family support".

Table 13 presents the means and standard deviations for Triple P pilot sites and non-Triple P PLCs, and the F test statistic from MANOVA group comparisons on primary and selected secondary outcome measures. A statistically significant difference in favour of the Triple P pilot sites was found for positive parenting. However the difference is very small and therefore not very meaningful. No other difference was found.

Receipt of Triple P v. services-as-usual

The findings from logistic regression analyses, reported in tables 14-17, show that the two intervention groups, Triple P and services-as-usual, were virtually equivalent with respect to child, parent and household/family characteristics. Notwithstanding, having 'received special support with learning at school' increased the odds of being in the Triple P group by a factor of two. There was also a weak but statistically significant association between group membership and age of the nominated child, with the odds of being in the Triple P group increasing by about 1% for each year of child age. Figure 2 shows a comparison of Triple P and 'service-as-usual' parent groups on selected demographic variables.

The two intervention groups were also equivalent with respect to PLC service history (i.e., recent v. longstanding clients) and service frequency (i.e., number of times PLC services were utilised). However, the two groups were found to be different in terms of parent concerns/support received and service type/mode. Specifically, a significant positive association was found between receipt of Triple P and (i) support with issues to do with a toddler or elementary school-age child; (ii) parenting information (i.e., tip sheets or hand-outs); (iii) one-to-one parent

training; (iv) group-based parent education; and, (v) family support (e.g., utilised the community kitchen). Further, receipt of Triple P was negatively associated with participation in a drop-in playgroup. That is, parents who utilised a drop-in play group were less likely to receive Triple P. Figures 3 and 4 show comparisons of Triple P and 'service-as-usual' parent groups on parent concerns/support received and service types.

Table 18 presents the means and standard deviations for Triple P and service-as-usual groups, and the F test statistic from MANOVA group comparisons on primary and secondary outcome measures. The results should be interpreted with caution because potential confounders (e.g., group differences in service types received) are not controlled in this analysis. Notwithstanding, a statistically significant difference ($p<.01$), in favour of the Triple P group was found for Parent Reported Need Satisfaction. No other statistically significant difference ($p<.01$) was found.

Table 19 presents the findings from multiple regression analysis of interaction effects. The findings show a statistically significant interaction between Triple P and parent participation in group-based parent education for Parent Reported Need Satisfaction. In other words, the effect of Triple P on Parent Reported Need Satisfaction varies depending on whether or not the parent participated in a PLC (Triple P or service-as-usual) group-program. Of course the reverse is also true: the effect of group-based parent education programs vary depending on whether parents received a Triple P intervention of some kind. This interaction effect is shown in Figure 5.

Interaction effect

- Triple P was more beneficial when it was coupled with some form of parent group seminar or program.
- Participation in some form of PLC parent group seminar or program was more beneficial when it was coupled with a Triple P intervention.

Due to the significant interaction between Triple P and group participation, separate regressions were performed for parents who did and parents who did not participate in a PLC parent group. The findings reported in Table 20 show no significant association between Triple P and Parent Reported Need Satisfaction, that is, when parents *did not* participate in a (Triple P *or* service-as-usual) group. Notably, higher Parent Reported Need Satisfaction in this sub-group of parents was associated with increased frequency of service (i.e., number of times that PLC services were utilised); receipt of parenting information (e.g., hand-outs, tip-sheets); and, support addressing issues to do with the parent's personal wellbeing or issues to do with a toddler. Conversely, lower need satisfaction was associated with having English as a second (or other) language; and, parental and/or child disability or chronic health condition.

Table 21 presents the findings from the serial regression of Parent Reported Need Satisfaction (on support, service, parent, child and family variables) in cases in which parents reported participation in a PLC group. The data shows that when *support and service variables, and parent, child and family characteristics are held constant,* Triple P was associated with greater Parent Reported Need Satisfaction. In addition, the data shows that among parents who reported participation in a PLC group program, need satisfaction was positively associated with receiving support with issues to do with an elementary school-age child, and negatively associated with parental educational attainment and child age. In other words, in this sub-group, parents with higher levels of educational attainment and parents concerned about an older child tended to report lower levels of need satisfaction.[34]

PLCs target parents whose children are under six years of age. Thus, most parents in the study and most parents served by PLCs have young children. It is possible that parents with older

[34] Notably, in this sub-group, no association was found between Parent Reported Need Satisfaction and having English as a second (or other) language, or between Parent Reported Need Satisfaction and parental and/or child disability or chronic health condition.

Figure 3. **Support received: Triple P and services-as-usual groups**

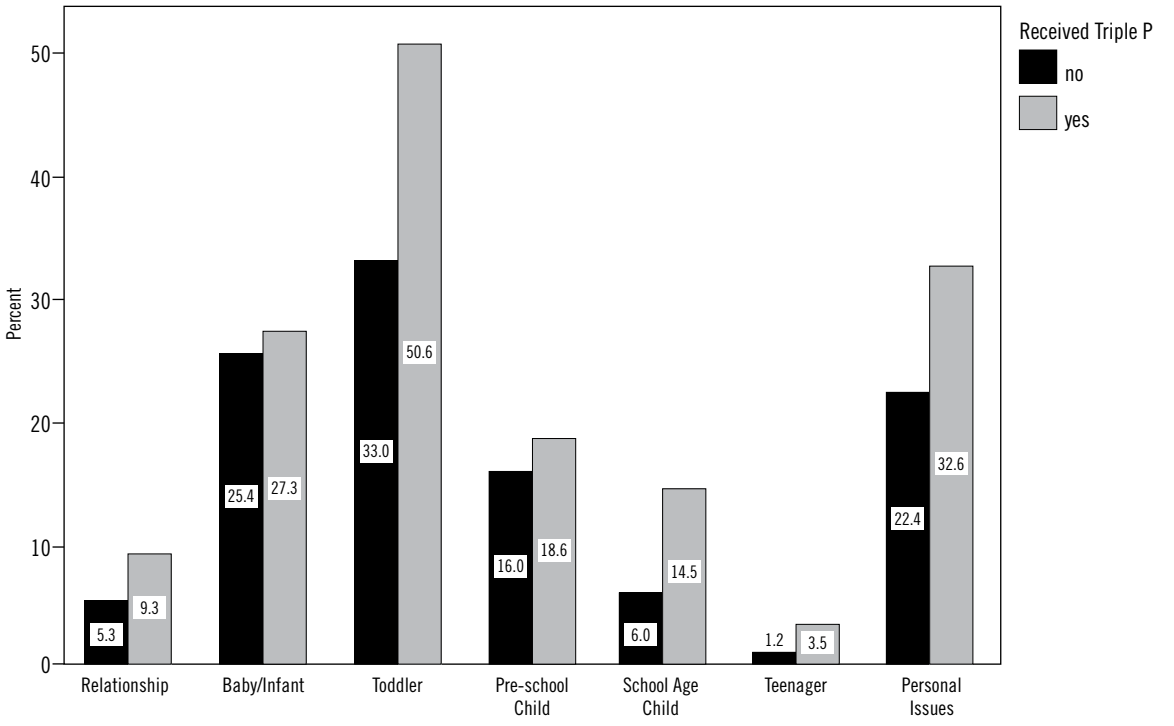


Figure 4. **Service type/mode: Triple P and services-as-usual groups**

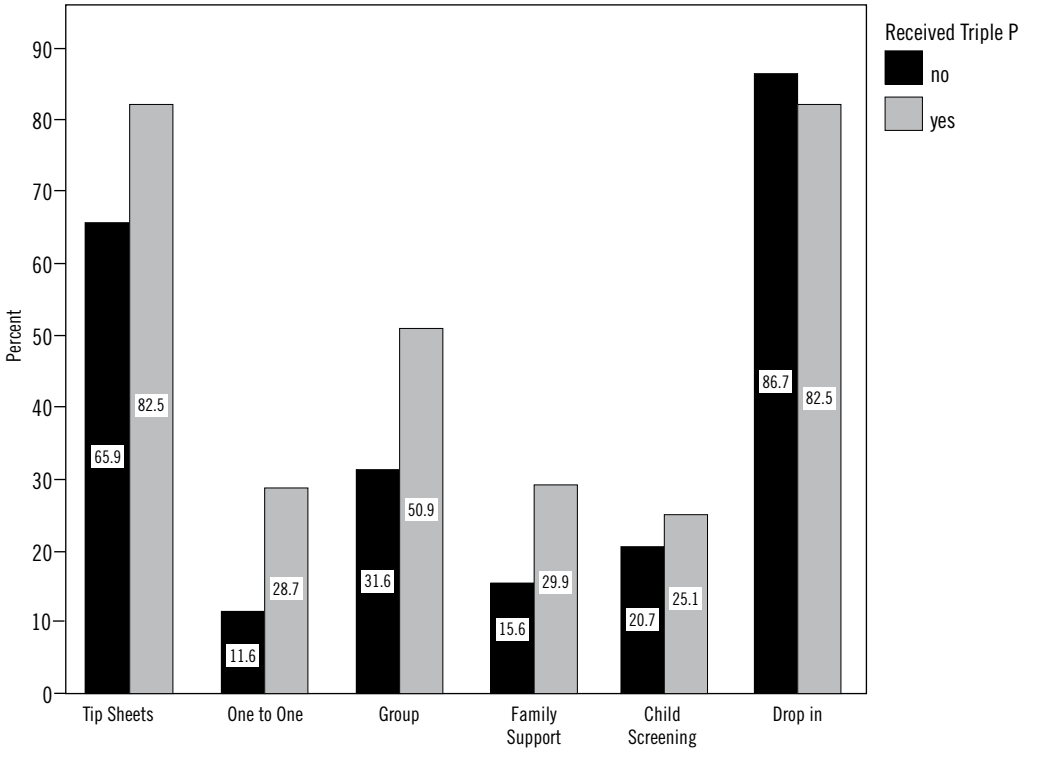


Table 14. ***Receipt of Triple P regressed on parent concerns/support received***

Support with issues to do with your…	Received Triple P			
	% of N=923	Beta	OR	95% CI
relationship with your partner	6.0%	.263	1.30	.675 – 2.506
baby/infant	25.8%	-.080	.923	.622 – 1.369
toddler	36.3%	.754	2.125***	1.488 – 3.034
pre-school age child	16.5%	-.235	.791	.494 – 1.266
elementary school age child	7.6%	1.042	2.835***	1.606 – 5.007
teenager	1.6%	.946	2.575	.869 – 7.629
personal wellbeing	24.3%	.183	1.201	.798 – 1.809

*** Signifies a statistically significant odds ratio at P<.001

Note. Model $x^2 = 37.688$, df7, p<.001, Cox & Snell $R^2 = .040$, Nagelkerke $R^2 = .065$

Table 15. ***Receipt of Triple P regressed on service variables***

Service variables	Received Triple P			
	% of N=923	Beta	OR	95% CI
new PLC client (new in last 3 months)	15.8%	-.358	.699	.409 – 1.195
service frequency (no. of contacts)		.128	1.137	.926 – 1.397
parenting information (e.g., tip sheets)	68.9%	.579	1.784*	1.134 -2.806
one-to-one training	14.8%	.765	2.149**	1.391 – 3.320
group program	35.2%	.395	1.485*	1.024 -2.154
family support (e.g., community kitchen)	18.1%	.536	1.709*	1.130 – 2.584
drop-in playgroup	85.9%	-.538	.584*	.355 – .960

*Signifies a statistically significant odds ratio at P<.05

** Signifies a statistically significant odds ratio at P<.01

Note. Model $x^2 = 61.269$, df7, p<.001, Cox & Snell $R^2 = .066$, Nagelkerke $R^2 = .106$

Table 16. ***Receipt of Triple P regressed on parent and child variables***

Parent and child variables	Received Triple P			
	% of N=923	Beta	OR	95% CI
age		.011	1.011	.982 – 1.041
gender – female	96.3%	.136	1.146	..446 – 2.945
aboriginal status	6.1%	.317	1.373	.698 – 2.704
English spoken at home	91.8%	-.431	.650	.369 – 1.147
educational attainment		.028	1.028	.893 – 1.183
No history of special education	91.4%	-.725	.484**	.282 - .831
longstanding health condition	17.0%	-.020	.980	.621 – 1.545
employed/working	42.1%	-.109	.897	.633 – 1.271
Child age		.094	1.099**	1.027 – 1.176
Child longstanding health condition	14.3%	-.072	.930	.565 – 1.531

** Signifies a statistically significant odds ratio at P<.01

Note. Model $x^2 = 19.640$, df10, p<.05, Cox & Snell $R^2 = .022$, Nagelkerke $R^2 = .035$

Table 17. ***Receipt of Triple P regressed on household/family variables***

Household/family variables	Received Triple P			
	% of N=923	Beta	OR	95% CI
sole parent household	3.4%	-.323	.724	.205 – 2.553
blended family	5.9%	-.645	.525	.190 – 1.449
original family	85.8%	-.316	.729	.350 – 1.518
household income		-.005	.995	.934 – 1.060
household size		.020	1.020	.810 – 1.284
no. of children < 6 years		.105	1.111	.826 – 1.495

Note. Model $x^2 = 2.662$, df6, p=.850

Table 18. ***MANOVA: Triple P v. services-as-usual on primary and secondary outcomes***

	Triple P group	Service-as-usual		
MANOVA 1	**Mean (SD)**	**Mean (SD)**	**F (1,831)**	**Partial Eta Squared**
Need satisfaction	21.54 (4.09)	20.36 (4.09)	10.351**	.012
PSI(SF) total parenting stressa	75.15 (19.05)	71.79 (18.27)	4.152	.005
PSI(SF) Personal distress	27.44 (8.28)	26.53 (8.23)	1.534	.002
PSI(SF) Childrearing stress	47.71 (13.03)	45.27 (12.40)	4.765	.006
Family functioning	42.92 (5.23)	43.46 (6.13)	1.034	.001
Positive interaction (0-11yrs)	21.16 (2.66)	21.38 (2.64)	.873	.001

Wilks' Lambda F(5,827)=3.714, p<.001, Partial Eta Squared=.022

MANOVA 2	**Mean (SD)**	**Mean (SD)**	**F (1,355)**	**Partial Eta Squared**
Ineffective parenting (2-11yrs)	18.37 (3.99)	17.93 (3.96)	2.401	.007
Consistent parenting (2-11yrs)	20.47 (3.14)	20.71 (2.92)	.744	.002
Rational parenting (2-11yrs)	9.24 (2.13)	9.25 (2.11)	.381	.001
Total child difficulties (3+yrs)	11.16 (5.94)	10.85 (5.89)	.028	.000
Emotional symptoms (3+yrs)	1.76 (1.80)	2.11 (2.10)	2.488	.007
Conduct problems (3+yrs)	2.46 (2.02)	2.29 (1.81)	.778	.002
Hyperactivity (3+yrs)	4.87 (2.70)	4.49 (2.57)	1.142	.003
Peer problems (3+yrs)	2.08 (1.91)	1.95 (1.80)	.021	.000
Pro-social behaviour (3+yrs)	6.64 (2.19)	7.04 (2.13)	2.233	.006

Wilks' Lambda F(8,348)=.925, p=.495, Partial Eta Squared=.021

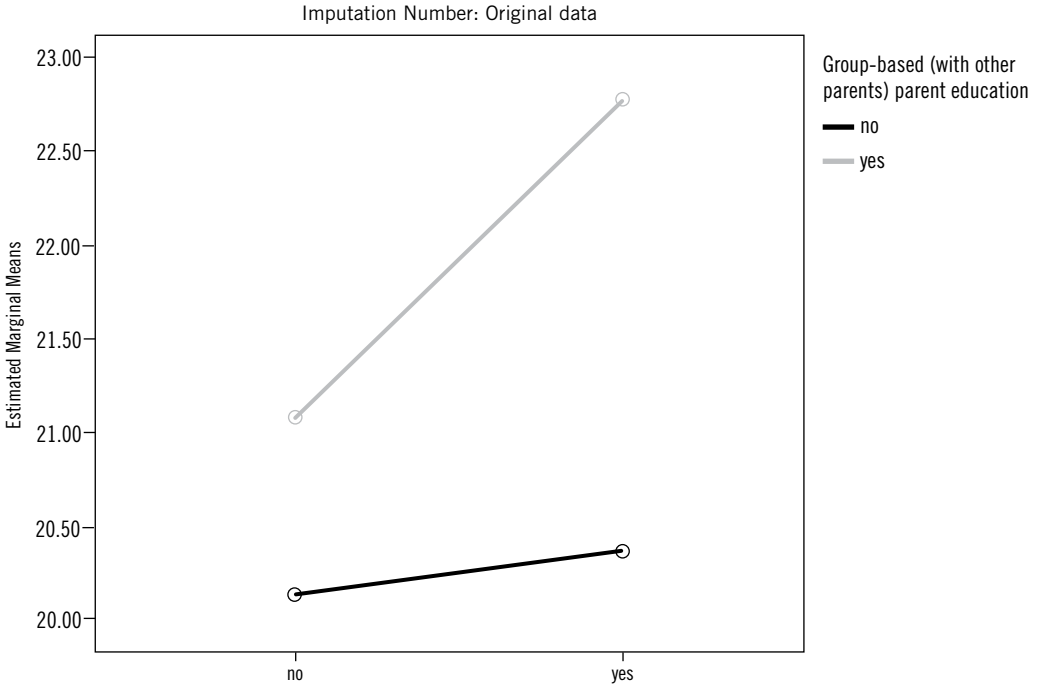
** Signifies a statistically significant difference at P<.01

a PSI(SF) = Parenting Stress Index-Short Form

Table 19. ***Regression: Interaction between Triple P and service variables***

	Parent Reported Need Satisfaction	
	β	***Sig.***
Constant		***.000***
Triple P (Levels 2/3)	.072	.613
new PLC client (new in last 3 months)	-.072	.038
service frequency (no. of contacts)	.119	.001
parenting information (e.g., tip sheets)	.152	.000
one-to-one training	.120	.004
group program	.111	.004
family support (e.g., community kitchen)	.078	.041
drop-in playgroup	.053	.163
PPP*new PLC client	.029	.440
PPP*service frequency	-.029	.839
PPP*parenting information	-.042	.603
PPP*one-to-one training	-.005	.908
PPP*group program	**.107**	**.037**
PPP*family support	-.012	.796
PPP*drop-in playgroup	-.048	.592

Figure 5. **Estimated Marginal Means of Need Satisfaction (Sum 8-11): Interaction between Triple P and Group participation**



Note. Covariates appearing in the model are evaluated at the following values: In the last three months, how many times have you been down to your Parent Link Centre = 3.23

Table 20. ***Predictors of Need Satisfaction when no group-based intervention is received***

	Parent Reported Need Satisfaction			
	R1: Full model		R2: Revised model	
	β	*Sig.*	*β*	*Sig.*
Constant		***.000***		***.000***
Triple P (Levels 2/3)	-.036	.408		
new PLC client (new in last 3 months)	-.043	.309		
service frequency (no. of contacts)	.150	.001	.161	.000
parenting information (e.g., tip sheets)	.103	.017	.139	.001
one-to-one training	.058	.207		
family support (e.g., toy exchange)	.063	.134		
drop-in playgroup	.030	.508		
Issue: relationship with your partner	.021	.636		
Issue: baby/infant	.019	.667		
Issue: toddler	.092	.042	.134	.001
Issue: pre-school age child	.082	.077		
Issue: elementary school age child	.078	.083		
Issue: teenager	.078	.091		
Issue: personal wellbeing	.144	.001	.163	.000
Parent age	-.001	.985		
Parent gender – female	-.014	.751		
aboriginal status	.022	.605		
English spoken at home	.101	.025	.166	.000
Parent educational attainment	-.037	.426		
Parent history of special education	.056	.187		
Parent longstanding health condition	-.100	.018	-.116	.004
Parent employed/working	.080	.062		
Child age	-.106	.043	-.053	.202
Child longstanding health condition	-.105	.013	-.088	.036
sole parent household	-.048	.362		
blended family	.060	.385		
original family	.047	.527		
household income	.087	.057		
household size	-.060	.328		
no. of children < 6 years	.031	.602		
	Adj R^2=.158, F(30,486)=4.231, p<.001		*Adj* R^2=.145, F(8,537)=12.544, p<.001	

Table 21. ***Predictors of Need Satisfaction when a group-based intervention is received***

	Parent Reported Need Satisfaction			
	R1: Full model		R2: Revised model	
	β	*Sig.*	*β*	*Sig.*
Constant		***.000***		***.000***
Triple P (Levels 2/3)	.155	.009	.190	.001
new PLC client (new in last 3 months)	-.071	.210		
service frequency (no. of contacts)	.010	.870		
parenting information (e.g., tip sheets)	.082	.164		
one-to-one training	.080	.174		
family support (e.g., toy exchange)	.033	.580		
drop-in playgroup	.063	.293		
Issue: relationship with your partner	.085	.156		
Issue: baby/infant	.078	.200		
Issue: toddler	.052	.398		
Issue: pre-school age child	.031	.617		
Issue: elementary school age child	.174	.012	.172	.005
Issue: teenager	.091	.181		
Issue: personal wellbeing	.116	.056		
Parent age	.065	.333		
Parent gender – female	-.011	.849		
aboriginal status	.010	.857		
English spoken at home	.093	.100		
Parent educational attainment	-.143	.021	-.111	.044
Parent history of special education	-.055	.344		
Parent longstanding health condition	-.071	.215		
Parent employed/working	.083	.140		
Child age	-.168	.041	-.178	.004
Child longstanding health condition	-.083	.166		
sole parent household	-.108	.190		
blended family	-.146	.056		
original family	-.054	.549		
household income	.084	.169		
household size	.017	.842		
no. of children < 6 years	.019	.806		
	Adj R^2=.146, F(30,271)=2.717, p<.001		Adj R^2=.145, F(8,537)=12.544, p<.001	

children are not deriving the same benefit from PLC services because there is less opportunity for them to mix with other parents who share similar experiences and face similar challenges. Explaining why parents with higher levels of educational attainment are not deriving the same benefit is more difficult. It could be that some programs are pitched 'too low' for some parents. Parents with higher levels of educational attainment may be more likely to conduct their own search (e.g., of the internet and literature) before turning to their PLC, and consequently the information provided by PLCs may not add much to what they have already gathered.

Key point

Triple P delivered in group-mode and/or Triple P in combination with group participation is positively associated with Parent Reported Need Satisfaction. In the absence of group participation however, there was no significant difference between Triple P and PLC services-as-usual with respect to Parent Reported Need Satisfaction.

DISCUSSION

The main finding is that participation in a Triple P group seminar, and/or *Triple P in combination with group participation* (i.e., a group seminar/activity that was in addition to receiving a non-group based Triple P intervention, such as tip sheets), is positively associated with Parent Reported Need Satisfaction. The effect size was small but potentially meaningful. With other significant predictors held constant, receipt of Triple P was associated with an increase in Parent Reported Need Satisfaction equivalent to .190 of a standard deviation in this sub-group (see Table 21 above). *In the absence of group participation however*, there was no significant difference between Triple P and PLC services-as-usual with respect to Parent Reported Need Satisfaction.

Precisely why 'group participation' would moderate the effect of Triple P is unclear. One possibility is that group participation addresses certain needs (e.g., reduces parent sense of social isolation) which, in turn, enables parents to benefit more from Triple P education and training. However, inspecting Figure 5 and reviewing the beta weights reported in Table 19 above, it may be more accurate to say that Triple P is enhancing the outcomes of group-based parent education than *vice versa*. The question then is "why would Triple P moderate the effects of group-based parent interventions?" The answer may include the high quality Triple P educational materials, including video resources and tip sheets.

The study findings are consistent with previous research which has generally found only modest effects for low-level parent training and support interventions for 'normal risk' populations (e.g., Nowak & Heinrichs, 2008; Layzer et al., 2001). Notwithstanding, this study had some limitations. Firstly, participants were not randomly assigned and consequently the Triple P and services-as-usual groups may not be equivalent. Any pre-existing group differences could offer a plausible alternative explanation for the study findings. Further, because no pre-test measures were obtained, we cannot confirm that groups were equivalent with respect to the primary and secondary outcome measures prior to intervention. To minimise the selection threat to internal validity, participants were drawn from matched Triple P and non-Triple P PLC sites, groups were compared and found to be equivalent across a range of known parent, child and family characteristics, and multiple regression was employed to control for many potentially confounding variables.

CONCLUSION

There is a large and compelling body of evidence supporting the efficacy of Triple P. However, most studies have been developer-led, few studies have compared Triple P with active 'services-as-usual' comparison groups, and only a small number of studies have evaluated levels 2 and 3 of the Triple P system. The findings of this study suggest that implementation of levels 2 and 3 of Triple P does not markedly enhance

parent, child and family outcomes compared with PLC services-as-usual. A small effect on parent perceived need satisfaction was found, but this was contingent: the study findings suggest that parent need satisfaction is enhanced when group participation is coupled with a Triple P intervention. Although these findings do not afford much support for the dissemination of Triple P (levels 2 and 3), there are other ways in which the dissemination of Triple P (levels 2 and 3) has added value to Parent Link Centre services, as documented in Chapter 2.

4
Supported Parenting

Aims

- To generate a profile of PLC clients, support needs and services received.
- To examine the relationship between parent reported need satisfaction, parenting stress, family functioning, parenting practices and child difficulties.
- To investigate the relationship between client and program characteristics and PLC service outcomes—that is, what works, for whom and under what circumstances?

Method

- Qualitative data (from Q169) was reviewed and parent testimonies were selected for inclusion in this chapter to illustrate parent perspectives and experiences of PLC services. Zero-order and partial correlations between parent reported need satisfaction, parenting stress, family functioning, parenting practices and total child difficulties were computed. Multiple regression analysis was employed to explore client and program predictors of parent, child and family outcomes.

Main Findings

- Based on the study sample, lone parents, parents with low educational attainment, and parents with low household incomes appear to be under-represented in PLC services.
- Higher levels of parent reported need satisfaction were associated with less parenting stress, fewer child problem behaviours, more positive parenting practices and better family functioning.
- Parent Reported Need Satisfaction was generally high. At the top of the scale, 29% of parents indicated that they "definitely" got the type of help they wanted, and 24% indicated that "almost all" of their needs as parents had been met.
- PLC services were not equally efficacious for all parents. Lower levels of need satisfaction were reported by low income parents, parents for whom English is a second language, parents with disability &/or chronic health condition, and parents caring for a child with disability &/or chronic health condition.
- Parents for whom English is a second language and parents with a disability or chronic health condition also reported higher levels of parenting stress, poorer family functioning, less positive interactions with their children and more child problem behaviours.
- Parent Reported Need Satisfaction was positively associated with participation in a group-based program and support with personal issues such as loneliness and depression.
- Utilization of a PLC drop-in playgroup was associated with positive parent-child interactions.

There is a burgeoning research literature about 'what works' in parenting support. Recent meta-syntheses and meta-analyses of the extant evidence have reached many of the same conclusions (see for example, Layzer et al., 2001; Moran, Ghate & van der Merwe, 2004; and, Wyatt Kaminski et al., 2008). Some 'messages from research' are summarised in Table 22. Less research attention has focussed on client and program characteristics that may contribute to or moderate the effects of parenting support—that is, not just 'what works', but for whom and under what circumstances (Moran et al., 2008). In this chapter, we examine the relationship between program and client characteristics and primary care parenting support outcomes for parents and families in Alberta, Canada. This knowledge could inform the design and delivery of primary care parent support services.

Supporting parents in Alberta

Primary care parenting support is offered by Parent Link Centres (PLCs) in Alberta. PLCs are non-government agencies offering a wide range of professional supports and services that are, at least in theory, available to all parents and families in the community. These universal services include but are not limited to child development screening; community information and referral; drop-in playgroup activities for parents with young children; parenting advice, education and training in one-to-one and group formats; and, family support (e.g., community kitchen, clothing and toy exchange, social activities for parents). PLC practitioners generally offer non-manualized parent education and training based on their professional training and experience and on a variety of theoretical frameworks (e.g., child development, social learning, and attachment theories), but some are now offering Triple P (levels 2 and 3).

Table 22. ***What works in parenting support?***

Messages from research
• Early intervention *and* later intervention.
• Services to which there are multiple referral routes (i.e., ways into) for families.
• Programs that target at-risk families and children with special needs.
• Programs delivered by appropriately trained and skilled professionals who have the support of their agency managers.
• Group work programs that provide parents with opportunities for peer support.
• Individual (one-to-one) work, i.e., when problems are more severe or entrenched.
• Behavioural interventions to teach specific parenting skills; home-based for parents with learning difficulties.
• Cognitive interventions for changing unhelpful beliefs, attitudes and self perceptions.
• Multi-level interventions for 'multiple-risk' families, which work in parallel with parents and children—although not necessarily at the same time.
• Multi-modal interventions, which involve more than one mode of parenting instruction and support.
• Manualized programs, where the core program is carefully structured and program integrity is maintained, and where outcomes are routinely evaluated.

Note. Adapted from Layzer et al. (2001) and Moran et al. (2004)

In this chapter, we present findings from an analysis of PLC service outcomes (Triple P and services-as-usual groups combined) for parents and their families. Previous chapters have focused on the process of disseminating and integrating Triple P into PLC services (Chapter 2), and on the question of whether Triple P is enhancing outcomes compared with PLC services-as-usual (Chapter 3). In this Chapter we (1) assess PLC service outcomes in terms of Parent Reported Need Satisfaction; (2) examine whether Parent Reported Need Satisfaction translates into lower levels of parenting stress and child problem behaviours, and more positive parenting and family functioning; and, (3) explore predictors of PLC service outcomes—i.e., *what works, for whom, and under what circumstances*?

Conceptual framework

Parenting is a complex, multi-dimensional activity influenced by multiple, interacting, intra- and inter-personal factors, as well as societal, community, and cultural environments (Belsky, 1984). Parenting is, in turn, a primary influence on child development: Parenting behaviours influence virtually every aspect, from the developing circuitry of the brain to the development of social competence and the human capacity for empathy (Shonkoff, 2003). Parent training and support programs aim to promote healthy child development by targeting intra- and interpersonal determinants of parenting behaviours, including for example parent knowledge, skills and resourcefulness, parenting stress and family relationships. This logic is presented in Figure 12.

HYPOTHESES

1. Parents who receive Triple P will, on average, report greater need satisfaction compared with parents who receive only PLC services-as-usual.[35]
2. Parent Reported Need Satisfaction is associated with parenting stress (-), positive parenting (+), family functioning (+), and child problem behaviour (-).

[35] Hypothesis 1 was addressed in Chapter 3.

METHODS

The methods are described in Chapter 3: For the reader's convenience we repeat some of this information here. The study employed mixed methods. The data analysed in this chapter come from the survey component. Survey respondents were drawn from 20 Parent Link Centres, representing urban and rural Alberta. Employing the Dillman method, the Supported Parenting Survey (see Appendix B) was administered to 1296 parents. Of these, 923 completed the survey, a response rate of 71%.

DATA COLLECTION

The Supported Parenting Survey (see Appendix B) collected demographic data, incorporated primary and secondary outcome measures, and included an open-ended question inviting parents to describe how their Parent Link Centre has helped them and their family.

Dependent variables

The primary outcome measure was *Parent Reported Need Satisfaction*. This was based on four items, each scored on a seven-point scale. The items were (1) did you get the type of help you wanted from your Parent Link Centre?; (2) to what extent did the Parent Link Centre meet your needs as a parent?; (3) did your Parent Link Centre help you to deal more effectively with your child's behaviour?; and, (4) did your Parent Link Centre help you to deal more effectively with problems that arise in your family? Secondary outcome measures included the *Parenting Stress Index-Short Form* (Abidin, 1995), the *(NLSCY Cycle 7) Parenting scales* (i.e., positive interaction, ineffective, consistent and rational parenting), the (*NLSCY Cycle 7) Family Functioning scale* (HRSDC, 2007a), and the *Child Strengths and Difficulties Questionnaire* (Goodman et al., 2000). The internal consistency reliability of these scales was high (see Chapter 3, Tables 4-7).

Independent variables

The survey included a 'checklist' of issues for which **support was received** *(see Q7a-Q7h, Appendix B)* based on the list of topics covered by the Triple P parenting tip sheets. In addition, survey items were developed to collect data on

service variables, including history (i.e., new or longstanding client) (Q3), frequency of contact/service (Q4), service type/mode (e.g., group-based, one-to-one, drop-in play group) (Q2), and receipt of Triple P (Q6); **child variables**, including age (Q13) and health status (Q16); **parent variables**, including age (Q117), gender (Q118), language spoken at home (Q121), Aboriginality (Q122), educational attainment (Q123), special support with learning at school (Q124), employment (Q127) and health/disability (Q129); and, **household/family variables** including total number of persons living in the household (Q143), number of persons < 6 years living in the household (Q144), household type (Q150) and income (Q168).

Family **financial hardship** (e.g., 'difficulty making ends meet') was measured using four items (see Q164-Q167), two originally validated in the Iowa Youth and Families Project (Conger & Elder, 1994) and two validated by the University of Michigan's Preventive Intervention Research Centre (Vinokur et al. 1996). More recently, these items were combined and the composite scale validated in studies by Barrera, Caples and Tein (2001). In the current study the internal consistency (standardized Chronbach's alpha) of this scale was 0.81.

ANALYSIS

Descriptive statistics were employed to develop a sample profile and review Parent Reported Need Satisfaction scores. Qualitative data (from Q169) was also reviewed at this time and parent testimonies were selected for inclusion in this report to illustrate parent perspectives and experiences of PLC services. To test hypothesis 2, zero-order and partial correlations between primary and secondary outcome measures were computed. Serial multiple regression analysis was then employed to explore client and program predictors of primary and secondary outcomes. This involved entering all of the independent variables in the first step, and then dropping non-significant independent variables from the model and repeating the regression analysis.

RESULTS

Figure 6 compares demographic characteristics of the study sample with demographics for families with children at home in Alberta (derived from census data). The sample profile is similar in many respects to that of the Alberta population of families with children at home. However, lone parents, parents with low educational attainment, and parents with low household incomes are under-represented in the sample. The reason for this is not clear. It may be that socioeconomically disadvantaged parents are over-represented among non-respondents (i.e., they may be less likely to participate in survey research). However, the high overall response rate of 71% suggests that these parents may also be less likely to be accessing PLC services.

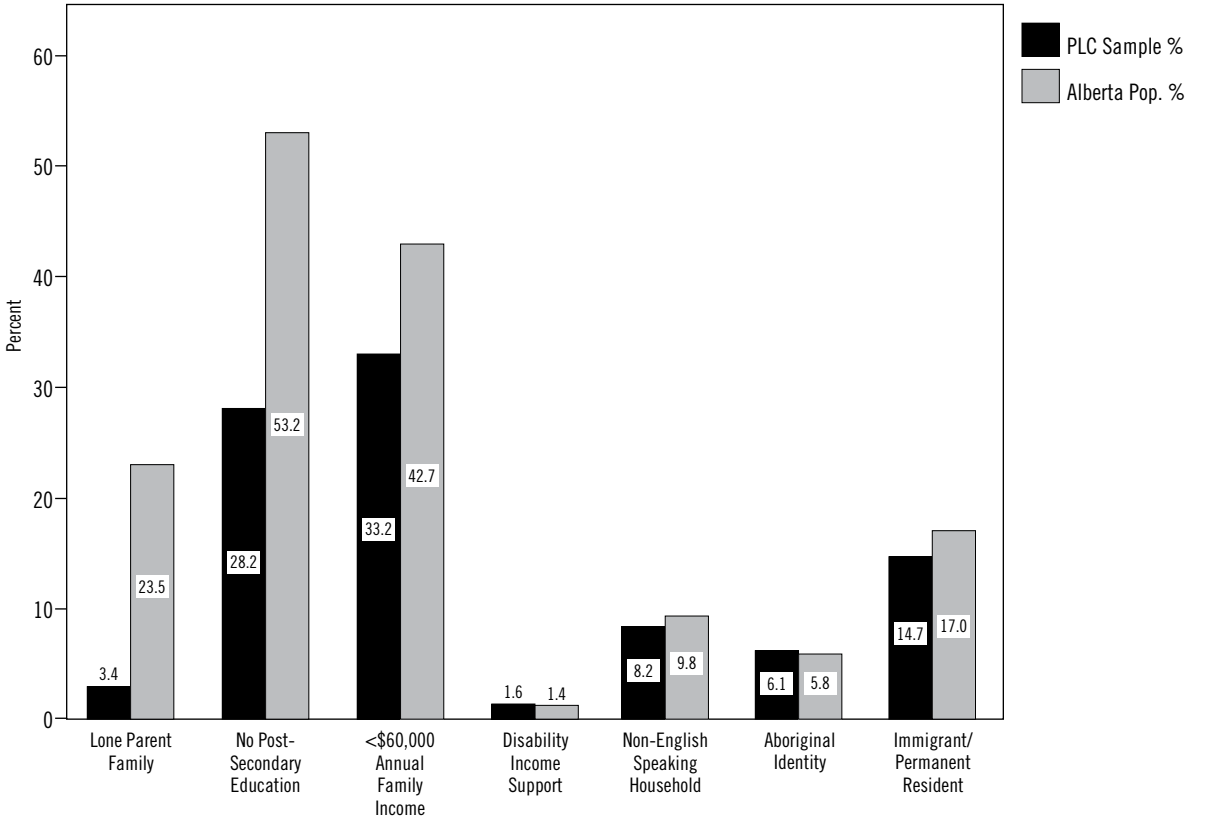
Tables 4 and 7-8 (in Chapter 3) present previously published normative data and summary data for the study sample on the Parenting Stress Index – Short Form (PSISF) and the Child Strengths and Difficulties Questionnaire (SDQ). Comparisons show that, on average, the study participants reported 'typical' (for a community sample) levels of parenting stress. However, on average, the study participants reported relatively high levels of total child difficulties (SDQ). Notably, 16.8% of the nominated children had clinically significant scores of 17 or above on the SDQ Total Child Difficulties scale.

16.8% of parents in the study had at least one child with a clinically significant score on the Total Child Difficulties sub-scale of the Child Strengths and Difficulties Questionnaire.

Parent concerns/support received

Parents are turning to Parent Link Centres for support in dealing with a broad range of issues (see Table 23). Approximately one in four parents surveyed indicated that they had received support to deal with personal (e.g. depression, loneliness) issues. 26% of parents surveyed had received support with issues relating to their infant child, including for example their sleeping patterns.

Figure 6. **Comparison: PLC sample and families with children in Alberta[36]**



36% of parents surveyed had received support with issues to do with their toddler, such as toilet training and tantrums. 17% of parents surveyed had received support with issues to do with their pre-school age child, including for example, separation issues and meal time problems. In addition, 8% of parents had received supported related to an elementary school age child.

Parent Reported Need Satisfaction

Parent Reported Need Satisfaction was generally high. At the top of the scale, 29% of parents indicated that they "definitely" got the type of help they wanted, and 24% indicated that "almost all" of their needs as parents had been met. Further, 12% and 9% of parents respectively indicated that their Parent Link Centre

[36] #Government of Alberta. (June 30, 2009). Annual Report 2008-2009. Edmonton: Seniors and Cmunity Supports. (ISSN 1913-908X). # Statistics Canada. (2006). "Number of Children at Home (8) and Census Family Structure (7) for the Census Families in Private Households of Canada, Provinces, Territories and Forward Sortation Areas, 2006 Census" (table). Statistics Canada catalogue no. 97-553-XCB2006008. # Statistics Canada. (2006). "After-tax Household Income Groups (21) and Household Type (11) for the Private Households of Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomeration Census of Population" (table). Statistics Canada catalogue no. 97-563-XCB2006046. # Statistics Canada. (2006) "Highest Certificate, Diploma or Degree (14), Age Groups (10A) and Sex (3) for the Population 15 Years and Over of Canada, Provinces, Territories, Census Divisions and Census Subdivisions, 2006 Census" (table). Census of Population, Statistics Canada catalogue no. 97-560-XCB2006008. #Statistics Canada. (2007). Alberta (table). 2006 Community Profiles. 2006 Census. Statistics Canada Catalogue no. 92-591-XWE. Ottawa. Released March 13, 2007. http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-591/index.cfm?Lang=E (accessed February 01, 2010). # Statistics Canada. (2009). Alberta (table). Health Profile. Statistics Canada Catalogue no. 82-228-XWE. Ottawa. released June 25, 2009. http://www12.statcan.gc.ca/health-sante/82-228/2009/06/index.cfm?Lang=E (accessed February 23, 2010).

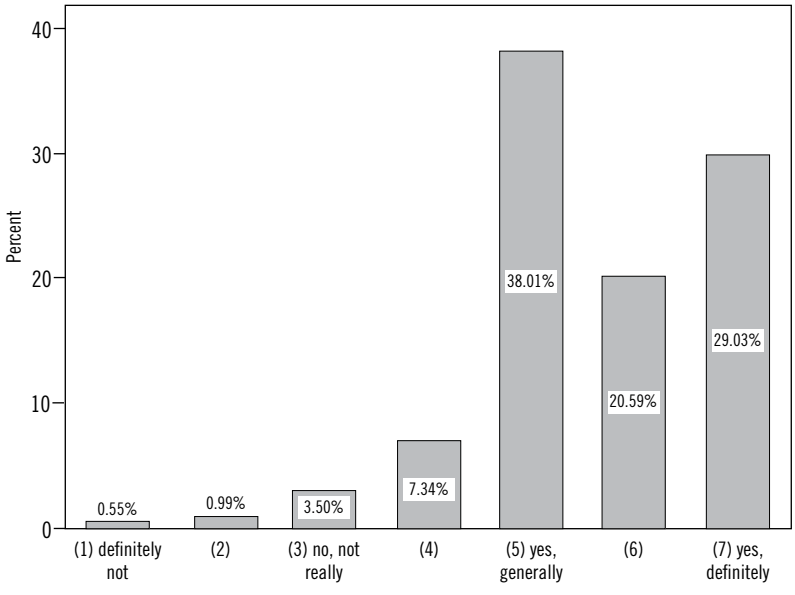
Table 23. ***Support received by PLC client sample***

In the past 3 months did you receive any support from your PLC with issues to do with:	**Total (*n*=923)**	**Triple P (*n*=172)**	**Services-as-usual**
your relationship with your partner	6.0%	9.3%	5.3%
your baby/infant	25.8%	27.3%	25.4%
sleep patterns	10.2%	12.2%	9.7%
crying or irritable baby	4.9%	3.5%	5.2%
separation anxiety	4.8%	4.7%	4.8%
development	17.8%	18.0%	17.7%
your toddler	36.3%	50.6%	33.0%
sharing	13.3%	16.9%	12.5%
tantrums	12.8%	21.5%	10.8%
hurting others	5.0%	8.1%	4.3%
listening/obedience	14.3%	23.3%	12.3%
bedtime problems	5.9%	10.5%	4.8%
toilet problems	10.7%	13.4%	10.1%
language development	12.1%	15.1%	11.5%
whining	6.0%	9.3%	5.2%
your pre-school age child	16.5%	18.6%	16.0%
separation problems	2.9%	2.3%	3.1%
nightmares and night terrors	1.4%	1.2%	1.5%
mealtime problems	4.9%	5.2%	4.8%
listening/obedience	9.4%	12.8%	8.7%
fighting and aggression	3.9%	7.0%	3.2%
going shopping	1.5%	0.6%	1.7%
your elementary school child	7.6%	14.5%	6.0%
behaviour at school	2.9%	7.0%	2.9%
being bullied	1.8%	2.3%	1.7%
bedwetting	0.7%	1.2%	0.5%
self esteem	3.3%	6.4%	2.5%
listening/obedience	3.9%	9.3%	2.7%
lying or stealing	1.0%	2.3%	0.7%
homework	1.0%	1.2%	0.9%
fears	1.5%	2.3%	1.5%
chores	2.2%	3.5%	1.9%
ADHD	1.3%	2.3%	1.1%
your teenager	1.6%	3.5%	1.2%
friends and peer relationships	1.1%	1.7%	0.9%
coping with anxiety and depression	0.4%	0.0%	0.5%
drug or alcohol use	0.4%	0.0%	0.5%
sexual activity and dating	0.3%	0.6%	0.3%
rudeness and disrespect	1.2%	2.9%	0.8%
truancy / skipping school	0.4%	0.0%	0.5%
fads and fashions	0.2%	0.6%	0.1%
smoking	0.3%	0.0%	0.4%

Table 23. ***Support received by PLC client sample (cont'd)***

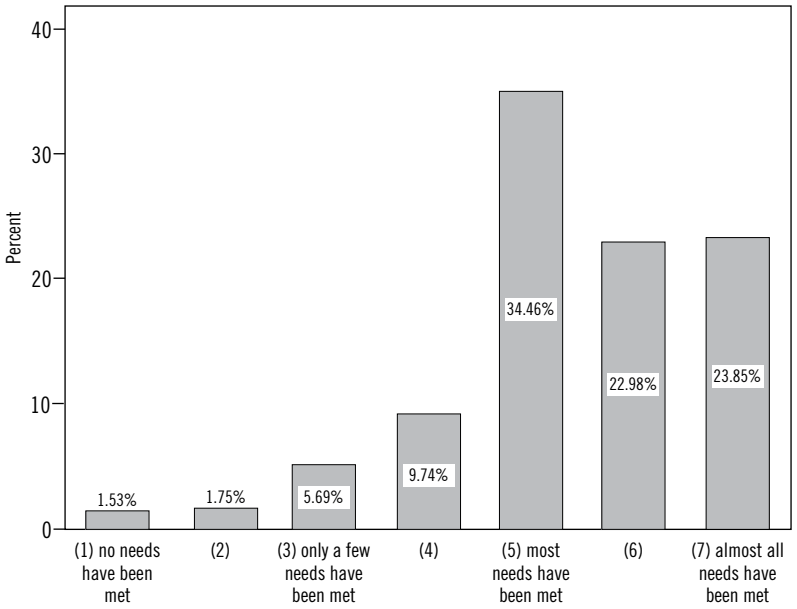
In the past 3 months did you receive any support from your PLC with issues to do with:	**Total (*n*=923)**	**Triple P (*n*=172)**	**Services-as-usual**
your personal issues	24.3%	32.6%	22.4%
feeling depressed	3.4%	4.7%	3.1%
coping and stress	9.3%	12.2%	8.7%
feeling alone	3.3%	2.3%	3.5%
balancing work and family	6.8%	10.5%	6.0%
being a parent	17.9%	25.0%	16.2%

Figure 7. **Did you get the help you wanted?**



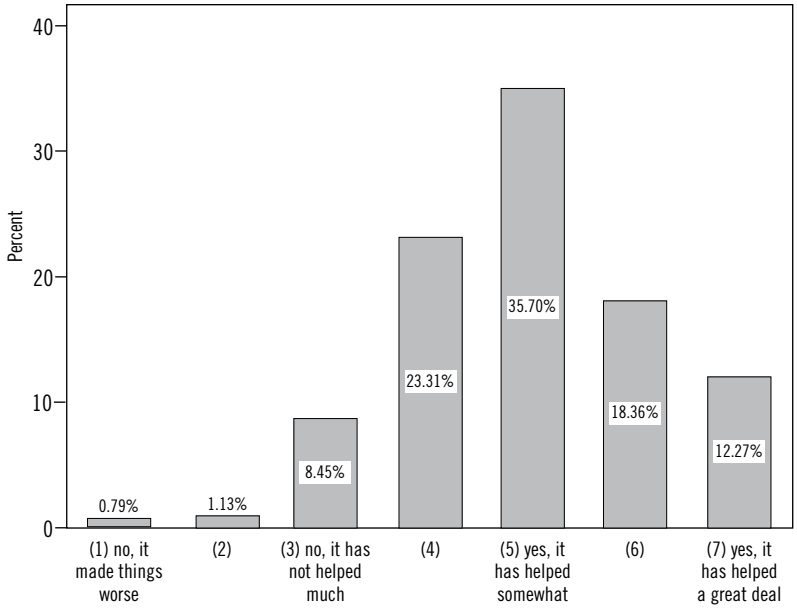
In the last three months, did you get the type of help you wanted from your Parent Link Centre?

Figure 8. **To what extent were your needs as a parent met?**



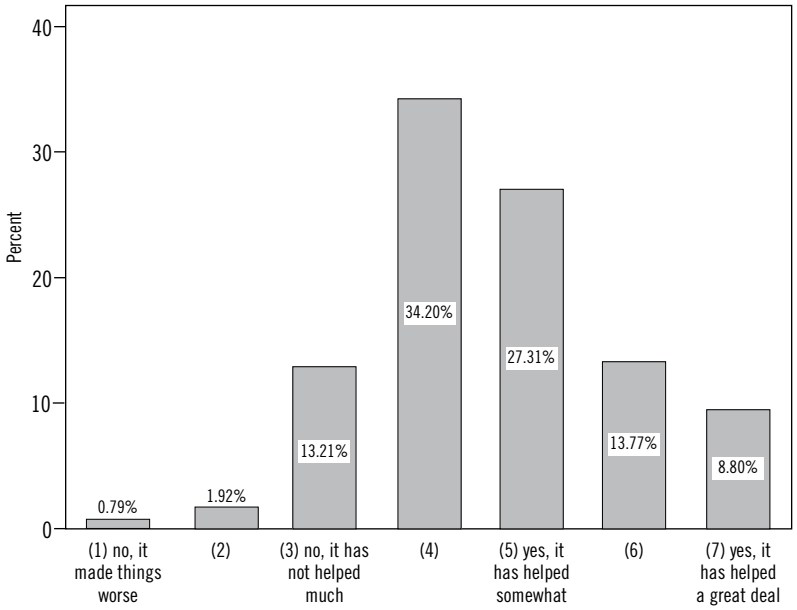
In the last three months, to what extent did the Parent Link Centre meet your needs as a parent?

Figure 9. **Did your PLC help you to deal more effectively with your child's behaviour?**



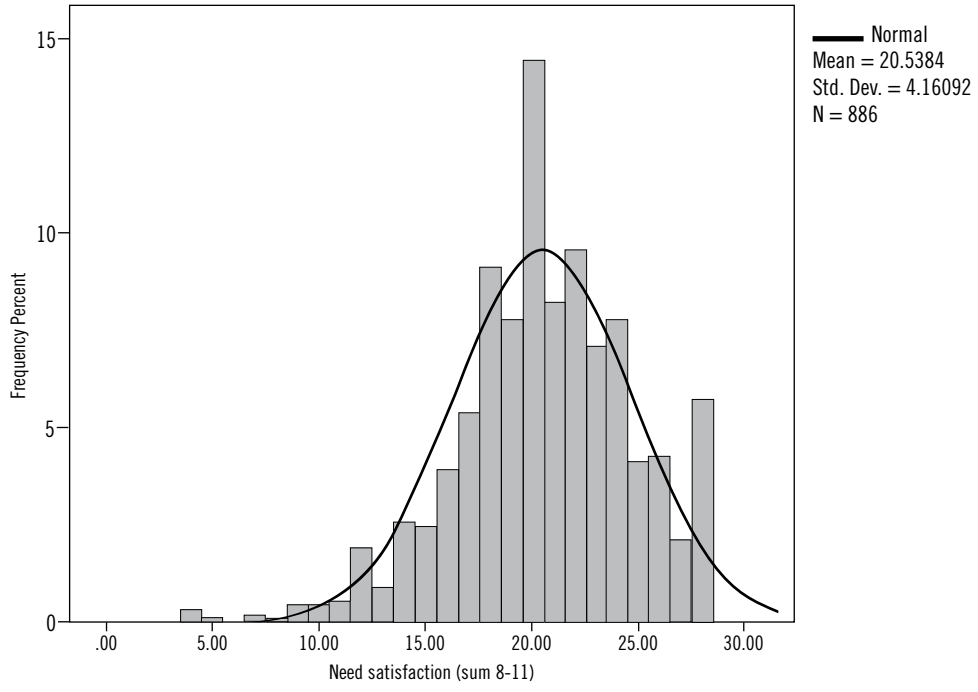
In the last three months, did your Parent Link Centre help you to deal more effectively with your child's behaviour?

Figure 10. **Did your PLC help you to deal more effectively with family problems?**



In the last three months, did your Parent Link Centre help you to deal more effectively with family problems?

Figure 11. **Total Score: Parent Reported Need Satisfaction**



In the last three months, did your Parent Link Centre help you to deal more effectively with family problems?

had helped them "a great deal," that is, to deal more effectively with their child's behaviour and to solve problems that arise in their family.[37] The distribution of scores on each of the four questions comprising the Parent Reported Need Satisfaction scale, and for total Parent Reported Need Satisfaction are shown in figures 7-11.

Parent testimonials[38] of support from their PLC

Many parents explained, in their own words, how their PLC had helped them. The parent testimonies highlight the important role that Parent Link Centres play in social networking, that is, in connecting parents together and fostering supportive social relationships. Parents also reported 'breakthroughs' as they applied the parenting strategies they learned from Triple P and observed changes in their child's behaviour. Parents described how their interaction with their children had changed for the better, and how they were now "enjoying each other" more. The following quotes capture some of the positive effects described by respondents.

> "It (the PLC) basically saved my sanity. I had just moved from another province to a place where I knew no one. I was told about the Parent Link center and began to meet many other mothers whom I now consider friends. It was a great support to my family when I was experiencing post-partum depression with my second child. They informed me of the many resources that were available and allowed me to just talk about my feelings. Without the PLC I would have never made it. I'm very fortunate to have such a program in our town. I feel at home here thanks to them."

"It (the PLC) provided us with a great deal of connection, to other parents and available resources. My daughter loved it right away as she is a very social and interactive kid. It became a place for me and her to play and reconnect in a sometimes busy schedule. It allowed me to observe what kind of toys she was attracted to. They also have bigger toys that I would not have the space or money for at home. We went through a very stressful year financially so it was very helpful to me to go out and talk to other parents. We have participated in the offered workshops, we attended special events and even use the couple's counselling service. I sometimes use Parent Link with another parent to meet at and exchange watching the kids. All that has given me more confidence as a parent, opportunities to have fun and relax, and a great deal of knowledge. I have always felt welcomed and valued as a part of the community."

"Parent Link has been my life line. The reason I have close friends and a good support group and people I can count on is because I met them at Parent Link. My mom passed away in 2000 so when I had my first I had no one to turn to for "mothering" advice. So I turned to Parent Link. Without them I would have packed my bags and moved back to Saskatchewan, but because of the people I met I now am a volunteer fire fighter, I have a close circle of friends I can count on. I have nothing but good things to say about it."

"If it wasn't for my Parent Link Centre, I wouldn't have a lot of the friends I have now. I am still fairly close with ladies that I first met taking my now 9½ yr old to playgroups when she was 2 and 3 yrs old. I now also have a 4 yr old and have once again met a great groups of mums that I'm sure I will remain friends with. It is so nice

[37] Looking at some parent written comments, it appears that some parents may have recorded low scores on these two items because they did not have any serious concerns about 'dealing with their child's behaviour' or 'problems arising in their family' to begin with. In other words, their PLC service did not assist them in these ways (as indicated by their low ratings) because they did not need such assistance.
[38] We did not correct grammar or spelling in quotes.

to know I am not alone in some of my parenting struggles and to listen to different ideas and points of view. I very recently received some very helpful advice regarding a bullying issue my 9 yr old was dealing with at school. I was also thankful for listening ears this past winter when I was dealing with a husband diagnosed with depression and coping with a job loss. I am very thankful for my Parent Link Centre."

"My son enjoys the Parent-Link centre, to be able to play with lots of his friends, and to make new friends. For myself, I enjoy having a coffee and chatting with other moms & dads and hearing advice and stories from their homes that I may be able to take home with me. I've learnt about different training courses for new parents, and even met my son's dentist at the Centre."

"The Parent Link Centre has become a part of our weekly routine. I take my son to playgroup 1-2 times a week for over a year now. I have met so many parents that I have befriended. My son also has learned how to share and play with others his age. There is always a great deal of information available for me in regards to parenting and stages of growth/development. I am so thankful that this program exists! I believe it has helped me become part of the community a little more and has opened many doors in terms of activities and program availability. The staff at the Parent Link Centre are also very helpful and friendly, offering advice and personal attention. I work from home so the playgroups are a great place for my son and I to socialize. I can't say enough about how GREAT it has been for us!"

"Because I have 3 kids, I try to do everything to protect them including not talking to my life long friends who aren't willing to accept the fact that I have kids and they will always come first, therefore I didn't have very many friends. Parent Link provided communication with other human beings, other adults, other parents to talk to. Even though I haven't been going to Parent Link very long, they have already helped me with so many problems. Problems in my personal life, problems with my spouse and problems with being a young mother of 3. I am and will forever be thankful that I was introduced to Parent Link and grateful that a service like this even exists. Thank you for this program! :)"

"The people you meet thru the Parent Link center are very important. Knowing other mom's through the programs creative with kids, creative kitchens, etc, give you a great support system. Being a stay at home mom can be isolating but knowing Parent Link staff and mom's makes you feel part of a community. Recently our community lost a little girl in a car accident. All the Mom's from the Parent Link programs got together and cooked meals for the family and the Parent Link Centre/Families First offered the family information on grief counselling and offered support to the parents. I started going to the Parent Link programs 2 years ago and feel that they are vital to our community. Living in a rural community some might think we have few opportunities for programs and resources. The Parent Link Centre offers us so many things and activities that focus on families - they are great!"

"We've got to meet new people and we're able to associate with them. The only problem I think of the program is transportation as a lot of people who come are low income and cannot afford to attend most sessions but it's a great resource for all needs. I've felt like I was a part of the family and would like to see the groups go on for

longer (each day). I still struggle with parenting and will continue (try) going to the programs with all 4 of my children… Now I can see friends who are sober or not on any drugs. The staff are helpful at getting other resources too, so I'll be taking their Programs again."

"The Parent Link Centre helped me to meet other moms with kids the same age as my son. Helped my son to learn how to share and play with different kids. Gave me a reason to get out of the house and meet people instead of being lonely at home."

"I find that when I'm having a rough week or an issue with my child (e.g., teething) that it's nice to talk to other moms or the Parent Link staff about how they handled it or if they have any information on it. I look forward to the coffee and visit and letting my child play and interact with other children. Sometimes it's the only time I get out of the house for the week."

"I first started bringing my children to the Parent Link Centre simply to get out of the house. I did it reluctantly as I imagined it to be one of those places that bored moms hang out at just to fill up their days - like a shopping mall. I quickly realized it was not the case. More than anything the Parent Link Centre has become a place of refuge for me and a constant source of emotional support - both employees and other moms being the source of support. Feeling I can't always confide in someone at home, the PLC has become a place where I can do just that...and be myself. In terms of my children it has given us a place for them to socialize. I have learned a great deal about my children by watching them interact with others. My husband enjoys taking our kids to playroom as there are often fathers there. He also uses it as a meeting place when planning with other fathers. Overall the PLC has provided us with a greater sense of community."

"I myself am a very shy and withdrawn person and it helped me get out and meet new people. I have now gone back to work and I still get together with some of the other moms for coffee or for a walk. It is the Best thing I could have done. My daughter is a very active 15 month old and it helps I can go there and get somewhat of a break as they have a play area for the kids and everybody watches everybody's kids. I love the Parent Link Program and am very grateful to them. Thank you and I hope they get more support."

"Well I from atnother country so help me to meet other people or some people with my same language (Spanish) and help my son to interactive with other toddlers."

"As a brand new mother, I took my baby to a infant massage class held at the Parent Link center. It was so nice to know there were activities for Mom's and babies. It helped me bond with my new baby as well as meet other new mom's going through the same changes both physically and mentally as me. I was also offered resource books, parent classes and the opportunity to come to a drop-in Mom & tots. I have me a sense of belonging as well as support as I knew there were other Mom's I could find answers from. It's a great place to meet people, for my child to interact with other children and to do something for yourself."

"My family only recently moved to …. Parent Link has been invaluable in helping my family make friends and feel a part of this community. It has been the GREATEST resource for me as I have struggled with feelings of isolation + loneliness since having a child. Parent Link Centre has made

an ENORMOUS difference in the quality of our lives. THANK YOU!"

"We attend a mom and tots group in town sponsored by Parent Link. It has taught me songs and rhymes to share with my children. Since first attending the program over 5 months ago, my 2 year old has really become social. She was so shy but I've watched grow so much with this group. Going to the program has given me a chance to get off the acreage I live on to meet other families and avoid a feeling of isolation. Our house burned down in a fire a couple of months ago and Parent Link provided toys and clothes for our kids. They are an incredibly valuable resource in our community."

"Great place to find community resources for my family. I attend a regular play group which has been a wonderful place to make new friends - other parents - with similar aged children; they all have gone or will eventually go through some things, so it's a great place to talk about parenting issues. Also, a great place for my kids to meet new friends."

"I have found the Parent Link Centre that I have been involved with very helpful. I began attending the "coffee and chatter" group when my son was 4 months old. It has been a fantastic group! We are able to talk, discuss and ask questions about anything that concerns us. It is a very relaxed, comfortable and safe environment for all of the moms & babies. It has been wonderful in helping moms meet up and develop friendships! Our group often meets up outside of the "coffee & chatter" time to do activities such as zoo trips, swimming lessons and birthday parties. I have recommended this group to other moms I have met and will continue to do so. Overall I have had an amazing experience with my Parent Link group. It is so comforting knowing that other moms have the same questions, concerns, troubles, doubts and wonderful times with their children. Without the Parent Link Centres, becoming a new mom would have been a little more scary and I would have had trouble finding other new moms to develop friendships with. The Parent Link Centres and its programs are an excellent resource for new families!"

"As a mother of a 20 month old & 5 month old I sometimes feel overwhelmed due to lack of sleep and the family centre is an awesome outlet to visit, get others stories, and to have my girls play with others. My oldest daughter has been potty trained for two months because I couldn't see why she couldn't do what the other kids were doing. She plays with them talks to and with them so I figured she might as well be big like them. It's also nice to know when I have lack of sleep and feel like things aren't great I'm not alone. The past 10 days have been a little hard with both girls having ear infections but in the big picture I am so lucky compared to some others. That's the worst I have to deal with. The other mom's are great sounding boards, and the staff have so much knowledge to help through phases. It's nice to know that at any time there is someplace nice to go & visit where my girls can learn to play with others and where I can get parenting tips from other mothers with older children & more experience. Thank-you for the family centre its been a life saver to me & others I'm sure."

"Parent Link provides a great escape from the house. You can get out and meet other parents that have children the same age as yours and develop new friendships and enjoy new activities. There are so many topics brought up at Parent Link and lots of great resources

there, as well as what is brought in (i.e., guest speakers). With Parent Link, parenting doesn't quite feel like a solo-undertaking. I think that Parent Link really embodies the idea that it takes a community to raise a child."

"The Parent Link Centre helped my family by teaching us how to deal with anger in a proper manner. It has helped me to become a more confident parent and to believe in myself. I have also learned more effective discipline techniques that work a lot better than what I had been using. We now know how to successfully deal with our child's tantrums. After completing the Triple P program parenting has become a lot less stressful and more enjoyable for the children and I. I really enjoy every minute with my children now and they listen so much better. The ongoing support from The Parent Link Centre is wonderful and I am grateful they were able to help my family."

"The Triple P program has really changed our whole interaction for the better. I feel that we are now much better equipped to deal with our children. The program really helped us to "change" our household for the better. Other factors may have helped as I have a less stressful job now. But the majority of the positive change came from the program teaching us- the parents - to behave and communicate with a "goal" in mind. They helped us to analyze the situation and correct it properly. It really was extremely helpful to us!"

Relationship between primary and secondary outcome measures

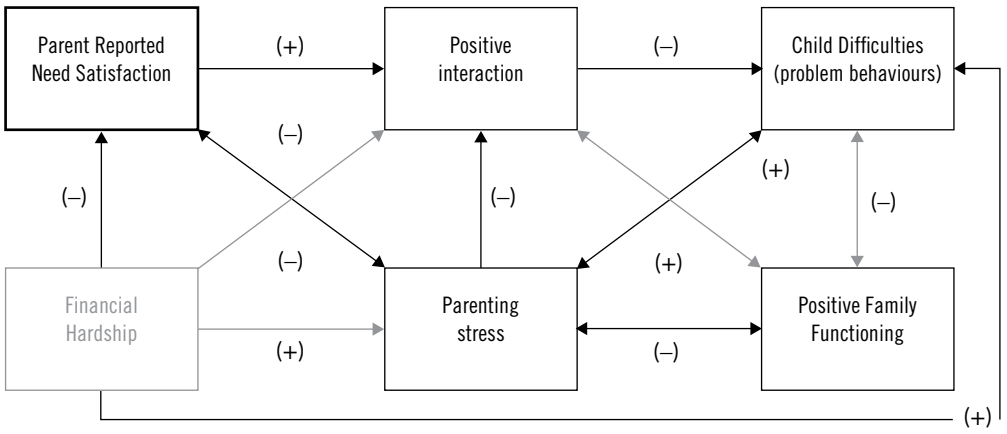
Zero-order correlation coefficients are presented in Table 24. The zero-order correlations between Parent Reported Need Satisfaction (i.e., the extent to which PLCs had addressed parent wants and needs, and helped the parents to deal with child behaviour and other problems arising in the family) and all secondary outcome measures were statistically significant. Partial correlation coefficients, presented in Table 25, provide some support for the logic/model presented in Figure 12. Specifically, the partial correlation between Parent Reported Need Satisfaction and both family functioning and total child difficulties—after controlling for financial hardship, parenting stress and positive interaction—were *not* statistically significant. This finding suggests, as Figure 12 shows, that parenting stress and positive interaction mediate the relationship between Parent Reported Need Satisfaction and both family functioning and total child difficulties.

Although this data is correlational and causality cannot be inferred, the data supports the contention that PLCs are having a positive impact on parent stress and parenting practices and further, that this is translating into improved family functioning and fewer child problem behaviours. Notwithstanding, the weak but statistically significant negative association between financial hardship and Parent Reported Need Satisfaction suggests that PLC services are less effectively meeting the parenting and support needs of families who are 'struggling to make ends meet.' The relationship between socioeconomic and other adversity and both primary and secondary outcomes is explored further below using serial multiple regression analyses.

Key Point

PLCs are having a positive impact on parent stress and parenting practices, and this is translating into improved family functioning and fewer child problem behaviours. Notwithstanding, a weak but statistically significant association between financial hardship and lower levels of parent reported need satisfaction suggests that PLC services are less effectively meeting the parenting and support needs of families who are 'struggling to make ends meet.'

Figure 12. **Transactional model showing links between primary and secondary outcomes**



Note. Relationships that were empirically supported are shown by solid arrows.

Table 24. ***Zero-order correlations between financial hardship, primary and secondary outcomes***

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Need satisfaction	1.0	-.097**	-.205***	-.208***	-.167***	.162***	.165**	-.119**	-.153**
2. Financial hardship		1.0	.220***	.221***	.179***	-.213***	-.165***	.141**	.275***
3. PSISF Total			1.0	.819***	.933***	-.563***	-.398***	.596***	.628***
4. PSISF Personal				1.0	.557***	-.555***	-.239***	.440***	.402***
5. PSISF Childrearing					1.0	-.457***	-.426***	.597***	.665***
6. Family functioning						1.0	.236***	-.346***	-.338***
7. Positive interaction							1.0	-.345***	-.398***
8. Ineffective parenting								1.0	.436***
9. Total child difficulties									1.0

** Signifies a statistically significant correlation at P<.01

*** Signifies a statistically significant correlation at P<.001

Table 25 Partial correlations between primary and secondary outcomes

	Need satisfaction	Financial hardship	PSISF Total	Family functioning	Positive interaction	Total child difficulties
Need satisfaction	1.0	-.090*	-.109*	.028	.105*	.014
Financial hardship		1.0	.048	-.071	-.084	.133**
PSISF Total			1.0	-.460***	-.177***	.514***
Family functioning				1.0	.019	.046
Positive interaction					1.0	-.093*
Total child difficulties						1.0

* Signifies a statistically significant correlation at P<.05

** Signifies a statistically significant correlation at P<.01

*** Signifies a statistically significant correlation at P<.001

Note. Correlations controlling for all other variables shown in Figure 12. For example, the correlation between Parent Reported Need Satisfaction and PSI(SF) total is -.109, controlling for financial hardship, family functioning, positive interaction and total child difficulties.

Predictors of Parent Reported Need Satisfaction

Parent Reported Need Satisfaction was regressed on service/program and client characteristics. The final model is presented in Table 26. Ten independent variables explained a modest but statistically significant 17.9% of the variance in need satisfaction. The strongest 'predictor' of need satisfaction is whether or not the parent received support with personal issues (e.g., feeling depressed, loneliness, balancing work and family). Participation in a PLC parent group, receipt of parenting information (e.g., hand-outs, tip sheets) and frequency of contact were also strong predictors of Parent Reported Need Satisfaction. The data further suggests that PLCs are having a harder time meeting the parenting and support needs of low income parents, parents for whom English is a second language spoken at home, parents with disability &/or chronic health condition, and parents caring for a child with disability &/or chronic health condition.[39]

Parenting stress and family functioning

Table 27 presents the final regression models for parenting stress and family functioning. Both models are statistically significant, but they explain only a small proportion of the variance. Receiving 'support with issues to do with your relationship with your partner' was positively associated with parenting stress and negatively associated with family functioning. This is most likely a case of reverse causation. That is, parents who report poor family functioning are actually receiving support with this issue. Parental disability or chronic health condition is a significant predictor of both parenting stress and poor family functioning. Concerns about a baby or infant, and at the other end of the child age spectrum, concerns about an older child (e.g. an elementary or teenage child) predicted parenting stress, and so did the number of children < 6 years living in the household.

Positive parenting and child behaviour difficulties

The regression models (Table 28) predicting positive interaction and total child difficulties were stronger, explaining 26.1% and 22.1% of the variance respectively. Notably, the service/program characteristic most strongly related to positive parent-child interaction was participation in a PLC drop-in playgroup. The service/program characteristic most strongly related to total child difficulties was receipt of individual/one-to-one training and support. In both cases, the outcome may in fact be the 'predictor': it is *possible* that parents who are more positive

[39] Some of these parents may have more complex needs which PLC centres are not expected to address. These parents would, at least in theory, be referred on to a more appropriate and intensive service.

Table 26. ***Regression: Parent Reported Need Satisfaction***

	Parent Reported Need Satisfaction*			
	b	***SE b***	***b***	***Sig.***
Constant	***16.057***	***.856***		***.000***
service frequency (no. of contacts)	.555	.138	.130	.000
parenting information (e.g., tip sheets)	1.271	.292	.142	.000
group-based program	1.242	.282	.147	.000
Issue: personal wellbeing	1.776	.305	.189	.000
English spoken at home	1.274	.479	.086	.008
Parent educational attainment	-.284	.105	-.089	.007
Parent longstanding health condition	-.887	.344	-.082	.010
Parent employed/working	.587	.262	.071	.025
Child longstanding health condition	-.949	.370	-.082	.010
household income	.173	.048	.117	.000

Adj R^2=.179, F(10,830)=19.313, p<.001

*Final model after eliminating non-significant predictors

Table 27. ***Regression: Parenting stress and family functioning***

	Parenting Stress*		Family Functioning*	
	b	***Sig.***	***b***	***Sig.***
Constant		***.000***		***.000***
Issue: relationship with your partner	.075	.019	-.132	.000
Issue: baby/infant	.070	.032		
Issue: toddler	.122	.000		
English spoken at home			.066	.043
Parent longstanding health condition	.126	.000	-.088	.007
Child age	.279	.000		
no. of children < 6 years	.093	.004		
	Adj R^2=.127, F(6,882)=22.504, p<.001		*Adj* R^2=.028, F(3,916)=9.838, p<.001	

* Final model after eliminating non-significant predictors

Table 28. ***Regression: Positive interaction and total child difficulties***

	Positive interaction*		Total child difficulties*	
	b	***Sig.***	***b***	***Sig.***
Constant		***.000***		***.000***
one-to-one training			.152	.001
drop-in playgroup	.150	.000		
Issue: toddler			.129	.004
Parent educational attainment	.097	.001		
Parent history of special education	.064	.032	-.131	.003
Parent longstanding health condition	-.062	.036	.164	.000
Child age	-.417	.000	.264	.000
Child longstanding health condition			.169	.000
no. of children < 6 years	-.133	.000		
	Adj R^2=.261, F(6,859)=51.877, p<.001		*Adj* R^2=.221, F(6,421)=21.231, p<.001	

* Final model after eliminating non-significant predictors

in their interactions with their child are more likely to utilise PLC drop-in play groups; and, it is *probable* that parents of children who display more challenging behaviours are more likely to receive individual support.

Age of the nominated child (i.e., the child the parent is most concerned about) is a strong predictor of both positive parent-child interaction and total child difficulties: as child age increases parents report less positive interactions and more child difficulties. The parent characteristics that were most strongly associated with less positive interactions and more child difficulties were disability/chronic health condition, and history of special education (i.e., special support with learning at school).

DISCUSSION

The qualitative *and* quantitative findings of this study confirm that Parent Link Centres are making a profound and positive difference in the lives of many parents and families in Alberta. The theoretical/logic model underpinning the analysis, shown in Figure 12, is supported by the data: Hypothesis 2 is confirmed. Most parents reported high levels of need satisfaction, and this was linked to lower levels of parenting stress and more positive parenting. Parenting stress and positive interaction were, in turn, linked to family functioning and total child difficulties.

One way that PLCs are making a positive difference is by creating opportunities for parents to support one another, develop meaningful social relationships, and experience a sense of 'belonging' to a community. Through such positive social interactions parent identity is formed, parents' experiences (e.g., doubts and delights) are normalised, parenting norms are perpetuated and parenting ideas are shared. Another way that PLCs are supporting parents and children is through education and training facilitated by PLC professionals. Equipped with effective parenting strategies, parents' report feeling more confident and less stressed by the everyday demands of parenting.

Key Point

PLCs are creating 'natural' learning opportunities for parents. Through positive informal social interactions parent identity is formed, parents' experiences are normalised, parenting norms are perpetuated, and parenting ideas are shared.

Through multiple regression analysis several service/program characteristics that are associated with more positive parent, child and family outcomes were identified. Participation

in group-based parent education, and support with personal issues such as loneliness and depression, were among the strongest predictors of Parent Reported Need Satisfaction. Further, utilization of a PLC drop-in playgroup was one of the strongest predictors of positive parenting interactions. Notably, provision of Triple P (levels 2 and 3) was not a significant predictor of any secondary outcome, and was therefore dropped from each of the final models.

The findings also show that not all parents are benefitting equally. Based on the study sample, parents with low socioeconomic status and/or financial hardship appear to be at least somewhat under-represented among PLC clients, and when these parents do access PLC services they report lower levels of need satisfaction. This finding is consistent with recent meta-analytic reviews that have identified socioeconomic status as a significant moderator of parent training success (e.g., Lundahl et al., 2006). Parents for whom English is a second language and parents with a disability or chronic health condition also report lower levels of need satisfaction, higher levels of parenting stress, poorer family functioning, less positive interactions with their children and more child problem behaviours. PLC services also appear to have a harder time meeting the learning and support needs of parents caring for a child with a disability or chronic health condition and parents who have an older child with problem behaviours. These families may want/need a level of support that exceeds the PLC service mandate.

Key Point

Parents for whom English is a second language and parents with a disability or chronic health condition also report lower levels of need satisfaction, higher levels of parenting stress, poorer family functioning, less positive interactions with their children and more child problem behaviours.

Innovation coupled with research is needed to develop and implement a strategy that will build on PLC program strengths—i.e., in strengthening social relationships—to reach out to and support families on 'the fringe.' One relatively simple step that could be taken immediately to increase program accessibility is the translation of Triple P parenting tip sheets into other languages. Another step is the dissemination of evidence-supported programs/resources targeted to families with more complex needs. This could, for example, include dissemination of Triple P levels 4 and 5. The major strength and appeal of the Triple P program is its multi-level system that facilitates matching of intervention intensity to parent learning and support needs. This feature of Triple P makes the program more than the sum of its parts. Selective implementation of Triple P (e.g., levels 2 and 3 only) will not realise this added-value.

Notwithstanding, meta-analytic studies have found that targeted parent training and support programs are generally less effective for parents and families with multiple stressors and/or more limited adaptive resources, including low income (Lundahl et al., 2006). Therefore the dissemination of evidenced supported, targeted parent training programs, such as Triple P levels 4 and 5, is unlikely to meet all of the needs, *or the needs of all* 'disadvantaged' families identified in this study. It may however be an important component of a multi-level, multi-faceted continuum of services designed to strengthen families and communities, and promote a healthy start to life for children.

5
Spotlight on Social Support

Aim

- To investigate risk factors for low social support, and to examine the relationship between social support and parent, child and family outcomes.

Methods

- Social support was regressed on indicators of socioeconomic status and other vulnerability. A zero-order correlation matrix of social support, financial hardship, family functioning, parenting stress, positive parent-child interaction and total child difficulties was then computed. Multiple regression analysis was then employed to investigate main, mediating and moderating effects of social support.

Main findings

- The primary risk factors for low social support are (1) low household income, (2) parental disability/chronic health condition, and (3) English as a second language.
- Parents with high social support report more positive parenting practices.
- Parents with low social support report higher levels of parenting stress, with financial hardship, family functioning and total child difficulties held constant.
- Parents with low social support report poorer family functioning, with financial hardship, parenting stress and child difficulties held constant.
- Parents with low social support report more child behaviour problems, but this relationship is fully mediated by parenting stress and parenting practices. In other words, social support reduces parenting stress and promotes more positive parenting practices, and these, in turn, affect child behaviour.
- Social support did not moderate the relationship between primary stressors (financial hardship, total child difficulties and poor family functioning) and parenting stress.
- Social support did moderate the relationship between financial hardship and family functioning. Put simply, when parents have stronger social support, financial hardship has a less negative impact on family functioning.

Parent testimonies, documented in Chapter 4, highlight the important role that Parent Link Centres play in strengthening the social relationships of many parents and families across Alberta. This includes enhancing parent's social support and promoting parent-child social integration (i.e., participation in meaningful social activities, roles and relationships, and sense of communality). In this chapter we shine a spotlight on social relationships by investigating 'main, mediating and moderating' effects of social support/integration on parent, child and family outcomes.

BACKGROUND

There is an unequivocal relationship between social support (feeling connected and having people you can turn to for support when you need it), social integration and parent-child health and wellbeing. Low maternal social support has been linked to perinatal complications (Klaus, Kennell, Robertson & Sosa, 1986); low birth weight and non-optimal foetal growth (Feldman, Dunkel-Schetter, Sandman & Wadhwa, 2000); pre and post-natal depression (Collins, Dunkel-Shetter, Lobel & Scrimshaw, 1993; Cutrona & Troutman, 1986; McConnell, Mayes & Llewellyn, 2008); higher levels of parenting stress (Adamakos et al., 1986); less maternal warmth and responsiveness (Burchinal, Follmer & Bryant, 1996; Crnic, Greenberg, Ragozin, Robinson & Basham, 1983; Pascoe, Loda, Jeffries & Earp, 1981); insecure attachment relationships (Jacobson & Frye, 1991); higher risk of child abuse and neglect (Bishop & Leadbeater, 1999; Garbarino & Crouter, 1978; Kotch, Browne, Dufort & Winsor, 1999; Wandersman & Nation, 1998); poorer child cognitive, emotional and social development (Melson, Ladd & Hsu, 1993; Pianta & Ball, 1993; Sameroff, Seifer, Baldwin & Baldwin, 1993); and, lower levels of child health care use (Riley et al., 1993).

Over the last two decades research attention has turned to explaining how social support and social integration influence physical and mental health, and maternal and child outcomes. This research suggests that social support primarily exerts influence by buffering the effects of stress. The perception of social support, irrespective of social network size, appears to be the most salient determinant of health and wellbeing (Dunkel-Schetter & Bennett, 1990; Thoits, 1995). The belief that social support resources are available is associated with increased sense of control or 'power over destiny', that is the power to influence one's environment and circumstances (Syme, 1998). Social integration on the other hand appears to influence maternal and child health and wellbeing in a more direct way, that is by promoting positive psychological states, including for example, sense of identity, purpose and self-worth. Further, social integration is identified as a source of motivation or social pressure to care for oneself (Cohen, 2004).

In this chapter we begin by exploring selected 'risk factors' for low social support. These include indicators of low socioeconomic status, such as lone parenthood, low household income and low educational attainment, and other vulnerability factors such as minority language, parental disability and/or poor parental health (which is both a cause and consequence of tenuous social relationships), and caregiving for a child with disability or chronic health condition (Fioto, 2002; Klebanov, Brooks-Gunn & Duncan, 1994; Llewellyn, McConnell & Mayes, 2003; Strecher, deVellis, Becker & Rosenstock, 1986). The relationship between social support and parent, child and family outcomes is then examined. Specifically we examine the main, mediating and moderating effects of social support on parenting stress, family functioning and child behaviour problems. Our specific hypotheses are as follows:

HYPOTHESES

3. Social support 'predicts' parenting stress with financial hardship, family functioning & child difficulties held constant (see Figure 13).
4. Social support 'predicts' family functioning with financial hardship, parenting stress and child difficulties held constant (see Figure 14).

5. Social support 'predicts' total child difficulties *via* parenting stress and parenting practices (see Figure 15).
6. Social support *moderates* the relationship between primary parent stressors (i.e., financial hardship, family functioning and child behaviour problems) and parenting stress (see Figure 16).
7. Social support *moderates* the relationship between primary parent stressors (i.e., financial hardship, parenting stress and child behaviour problems) and family functioning (see Figure 17).

METHODS

The Supported Parenting Survey was administered to a sample of 1296 parents who had utilised primary care, specifically Parent Link Centre services, in the prior 3 months. Participants were drawn from 20 PLCs in urban and rural areas of Alberta. A total of 923 parents responded to the survey—a response rate of 71%. The sampling and survey methods are described in Chapter 3.

DATA COLLECTION

The survey incorporated a number of well validated measures. A single, integrated measure of social support (Q135-Q140) and social integration (Q141-Q142) was obtained using the National Longitudinal Survey of Children and Youth (NLSCY Cycle 7) Social Support Scale (see Appendix B). The internal consistency reliability (standardised Chronbach's alpha) of this scale was a high .878.

Dependent and independent variables

The scales used in this analysis include 'total parenting stress' derived from the *Parenting* Stress Index-Short Form (Abidin, 1995); the NLSCY (Cycle 7) Parenting scales (i.e., positive interaction, ineffective, consistent and rational parenting); the NLSCY (Cycle 7) Family Functioning scale; and, 'total child difficulties' derived from the Child Strengths and Difficulties Questionnaire (Goodman et al., 2000). Family financial hardship was measured using four previously validated items (Barrera et al., 2001) (Q164-Q167). Data on the internal consistency reliability of these scales is documented in Chapters 3 and 4, and tables 4-7.

Demographic data used in this study include **indicators of socioeconomic status,** including lone parenthood (Q150), parent educational attainment (Q123), receipt of special support with learning at school (Q124), parent employment (Q127) and household income (Q168); and, selected **other vulnerability factors** including health/disability status of the nominated child (i.e., the child the parent is most concerned about) (Q16), parent health/disability status (Q129), and primary language spoken at home (Q121).

ANALYSIS

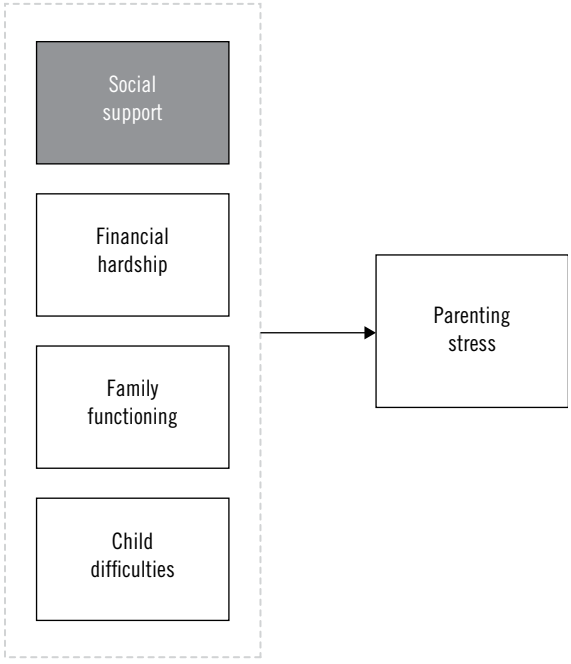
Demographic data for the sample is presented in Chapter 4. The first step in the analysis reported here was the serial regression of social support on indicators of socioeconomic status and other vulnerability. The next step involved generating a zero-order correlation matrix of social support, financial hardship, family functioning, parenting stress and total child difficulties. Multiple regression analysis was then employed to test each hypothesis. For hypotheses 5-7, the steps outlined by Baron and Kenny (1986) for testing mediation and moderation were followed.[40]

RESULTS

Table 29 presents the findings from the multiple regression of social support on indicators of socioeconomic status and other vulnerability factors. The primary risk factors for low social support identified in this study were low household income, parental disability/chronic health condition, and a language other than English primarily spoken in the home. Notably, with all other variables in the model held constant, no significant association was found between social support and lone parenthood or between social support and caregiving for a child with disability or chronic health condition.

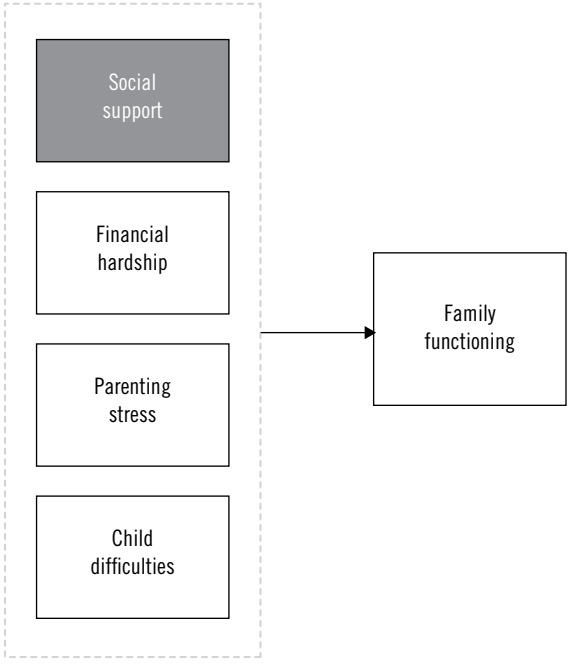
[40] For the tests of moderation, all independent variables were centered for the analysis

Figure 13. Social support and parenting stress



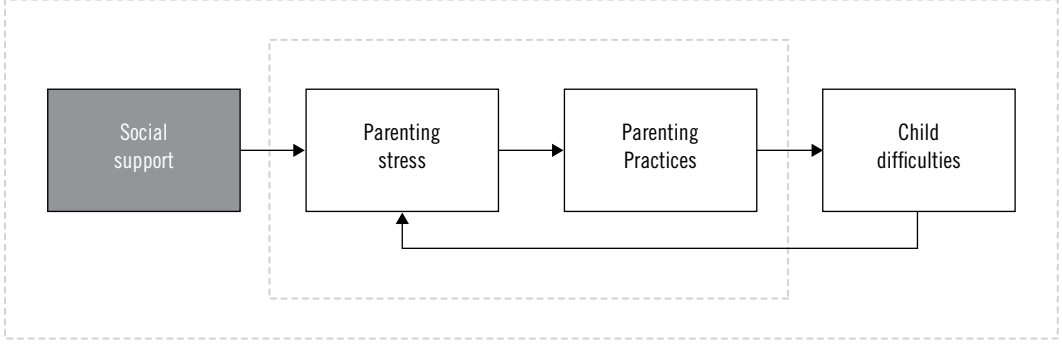
Hypothesis 3: Social support 'predicts' parenting stress with financial hardship, family functioning & child difficulties held constant.

Figure 14. Social support and family functioning



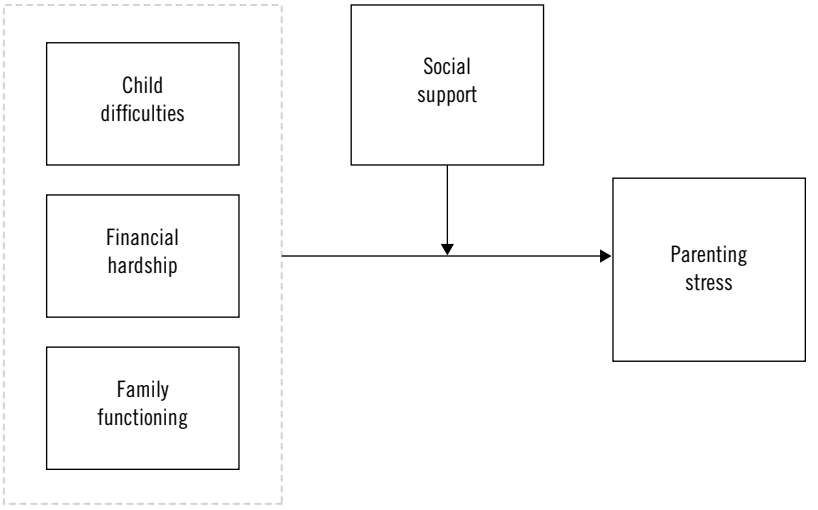
Hypothesis 4: Social support 'predicts' family functioning with financial hardship, parenting stress and child difficulties held constant

Figure 15. Social support and total child difficulties



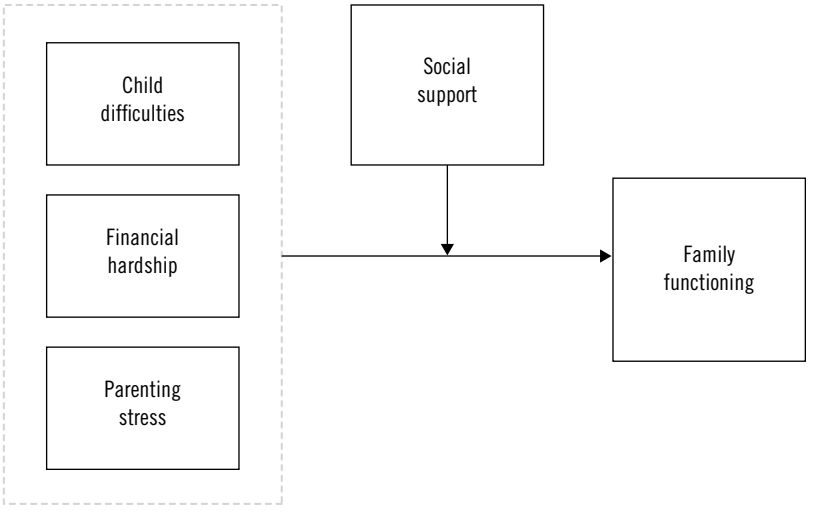
Hypothesis 5: Social support 'predicts' child difficulties *via* parenting stress and practices

Figure 16. Social support moderates the effect of primary stressors on parenting stress



Hypothesis 6: Social support moderates the relationship between primary stressors and parenting stress

Figure 17. Social support moderates the effects of primary stressors on family functioning



Hypothesis 7: Social support moderates the relationship between primary stressors and family functioning

Table 29. ***Predictors of social support***

	Social Support			
	Model 1		Model 2[a]	
	b	***Sig.***	***b***	***Sig.***
Constant		***.000***		***.000***
Sole parent status	-.017	.606		
Parent employed/working	.057	.085		
household income	.118	.001	.140	.000
Parent educational attainment	.038	.260		
Parent history of special education	.060	.071		
Parent longstanding health condition	-.088	.008	-.104	.002
Child longstanding health condition	-.034	.313		
English spoken at home	.177	.000	.165	.000
	Adj R^2=.066, F(8,871)=8.708, p<.001		*Adj* R^2=.061, F(3,877)=20.081, p<.001	

a. non-significant (p<.05) predictors in Model 1 were dropped from the regression analysis

Table 30. ***Zero-order correlation matrix: social support by parent, family and child outcomes***

	1.	**2.**	**3.**	**4.**	**5.**	**6.**
1. Social support	1.0	-.235***	-.478***	.543***	-.263***	.203***
2. Financial hardship		1.0	.222***	-.215***	.275***	-.139***
3. Total parenting stress			1.0	-.563***	.635***	-.360***
4. Family functioning				1.0	-.340***	.214***
5. Total child difficulties					1.0	-.227***
6. Positive interaction (0-11yrs)						1.0

*** Signifies a statistically significant correlation at P<.001

Table 31. ***Regression: testing hypothesis 3***

	Total Parenting Stress (PSISF Total)[a]			
	b	***SE b***	***b***	***Sig.***
Constant	***133.319***	***6.802***		***.000***
Social support	-.907	.160	-.213	.000
Financial hardship	.130	.257	.017	.611
Family functioning	-1.036	.130	-.301	.000
Total child difficulties	1.680	.122	.471	.000

Adj R^2=.580, F(4,428)=150.198, p<.001

a. analysis limited to cases in which the nominated child was 3+ years of age

Table 32. ***Regression: testing hypothesis 4***

	Family functioning[a]			
	b	***SE b***	***b***	***Sig.***
Constant	***38.965***	***2.639***		***.000***
Social support	.390	.054	.316	.000
Financial hardship	-.060	.089	.027	.502
Family functioning	-.124	.016	-.427	.000
Total child difficulties	.029	.051	.028	.568

Adj R^2=.410, F(4,428)=74.242, p<.001

a. analysis limited to cases in which the nominated child was 3+ years of age

Table 33. ***Regression: testing hypothesis 5***

	Total child difficulties[a]			
	Block 1		Block 2	
	b	***SE b***	***b***	***Sig.***
Constant		***.000***		***.000***
Social support	-.306	.000	.038	.452
Total parenting stress			.604	.000
Positive interaction			-.066	.153
Ineffective parenting			.101	.085
Consistent parenting			.028	.513
Rational parenting			-.105	.033
	Adj R^2=.091, F(1,348)=35.977, p<.001		*Adj* R^2=.397, F(6,343)=39.219, p<.001	

a. analysis limited to cases in which the nominated child was 3+ years of age

Table 34. ***Regression: testing hypothesis 6***

	Total Parenting Stress (PSISF Total)[a]			
	b	***SE b***	***b***	***Sig.***
Constant	***76.367***	***.740***		***.000***
Social support	-.996	.169	-.234	.000
Financial hardship	.170	.278	.022	.540
Family functioning	-1.023	.132	-.297	.000
Total child difficulties	1.699	.124	.476	.000
Financial hardship*Social support	.039	.048	.030	.426
Family functioning*Social support	-.031	.022	-.049	.166
Total child difficulties* Social support	-.006	.024	-.010	.789

Adj R^2=.580, F(7,425)=86.210, p<.001

a. analysis limited to cases in which the nominated child was 3+ years of age

Table 35. ***Regression: testing hypothesis 7***

	Family functioning[a]			
	b	***SE b***	***b***	***Sig.***
Constant	***43.356***	***.263***		***.000***
Social support	.422	.059	.341	.000
Financial hardship	-.124	.095	-.056	.192
Total parenting stress	-.121	.016	-.418	.000
Total child difficulties	.009	.051	.009	.864
Financial hardship*Social support	-.034	.017	-.089	.044
Parenting stress*Social support	-.003	.003	-.053	.337
Total child difficulties* Social support	.005	.010	.028	.594

Adj R^2=.408, F(7,425)=43.533, p<.001

a. analysis limited to cases in which the nominated child was 3+ years of age

The zero-order correlation matrix (Table 30) shows that social support was significantly correlated with financial hardship, parenting stress, family functioning, positive parenting and total child difficulties. **We hypothesised that social support would predict parenting stress** when financial hardship, family functioning and total child difficulties were held constant. The regression findings shown in Table 31 confirm this hypothesis. The model explains a remarkable 58% of the variance in total parenting stress. Total child difficulties is the most potent predictor of parenting stress followed by family functioning and then social support. Financial hardship was not a significant predictor of parenting stress with the other variables in the model held constant. Given the significant association between low income and social support, reported in Table 29 above, it may be that the effect of financial hardship on parenting stress is at least partially mediated by social support.

We hypothesised that social support would predict family functioning with financial hardship, parenting stress and child difficulties held constant. As the regression findings reported in Table 32 show, this hypothesis was also confirmed. The regression model explains 41% of the variance in family functioning. Both social support and total parenting stress were significant predictors. However, with all other variables in the model held constant, neither financial hardship nor total child difficulties contributed significantly to the model.

We hypothesised that social support would 'predict' child difficulties, and further, that this relationship would be *mediated* by parenting stress and positive parenting practices. Again, the hypothesis was confirmed. As the regression findings presented in Table 33 show, social support is a significant predictor of total child difficulties, alone explaining approximately 9% of the variance. However, when total parenting stress and positive parenting practices were added to the model in Block 2, the beta weight for social support decreased from -.306 to a negligible .038. This indicates that the relationship between social support and total child difficulties was all but fully mediated by parenting stress and parenting practices.

As represented in Figure 16, **we hypothesised that social support would *moderate* the relationship between primary stressors and parenting stress**. More specifically, we expected that the effect of financial hardship, poor family functioning and child behaviour problems on parent stress levels would vary depending on the parent's level of social support. For example, if a parent had low social support, we expected child problem behaviours to be far more 'stressful.' However, this hypothesis was rejected. As shown in Table 34, no statistically significant interaction was found: Social support had a large and statistically significant main effect on parenting stress, but it did not interact with any of the other three independent variables.

Finally, **we hypothesised that social support would *moderate* the relationship between [financial hardship, parenting stress and child behaviour problems] and family functioning** (see Figure 17). This hypothesis was partially confirmed. A weak but statistically significant interaction was found between financial hardship and social support (see Table 35). The interaction suggests that when parents have stronger social support, financial hardship has a less negative impact on family functioning.

DISCUSSION

In this study (1) social support was found to be a stronger predictor of parenting stress and family functioning than financial hardship, although social support and financial hardship were significantly correlated with each other; and, (2) social support was found to be a stronger predictor of family functioning than total child difficulties. Further, a sizeable correlation was found between social support and positive parent-child interaction. The study findings add to the now critical mass of data showing that social support and social integration are vital to parent-child health and wellbeing. The implication is that interventions to strengthen parent's social relationships may be just as important as interventions that are designed to enhance parenting knowledge and skills, and perhaps moreso in primary care settings. Parent Link Centres are performing both of these functions, and both functions should be recognised and highly valued.

Key Point

The study findings add to the now critical mass of data showing that social support and social integration are vital to parent-child health and wellbeing. The implication is that interventions to strengthen parent's social relationships may be just as important as interventions that are designed to enhance parenting knowledge and skills.

In this study a small number of risk factors for low social support were identified. In this sample, the single strongest 'risk factor' was English as a second language in the home. Low household income and parental disability or chronic health condition were also identified as significant risk factors for low social support with other variables in the regression model held constant. These findings confirm previous research that has consistently shown a link between parental disability and socioeconomic status on the one hand, and social support and positive parenting on the other (e.g., Feldman, Varghese, Ramsay & Rajska, 2002; McConnell, Feldman, Aunos & Prasad, 2010; Zolotor & Runyan, 2006). This compelling data points to the need for targeted 'social-networking' interventions, that is, interventions to strengthen the social relationships of those parents and families who experience social exclusion.

Limitations and directions for future research

The study findings are based on cross-sectional data: causal relationships can only be inferred from theory. Further research is needed—ideally involving well designed intervention studies targeting social relationships—to demonstrate that strengthening parent-child social relationships leads to reduced parenting stress, improved family functioning, more positive parenting practices, and in turn, fewer child behaviour problems.

REFERENCES

Aarons, G. A. & Palinkas, L. A. (2007). Implementation of evidence based practice in child welfare: Service provider perspectives. *Administration and Policy in Mental Health & Mental Health Services Research, 34*, 411–419.

Abidin, R. (1990). *The Parenting Stress Index-Short Form.* Charlottesville, VA: Paediatric Psychology Press.

Abidin, R. (1995). *The Parenting Stress Index professional manual (3rd edition).* Odessa, FL: Psychological Assessment Resources Inc.

Adamakos, H., Ryan, K., Ullman, D.G., & Pascoe, J. (1986). Maternal social support as a predictor of mother-child stress and stimulation. *Child Abuse and Neglect, 10*, 463–470.

Addis, M.E. & Krasnow, A.D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology, 68*(2), 331-339.

Addis, M.E. (2002). Methods for disseminating research products and increasing evidence-based practice: Promises, obstacles, and future directions. *Clinical Psychology: Science and Practice,* 9, 367–378.

Barlow, J. & Parsons, J. (2003). Group-based parent–training programmes for improving emotional and behavioural adjustment in 0–3 year old children. *Cochrane Database Systematic Reviews,* 2: CD003680.

Barlow J., Coren, E. & Stewart-Brown, S.S.B. (2007). Parent-training programmes for improving maternal psychosocial health [systematic review]. *Cochrane Database Systematic Reviews*, 2: 2.

Baron, R.M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51,* 1173-1182.

Barrera, M. Jr., Caples, H, & Tein, J.Y. (2001). The Psychological Sense of Economic Hardship: Measurement Models, Validity, and Cross-Ethnic Equivalence for Urban Families. *American Journal of Community Psychology, 29*(3), 493-517.

Bell, B.G. & Belsky, J. (2008). Parenting and children's cardiovascular functioning. *Child: Care, Health and Development, 34*(2), 194-203.

Belsky, J. (1984). The Determinants of Parenting: A Process Model. *Child Development*, *55*(1), 83-96.

Berwick, D.M. (2008). The science of improvement. *Journal of the American Medical Association, 299*(10),1182-1184.

Berwick, D.M. (2003). Disseminating innovations in health care. *Journal of the American Medical Association, 289,* 1969-1975.

Bishop, S. J., & Leadbeater, B. J. (1999). Maternal social support patterns and child maltreatment: Comparison of maltreating and nonmaltreating mothers. *American Journal of Orthopsychiatry*, *69,* 172–181.

Boyle, C.L., Sanders, M.R., Lutzker, J.R., Prinz, R.J., Shapiro, C. & Whitaker, D.J. (2010). An Analysis of Training, Generalization, and Maintenance Effects of Primary Care Triple P for Parents of Preschool-Aged Children with Disruptive Behavior. *Child Psychiatry Hum Dev, 41*, 114–131.

Burchinal, M.R., Follmer, A. & Bryant, D.M. (1996). The relations of maternal social support and family structure with maternal responsiveness and child outcomes among African American families. *Developmental Psychology, 32,* 1073–1083.

Byles, J., Byrne, C., Boyle, M.H., & Offord, D.R. (1988). Ontario Child Health Study: Reliability and Validity of the General Functioning Subscale of the McMaster Family Assessment Device. *Family Process, 27*, 97-104.

Carter, B. (2007). Parenting: A glut of information. *Journal of Child Health Care, 11*(2), 82-84.

Chamberlain, P. Price, J. Reid, J. & Landsverk, J. (2008). Cascading Implementation of a Foster and Kinship Parent Intervention. *Child Welfare, 87*(5), 27–48.

Cohen, S. (2004). Social relationships and health. *American Psychologist, 59,* 676–684.

Collins, N.L., Dunkell-Shetter, C., Lobel, M. & Scrimshaw, S.C. (1993). Social support in pregnancy: psychosocial correlates of birth outcomes and postpartum depression. *J Pers Soc Psychology*, *65,* 1243–58.

Conger, R.D. & Elder, G.H., Jr. (1994). Families in troubled times: The Iowa Youth and Families Project. In R.D. Conger & G.H. Elder, Jr. (Eds.), *Troubled times: Adapting to change in rural America* (pp. 3–19). New York: Aldine.

Conger, R.D. & Donnellan, M.B. (2007). An interactionist perspective on the socio-economic context of human development, *Annual Review of Psychology, 58,* 175-199.

Costa, D. & Kahn, M. (2003). Understanding the American Decline in Social Capital, 1952–1998, *Kyklos, 56*(1), 17–46.

Cox, E. (1995). *The companionable state, a truly civil society.* Sydney, NSW: Boyer Lectures, Australian Broadcasting Commission.

Crisante, L. (2003). Training in parent consultation skills for primary care practitioner's early intervention in pre-school. *Australian e- Journal for the Advancement of Mental Health*, 2. http://www.auseinet.com/journal/vol2iss3/crisante.pdf

Crnic, K.A., Greenberg, M.T., Ragozin, A.S., Robinson N.M. & Basham, R.B. (1983). Effects of Stress and Social Support on Mothers and Premature and Full-Term Infants**,** *Child Development*, *54*(1), 209-217.

Curtis, N., Ronan, K., Borduin, C. (2004). Multisystemic treatment: a meta-analysis of outcome studies. *Journal of Family Psychology, 18*, 411–419.

Cutrona, D. E., & Troutman, B. R. (1986). Social support, infant temperament, and parenting self-efficacy: A mediational model of post-partum depression. *Child Development, 57,* 1507-1518.

de Graaf, I., Speetjens, P., Smit, F., de Wolff, M., & Tavecchio, L. (2008a). Effectiveness on the Triple P Positive Parenting Program on parenting: A meta-analysis. *Family Relations, 57*(5), 553-566.

de Graaf, I., Speetjens, P., Smit, F., de Wolff, M., & Tavecchio, L. (2008b). Effectiveness of the Triple P positive parenting program on behavioral problems in children: a meta-analysis. *Behavior Modification, 32*(5), 714–735.

de Graaf, I., Onrust, S., Haverman, M. & Janssens, J. A. (2009). Helping Families Improve: An Evaluation of Two Primary Care Approaches to Parenting Support in the Netherlands. *Infant and Child Development, 18*, 481–501.

Dretzke, J., Davenport, C., Frew, E., Barlow, J., Stewart-Brown, S., Bayliss, S., Taylor, R.S., Sandercock, J. & Hyde, C. (2009). The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials. *Child Adolescent Psychiatry Mental Health, 3*, 7. doi:10.1186/1753-2000-3-7.

Dunkel-Schetter, C. & Bennett, T.L. (1990). The availability of social support and its activation in times of stress. In B.R. Sarason, I.G. Sarason, G.R. Pierce (Eds.) *Social Support: An Interactional View*. N.Y.: Wiley.

Eisner, M. (2009). No effects in independent prevention trials: can we reject the cynical view? *Journal of Experimental Criminology,* 5(2), 163-183.

Epstein, N.B., Baldwin, L.M. & Bishop, D.S. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy, 9*(2), 171-180.

Feldman M. A., Varghese J., Ramsay J. & Rajska D. (2002). Relationships between social support, stress and mother–child interactions in

mothers with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 15*, 314–323.

Feldman, P.J., Dunkel-Schetter, C., Sandman, C.A., & Wadhwa, P.D. (2000). Maternal social support predicts birth weight and fetal growth in human pregnancy. *Psychosomatic Medicine, 62,* 715–725.

Fioto, B. (2002). Social isolation: Important construct in community health. *Geriatric Nursing, 23*(1), 53-55.

Fowler, C., (2002). Maternal knowledge: beyond formal learning. *Australian Journal of Adult Learning, 42*(2), 155-68.

Garbarino, J., & Crouter, A. (1978). A note on assessing the construct validity of child maltreatment report data. *American Journal of Public Health, 68*, 598-599.

Guralnick, M.J, Hammond, M.A., Neville, B. & Connor, R.T. (2008). The relationship between sources and functions of social support and dimensions of child- and parent-related stress. *Journal of Intellectual Disability Research*, *52*(12), 1138-1154.

Goodman, R., Ford, T. Simmons, H., Gatward, R. & Meltzer, H. (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *British Journal of Psychiatry, 177*, 534-539.

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 1337-1345.

Goodman, R. (2005). *SDQ: Information for researchers and professionals about the Strengths and Difficulties Questionnaire*. Retrieved from http://www.sdqinfo.com/

Goodnow, J.J. & Collins, W.A. (1990). *Development according to Parents: The Nature, Sources, and Consequences of Parents' Ideas*. Hillsdale, NJ: Erlbaum.

Haskett, M.E., Ahern, L.S., Ward, C.S. & Allaire, J.C. (2006). Factor Structure and Validity of the Parenting Stress Index-Short Form. *Journal of Clinical Child and Adolescent Psychology*, *35*(2), 302-312.

Hoeve, M., Dubas, J.S., Eichelsheim, V.I., van der Laan, P.H., Smeenk, W. & Gerris, J.R.M. (2009). The Relationship Between Parenting and Delinquency: A Meta-analysis. *Journal of Abnormal Child Psychology, 37*, 749–775.

Holmes, W., Stewart, P., Garrow, A., Anderson, I. & Thorpe, L. (2002). Researching Aboriginal health: experience from a study of urban young people's health and well-being. *Social Science & Medicine, 54*(8),1267-1279.

Human Resources and Social Development Canada [HRSDC]. (2007a). *National Longitudinal Survey of Children and Youth, Cycle 7 survey instruments 2006/2007: Book One.* Ottawa, ON: Statistics Canada, Special Surveys Division.

Human Resources and Social Development Canada [HRSDC]. (2007b). *National Longitudinal Survey of Children and Youth, Cycle 7 – User Guide*. Ottawa, ON: Statistics Canada, Special Surveys Division.

Human Rights and Equal Opportunity Commission, (2007). *It's about time: Women, men, work and family: Final Paper 2007.* Sydney, NSW: Human Rights and Equal Opportunity Commission. Accessible at: http://www.humanrights.gov.au/sex_discrimination/its_about_time/

Invest in Kids. (2002). *A National Survey of Parents of Young Children*. Toronto, ON: Author.

Jacobson, S.W., & Frye, K. (1991). Effect of maternal social support on attachment: Experimental evidence. *Child Development, 62*, 572 – 582.

Jeynes, W.H. (2005). A meta-analysis of the relation of parental involvement to urban elementary school student academic achievement. *Urban Education, 40*(3), 237-269.

Jeynes, W.H. (2007). The Relationship Between Parental Involvement and Urban Secondary School Student Academic Achievement: A Meta-Analysis. *Urban Education, 42*(1), 82-110.

Karreman, A., van Tuijl, C., van Aken, M.A.G. & Dekovic, M. (2006). Parenting and Self-Regulation in Preschoolers: A Meta-Analysis. *Infant and Child Development, 15*, 561-578.

Kazdin AE. 2005. *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents*. New York: Oxford Univ. Press

Klaus, M., Kennell, J., Robertson, S. & Rosa, R. (1986). Effects of social support during parturition on maternal and infant morbidity. *British Medical Journal*, *293,* 585-587.

Klebanov, P.K., Brooks-Gunn, J., & Duncan, G.J. (1994). Does neighbourhood and family poverty affect mothers' parenting, mental health, and social support? *Journal of Marriage and the Family, 56*, 441–455.

Kotch, J. B., Browne, D. C., Dufort, V., Winsor, J., & Catellier, D. (1999). Predicting child maltreatment in the first 4 years of life from characteristics assessed in the neonatal period. *Child Abuse & Neglect*, *23*, 305-319.

Kumpfer, K.L., Alvarado, R., Smith, P., & Bellany, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science, 3*, 241-246.

Landry, R., Amara, N., Pablos-Mendes, A., Shademani, R. & Gold, I. (2006). The knowledge-value chain: a conceptual framework for knowledge translation in health. *Bulletin of the World Health Organization, 84*(8), 597-601

Layzer, J., Goodson, B., Bernstein, L., & Price, C. (2001). *National Evaluation of Family Support Programs: Final Report.* Prepared for the Federal Administration for Children, Youth, and Families. Cambridge, MA: Abt Associates.

Linney, J.A. (1990). Community psychology into the 1990s: Capitalizing opportunity and promoting innovation. *American Journal of Community Psychology, 18*, 1–17.

Llewellyn, G. (1997) 'Parents with intellectual disability learning to parent: the role of experience and informal learning', *International Journal of Disability, Development and Education*, *44*(3), 243–261.

Llewellyn, G., McConnell, D., & Mayes, R. (2003). Health of mothers with intellectual limitations. *Australian and New Zealand Journal of Public Health,* 27(1), 17-19.

Lundahl, B.W., Nimer, J. & Parsons, B. (2006). Preventing Child Abuse: A Meta-Analysis of Parent Training Programs. *Research on Social Work Practice*, *16*(3), 251-262.

Lundahl, B.W., Risser, H. J.,& Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clinical Psychology Review*, *26*, 86-104.

Maughan, D.R., Christiansen, E., Jenson, W.R., Olympia, D. & Clark, E. (2005). Behavioral parent training as a treatment for externalizing behaviors and disruptive behavior disorders: A meta-analysis. *School Psychology Review, 34*, 267–286.

Mayan, M. (2009). *Essentials of qualitative inquiry.* Walnut Creek, CA: Left Coast Press.

McCart, M.R., Priestner, P.E., Davies, W.H. & Azen, R. (2006). Differential effectiveness of behavioral parent-training and cognitive-behavioral therapy for antisocial youth: A meta-analysis. *Journal of Abnormal Child Psychology, 34*(4), 527-543.

McCurdy, K. (2005). The influence of support and stress on maternal attitudes. *Child Abuse & Neglect, 29*(3), 251-268.

McConnell, D., Feldman, M., Aunos, M. & Prasad, N. (2010). *Child welfare process and outcomes: Caregiver cognitive impairment*. Edmonton, Alberta: University of Alberta Press.

McConnell, D., Mayes, R. & Llewellyn, G. (2008). Pre-partum distress in women with intellectual disabilities. *Journal of Intellectual & Developmental Disability*, *33*(2), 177 – 183.

McPherson, M., Brashears, M.E. & Smith-Lovin, L. (2006). Social Isolation in America: Changes in core discussion networks over two decades. *American Sociological Review, 71*, 353-375.

McLeod, B.D., Weisz, J.R. & Wood, J.J. (2007). Examining the association between parenting and childhood depression: A meta-analysis. *Clinical Psychology Review, 27*, 986–1003

McLeod, B.D., Wood, J.J. & Weisz, J.R.(2007). Examining the association between parenting and childhood anxiety: A meta-analysis. *Clinical Psychology Review, 27*, 155-172.

Mellor, D. (2005) Normative data for the Strengths and Difficulties Questionnaire in Australia. *Australian Psychologist*, *40*, 215-222.

Melson, G.F., Ladd, G.W. & Hsu, H.C. (1993). Maternal Support Networks, Maternal Cognitions, and Young Children's Social and Cognitive Development. *Child Development*, *64*(5), 1401-1417.

Meltzer, H., Gatward, R., Goodman, R., and Ford, F. (2000) *Mental health of children and adolescents in Great Britain*. London: The Stationery Office.

Miles, M. & Huberman, A (1994). *Qualitative data analysis: A sourcebook of new methods (2nd ed)*. Thousand Oaks, CA: Sage.

Moran, P., Ghate, D. & van de Merwe, A. (2004) *What Works in Parenting Support? A Review of the International Evidence*. London: Department for Education and Skills.

Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P-positive parenting program using hierarchical linear modeling: effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, *11*(3), 114–144.

Pascoe, J. M., Loda, F. A., Jeffries, V., & Easp, J. A. (1981). The association between mother's social sup- port and provision of stimulation to their children. *Developmental and Behavioral Pediatrics, 2*, 15-19.

Peterson, R. & Prillaman, J. (2000). Implementation of a Web-Based, Self-Scoring Version of the Family Assessment Device (FAD) for parent Education. *Journal of Extension,* 38(6). Available from http://www.joe.org/joe/2000december/rb1.php

Pianta, R. C., & Ball, R. M. (1993). Maternal social support as a predictor of child adjustment in kindergarten. *Journal of Applied Developmental Psychology, 14*, 107-120.

Putnam, R.D. (2000). *Bowling alone, the collapse and revival of civic America*. New York: Simon and Shuchter.

Reitman, D., Currier. R.O., & Stickle, T.R. (2002). A critical evaluation of the Parenting Stress Index-Short Form (PSI-SF) in a head start population. *Journal of clinical child and adolescent psychology, 31*(3), 384-392.

Reyno, S.M. & McGrath, P.J. (2005). Predictors of parent training efficacy for child externalizing behavior problems – a meta-analytic review. *The Journal of Child Psychology and Psychiatry, 47*(1), 99-111.

Rikhy, S., Tough, S., Trute, B., Benzies, K., Kehler, H. & Johnston, D.W. (2010). Gauging knowledge of developmental milestones among Albertan adults: a cross-sectional survey. *BMC Public Health, 10,* 183. doi:10.1186/1471-2458-10-183.

Riley, A.W., Finney, J.W., Mellits, E.D., Starfield, B., Kidwell, S., Quaskey, S., Cataldo, M.F., Filipp, L. & Shematek, J.P. (1993). Determinants of children's health care use: An investigation of psychosocial factors. *Medical Care, 31,* 767-783.

Rogers, E.M. (1995). *The Diffusion of Innovations* (4th ed.) New York: Free Press.

Sameroff, A. (2010). A unified theory of development: A dialectic integration of nature and nurture. *Child development, 81*(1), 6-22.

Sameroff, A.J., Seifer, R., Baldwin, A. & Baldwin, C. (1993). Stability of intelligence from preschool to adolescence: the influence of social and family risk factors. *Child Development, 64*(1), 80-97.

Sanders, M.R. & Turner, K.M. (2005). Reflections on the Challenges of Effective Dissemination of Behavioural Family Intervention: Our Experience with the Triple P – Positive Parenting Program. *Child and Adolescent Mental Health, 10*(4),158–169.

Sanders, M. R., Bor, W., & Morawska, A. (2007). Maintenance of treatment gains: A comparison of enhanced, standard, and selfdirected Triple P-Positive Parenting Program. *Journal of Abnormal Child Psychology, 35,* 983–998.

Sanders, M.R. (2008). Triple P-Positive Parenting Program as a Public Health Approach to Strengthening Parenting. *Journal of Family Psychology, 22*(3), 506–517.

Sanders, M.R., Prinz, R.J. & Shapiro, C.J. (2009). Predicting Utilization of Evidence Based Parenting Interventions with Organizational, Service-Provider and Client Variables. *Admin Policy Mental Health, 36*, 133–143.

Schinke, S.P., Botvin, G.J., & Orlandi, M.A. (1991). *Substance abuse in children and adolescents: Evaluation and intervention (Vol. 22).* Thousand Oaks, CA: Sage.

Seng, A., Prinz, R., & Sanders, M. (2006). The role of training variables in effective dissemination of evidence-based parenting interventions. *International Journal of Mental Health Promotion*, *8*, 19–27.

Serketich, W.J., & Dumas, J.E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy, 27*, 171–186.

Shaw, B.F., Elkin, I., Yamaguchi, J., Olmsted, M., Vales, T.M., Dobson, K.S., Lowery, A., Sotsky, S.M., Watkins, J.T., & Imber, S.D. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology, 67*, 837-846.

Shonkoff, J.P. (2003). From Neurons to Neighborhoods: Old and New Challenges for Developmental and Behavioral Pediatrics. *Journal of Developmental & Behavioral Pediatrics*, *24*(1), 70-76.

Shonkoff, J.P. (2010). Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development*, *81,* 357–367.

Singer G. H. S., Ethridge B. L. & Aldana S. I. (2007) Primary and secondary effects of parenting and stress management interventions for parents of children with developmental disabilities: a meta-analysis. *Mental Retardation and Developmental Disabilities Research Reviews*, *13*, 357–367.

Strecher, V.J., deVellis, B.M., Becker, M.H. & Rosenstock, I.M. (1986). The Role of Self-Efficacy in Achieving Health Behavior Change. *Health Education and Behavior*, *13*(1), 73-92.

Syme, S.L. (1998). Social and Economic Disparities in Health: Thoughts about Intervention. *The Milbank Quarterly*, *76*(3), 493-505.

Thoits, PA. (1995). Stress, Coping, and Social Support Processes: Where Are We? What Next? *Journal of Health and Social Behavior*, *35*, 53-79.

Thomas, R. & Zimmer-Gembach, M.J. (2007). Behavioral Outcomes of Parent-Child Interaction Therapy and Triple P—Positive Parenting Program: A Review and Meta-Analysis. *Journal of Abnormal Child Psychology, 35,* 475 – 495.

Turner, K.M & Sanders, M.R. (2006a). Dissemination of evidence-based parenting and family support strategies: Learning from the Triple P—Positive Parenting Program system approach. *Aggression and Violent Behavior, 11*(2), 176-193.

Turner, K. M. T., & Sanders, M.R. (2006b) Help When it's Needed First: A Controlled Evaluation of Brief, Preventive Behavioral Family Intervention in a Primary Care Setting. *Behavior Therapy*, *37*(2), 131-142.

Vinokur, A. D., Price, R. H., & Caplan, R. D. (1996). Hard times and hurtful partners: How financial strain affects depression and relationship satisfaction of unemployed persons and their spouses. *Journal of Personality and Social Psychology, 71,* 166-179.

Wandersman, A., & Nation, M. (1998). Urban neighborhoods and mental health: Psychological contributions to understanding toxicity, resilience, and interventions. *American Psychologist, 53*(6), 647- 656.

Webster-Stratton, C. & Reid, M.J. (2010). Adapting The Incredible Years, an evidence-based parenting programme, for families involved in the child welfare system. *Journal of Children's Services, 5*(1), 25-42.

Wyatt Kaminski, J., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36*, 567–589. doi:10.1007/s10802-007-9201-9.

Zisser, A., & Eyberg, S.M. (2010). Treating oppositional behavior in children using parent-child interaction therapy. In A.E. Kazdin & J.R. Weisz (Eds.) *Evidence-based psychotherapies for children and adolescents* (*2nd ed*., pp. 179-193). New York: Guilford.

Zolotor, A.J. & Runyan, D.K. (2006). Social capital, family violence, and neglect. *Pediatrics, 117,* 1124–1131.

Appendix A

Triple P Positive Parenting Program Research Outcomes

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Level 1: Universal Triple P							
Universal Triple P Info Campaign (L:1) Group Triple P (L:4)	P. McTaggart & M. R. Sanders (2003) (Brisbane, Australia)	RCT	25 primary schools in Brisbane (n=495) children in control schools, (n=490) children at intervention schools	Comparison between Group Triple P, Universal Triple P and Waitlist control	Parenting Scale, Parenting Sense of Competence scale, Abbreviated Dyadic Adjustment Scale, Depression Anxiety Stress Scale, Eyberg Child Behavior Inventory, Sutter-Eyberg Student Behavior Inventory-Revised	Pre/Post 6 Mo-FU	Intervention schools: significant decreases in disruptive child behaviour maintained at 6-month follow-up. WL schools: increases in disruptive behaviour at post-test. Significant and reliable change was found for parents in the GTP condition on parenting style (laxness and verbosity) and efficacy in comparison to Universal intervention (newsletters) and the WL control condition. No effect was found for parental adjustment or relationship satisfaction.
Level 2: Selected Triple P (Seminar) / Selected Triple P (Individual Support) / Selected Teen Triple P							
Level 3: Triple P / Primary Care Teen Triple P							
Primary Care Triple P (L:3)	C.L. Boyle et al. (2010) (United States)	Multiple probe single-case design	Pre-school aged children with disruptive behaviour (n=10)	Families acted as own control	Independent Observation, Eyberg child behaviour inventory, parenting tasks checklist, Family Background Questionnaire, parenting experience survey, Client Satisfaction Questionnaire	Pre/Post 4 Mo-FU	Independent observations of parent-child interaction in the home revealed that the intervention was associated with lower levels of child disruptive behavior both in a target training setting and in various generalization settings. Parent report data also confirmed there were significant reductions in intensity and frequency of disruptive behavior, an increase in task specific parental self-efficacy, improved scores on the Parent Experience Survey, and high levels of consumer satisfaction. All short-term intervention effects were maintained at four-month follow-up.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Primary Care Triple P (L:3)	de Graaf, I., Onrust, S., Haverman, M. & Janssens, J. A. (2009). (Netherlands)	Quasi-experimental	129 parents of children aged 0-12, $\bar{x}$ child age 6.2 with mild to moderate behavioural and/or emotional problems	Care as usual control group	Parenting Scale, Being a parent scale, The Strengths and Difficulties Questionnaire	Pre/Post 3 Mo-FU	Both interventions: significant reductions in reported child emotional and behaviour problems, maintained at 3 months; parenting styles improved at both post-test and follow-up. Primary Triple P demonstrated greater reductions in parental laxness, total parenting dysfunction and greater improvement in total parenting competence. Triple P may produce better results in the long run concerning child behaviour and emotional problems.
Triple P (PCTP) (L:3)	K.M..Turner & M.R Sanders (2006) (Brisbane, Australia)	RCT: Randomized repeated measures design using a group comparison methodology	30 families with children ages 2-6 age 3.3, with developmental concerns or discrete child behaviour problems	Waitlist control	Family background questionnaire, Parent Daily Report, Eyberg child behaviour inventory, Home and Community Problem Checklist, Parenting scale, Family observation schedule, Parenting Sense of Competence Scale, depression-anxiety-stress scales, goal achievement scales, Parenting Experience Survey, client satisfaction questionnaire, observation of settings.	Pre/Post 6 Mo-FU	PCTP families showed a significant reduction in targeted child behaviour problem/s according to monitoring and mother-report. Mothers receiving the intervention reported significantly reduced dysfunctional parenting practices, greater satisfaction with their parenting role, and decreased anxiety and stress following the intervention in comparison to waitlist mothers. No group differences found for observed parent-child interaction. Consumer satisfaction with the program was high, and intervention gains were primarily maintained at 6-month follow-up.
Primary Care Triple P (L:3)	L. Crisante (2003) (Sydney, Australia)	Uncontrolled One group pre-test post-test design	Pre-school practitioners (n=20) from 19 centre's Pre-school Parent clients of the Western Sydney Area Health Service (n=39)	none	Practitioner Consultation Diary, Parent Consultation Background Form, Parenting Experience Survey, Client Satisfaction Questionnaire	Pre/Post at 3 months	The practitioners reported improvements in skill in managing difficult behaviour in the pre-school context. Parents reported improved experience of partner support and attitudes towards parenting, as well as high levels of satisfaction with the service provided. Significant differences were found on levels of parenting stress, believing that parenting was less depressing and feeling more supported in the parenting role by their partner as well as by others.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Level 4: Standard Triple P / Standard Stepping Stones Triple P / Group Triple P / Group Teen Triple P / Self-Directed Triple P							
Group Triple P (L:4)	G. Bodenmann, A. Cina, T. Ledermann & M. R. Sanders (2008) (Switzerland)	RCT	150 Swiss couples with children ages 2-12. Group Triple P (n=50) Control (n=50) Marital Distress Prevention Program (n=50)	Marital Distress Prevention Program (couples coping enhancement training; CCET) and an untreated control group	Parenting Scale, Parenting Sense of Competence Scale, Parent Problem Checklist, Eyberg Child Behavior Inventory, Dyadic Adjustment Scale	Pre/Post 12 Mo-FU	GTP was effective with Swiss families. Significant improvements in maternal parenting, parenting self-esteem, a decrease in stressors related to parenting and significantly lower rates of reported child misbehavior t. Triple P has a considerably higher impact on parenting variables than CCET. Few significant effects were found for men. Participants in the GTP group made significantly further gains than CCET, and CCET participant improved over control. Gains maintained for both at year follow up.
Group Triple P (L:4)	Y. Matsumoto, K. Sofronoff & M. R. Sanders (2007) (Australia)	RCT: Randomized group comparison design	50 Japanese parents living in Queensland Australia with children ages 2-10years GTP (n=25) WL (n=25)	Waitlist Control	Family Background Questionnaire, Eyberg Child Behaviour Inventory, Parenting Scale, Parent Problem Checklist, Relationship Quality Index, Problem Setting and Behaviour Checklist, Depression Anxiety Stress Scale, Client Satisfaction Questionnaire, Core Parenting Skills Questionnaire	Pre/Post 3 Mo-FU	GTP condition showed significant reductions in parent reported child behaviour problems, parental over-reactivity and laxness, and parental conflict as well as increasing parental competence. The acceptability of the program was found to be high.
Group Triple P (L:4)	K. Turner, M. Richards & M. R. Sanders (2007) (Queensland, Australia)	RCT: Repeated measures design	Indigenous families with children ages 1-13, age 5.8) (n=51) Group Triple P (n=26) Waitlist (n=25)	Waitlist control	Family background questionnaire, Eyberg child behaviour inventory, Strengths and Difficulties Questionnaire – extended version, Parenting scale, Parenting Experience survey, depression-anxiety-stress scales, client satisfaction questionnaire	Pre/Post 6 Mo-FU	GTP group showed significant decrease in rates of problem child behaviour, less reliance on dysfunctional parenting practices compared to WL group. Significantly greater movement from the clinical to non-clinical range for mean child behaviour scores on all measures. Most gains maintained at 6-month follow-up. Positive qualitative data on program content and process however few waitlist participants subsequently attended groups.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Group Triple P (L:4)	Leung, C., Sanders, M., Ip, F., & Lau, J. (2006). (Hong Kong)	Uncontrolled	661 parents self referred to child health services; children 2-12 years.	none	Parent Sense of Competence, Depression Anxiety Stress Scale-21, Eyberg Child Behavior Inventory	Pre/Post	There were significant decreases in disruptive child behaviours, levels of parenting stress, general stress and anxiety and an increase in parenting sense of competence. Greater change in reports of child behaviour problems was related to lower levels of family income, new immigrant family status, and higher pre-intervention levels of parenting stress.
Group Triple P (L:4)	S. Gallart & S. Matthey (2005) (Australia)	RCT	49 parents of children aged 3-8. Group Triple P program (n=16) Modified Group Triple P (n=17) Waitlist control condition (n=16)	Modified Group Triple P (4 group sessions without the 4 phone sessions) and a waitlist control	Eyberg Child Behavior Inventory (ECBI), the Depression Anxiety Stress Scales (DASS) and the Parenting Scale (PS). All self report.	Pre/Post (8 week intervention) 6 Mo-FU attempted; return rate too low to produce sufficient data.	The researchers assert that the 4 telephone sessions are not an essential component for the initial effectiveness of the Group Triple P program (though further research needs to explore whether they impact on maintenance of gains), and that Group Triple P is effective in bringing about change. Statistically and clinically significant main effects were found for attending either the full Triple P or the modified Triple P program on both the DASS and the ECBI, but not on the participant's perception of their parenting style .
Group Triple P (L:4)	S.R. Zubrick, K.A. Ward, S.R. Silburn, D. Lawrence, A.A. Williams, E. Blair, D. Robertson, M.R. Sanders (2005) (Australia)	Quasi-experimental two-group longitudinal design (Effectiveness trial)	Preschool aged children and their parents over a 2-year period. Intervention group: (n=804) Comparison group: (n=806)	Comparison participants were able to access health care and family support services as usual, but did not participate in Group Triple-P.	Family Background and Demographic Details, Eyberg Child Behavior Inventory, Parenting Scale, Depression Anxiety Stress Scales, Client Satisfaction, Parent Problem Checklist, Abbreviated Dyadic Adjustment Scale	Pre/9 weeks mid/Post 12&24 Mo-FU.	Intervention was associated with significant reductions in parent reported levels of dysfunctional parenting and parent- reported levels of child behavior problems. Effect sizes on child behavior problems ranged from large (.83) to moderate (.47). Positive and significant effects observed in parent mental health, marital adjustment, and levels of child rearing conflict.
Group Triple P (L:4)	C. Leung, M. R. Sanders, S. Leung, R. Mak & J. Lau (2003) (Hong Kong)	RCT	91 parents with children aged 3-7, age 4, reported to have conduct concerns. Group Triple P (n=46) Waitlist control (n=45)	Waitlist control	Parent Daily Report, Eyberg Child Behaviour Inventor, Strength and Difficulty Scale, Parenting Scale, Parenting Sense of Competence Scale, Parent Problem Checklist, Relationship Quality Index, Client Satisfaction Questionnaire	Pre/Post (8 week intervention)	At post intervention, participants in the GTP group reported significantly lower levels of child behavior problems, lower dysfunctional parenting styles, and higher parent sense of competence, compared to the WL group.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Group Triple P (L:4)	J. L. Ireland, M. R. Sanders & C. Markie-Dadds (2003) (Australia)	Fully randomized repeated measures group comparison design	37 couples with a child ages 2-5 experiencing child behavior problems and concurrent marital conflict Standard (n=19) Enhanced (n= 18)	Enhanced Group Triple P (8 standard group Triple P sessions plus 2 additional parent support group training sessions)	Eyberg Child Behavior Inventory, The Parenting Scale, Parent Problem Checklist, Depression Anxiety Stress Scale, Abbreviated Dyadic Adjustment Scale, Marital Communication Inventory, ENRICH Marital Satisfaction Scale, Client Satisfaction Questionnaire	Pre/Post 3 Mo-FU	Both interventions were associated with significant improvements in parent reported disruptive child behaviour, dysfunctional parenting strategies, parenting conflict, relationship satisfaction and communication. Treatment effects were generally maintained at 3-month follow up. For some measures, Group Triple P effects were achieved by follow-up rather than post assessment. No differences were found on parent adjustment measures.
Group Triple P (tailored: gifted children)	A. Morawska, M. Sanders (2009a) (Queensland, Australia)	Pilot study	Parents recruited from the Tasmanian Association of the Gifted (n=8)	N/A	The Strengths and Difficulties Questionnaire, The Parenting Scale, Client Satisfaction Questionnaire. Qualitative analysis of question: "What Areas, Strategies or Ideas Would You Like to See Covered in an Evidence-Based Parenting Program for Parents of Gifted and Talented Children?"	Pre/Post (only 50% of parents completed post evaluation)	Parents felt the range of strategies and the emphasis on praise were strengths of the program. Main concerns: lack of tailoring of program content to the needs of gifted and talented children, insufficient time devoted to cover the content and to tailor it to their specific needs. Parents reported that there were issues relating to parenting a gifted and talented child, which were not covered in sufficient depth in the program, and that some adaptations would be required to make it more relevant.
Group Triple P (tailored: gifted children)	A. Morawska, M. Sanders (2009b) (Queensland, Australia)	RCT (fully randomised, repeated measures design)	75 parents of children identified as gifted Intervention (n=32) Waitlist (n=34)	Waitlist Control	Family Background Questionnaire, Eyberg Child Behavior Inventory, Strengths and Difficulties Questionnaire, Parenting Tasks Checklist, Parenting Scale, Parent Problem Checklist, The Relationship Quality Index, Depression Anxiety Stress Scale-21, Client Satisfaction Questionnaire	Pre/Post 6 Mo-FU	Significant intervention effects for the number and frequency of parent reported child behaviour problems, as well as hyperactivity in the intervention group, relative to a waitlist control. Parents reported significant improvements in their own parenting style; less permissiveness, harshness, and verbosity when disciplining their child. No intervention effects were evident for teacher reports, except for a trend in relation to hyperactivity.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Group Teen Triple P (L:4)	A. Ralph & M. R. Sanders (2004) (Queensland, Australia)	Non-Equivalent Groups Design	771 parents with 12-13 year old children *n* from two similar schools in Queensland. One school was randomly assigned to receive the initial group program	Comparison made to similar waitlist school not offering the program.	Strengths and Difficulties questionnaire, Family background questionnaire, adolescent health and well being survey, assessment questionnaire	Pre/Post 12 Mo-FU via phone interview	High parental satisfaction with the program. Statistically significant improvement in parental adjustment scores and parenting styles. Parental beliefs also changed for the better, with parents reporting significant improvements on measures of self-efficacy, self-sufficiency and self-management. Parent–teenager conflict significantly reduced at post test and follow-up. No significant change in personal agency.
Group Teen Triple P (L:4)	A. Ralph, M. R. Sanders (2003) (Australia)	Uncontrolled One group pre-test post-test design	27 parents of children entering first year high school (12-13 years)	none	Conflict Behaviour Questionnaire, The Parenting Scale for adolescents, The parenting belief scale, Parent Problem checklist, The depression-anxiety-stress scales, the client satisfaction questionnaire	Pre/Post (8 week interven-tion)	Participating parents reported significant reductions in conflict with their teenager, and on measures of laxness, over-reactivity, and disagreements with their partner over parenting issues, significant improvements on measures of self-regulation, including self-efficacy, self- sufficiency, and self-management, and reductions on measures of depression, anxiety, and stress.
Telephone Supported and Group Triple P (L:4) behavioral family intervention (BFI)	Zubrick, S., Ward, K., Silburn, S., Lawrence, D., Williams, A., Blair, E., et al. (2005). (Australia)	Quasi-exparimental two-group longitudinal design (2 years)	1610 Australian parents from a socio-economically deprived region. (Intervention group, *n*=804 vs. Comparison region, *n*=806)	Control Region	Parenting Scale, Eyberg Child Behavior Inventory	Pre/Post 12 Mo-FU 24 Mo-FU	Group intervention was associated with significant reductions in parent- reported levels of dysfunctional parenting and parent reported levels of child behavior problems. Effect sizes on child behavior problems ranged from large (.83) to moderate (.47). Positive and significant effects were also observed in parent mental health, marital adjustment, and levels of child rearing conflict.
Telephone Supported Group Triple P (L:4)	L. Crisante & S. Ng (2003) (Sydney, Australia)	Uncontrolled One group pre-test post-test design	45 Cantonese-speaking parents (Children aged 3-10,age 5.7)	none	Strengths and Difficulties Questionnaire ($n = 15$), Client Satisfaction Questionnaire ($n = 17$), Family Background Questionnaire	Pre/Post (8 week interven-tion)	Significant improvements on the Pro-social Behaviour Score. Parents reported being satisfied with the program. Not all participants would complete each questionnaire.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Group, Workplace, Telephone Supported Triple P (L:4)	A. Martin & M. R. Sanders (2003) (Australia)	RCT	42 general and Academic university staff who were reporting difficulties managing home and work responsibilities and behavioural difficulties with their children ages 2-9,age 5.8	Waitlist control group, Standard Group Triple P	Strengths and Difficulties Questionnaire, Parenting Scale, Problem Setting and Behavior Checklist, Social Support Scale, Work Stress Measure, The Job Satisfaction Measure, Work Commitment Questionnaire, Eyberg Child Behaviour Inventory, Depression-Anxiety-Stress Scale 2, Work-related Self-efficacy scale	Pre/Post (8 week inter-vention) 4 Mo-FU for WPTP group	Workplace Triple P (WPTP) participants reported significantly lower levels of disruptive child behaviour, dysfunctional parenting practices, and higher levels of parental self-efficacy in managing both home and work responsibilities, than parents in the WL condition. Gains maintained at 4-months follow-up. Reported levels of work stress and parental distress continued to improve at follow-up in the WPTP group compared to post-intervention.
Group and Standard Triple P (L:4) (Recruitment Strategies)	Heinrichs, N., Krueger, S., & Guse, U. (2006). (Germany)	Uncontrolled Independent variables: payment, group Vs Ind. Intervention. Outcome variables: recruitment and retention rates.	197 parents of children aged 3 to 6 years (socially disadvantaged population)	4 Conditions (Group/Ind x Paid/ Unpaid)	Parenting Scale, Depression Anxiety Stress Scale, Abbreviated Dyadic Adjustment Scale, Fragebogen zur Lebenszufriedenheit [General Life Satisfaction Questionnaire], Child Behavior Checklist, Strengths and Difficulties Questionnaire	Pre/Post	Results demonstrate significant impact of payment on recruitment and initial attendance. Offering families payment for participation in Triple P led to additional 20% of recruited families. Individual Vs group intervention did not significantly influence these rates. Increase in privacy and attention that a family received in the individual condition was not a significant motivator for recruitment or attendance.
Group, Standard, Self-Directed Triple P (L:4) Enhanced (L:5)	W. Cann, H. Rogers & J. Matthews (2003) (Victoria, Australia)	Uncontrolled One group pre-test post-test design	589 mothers participating in the family intervention service metropolitan program (child age 4.5) GTP (n=572) STP (n=16) ETP (n=44) S-DTP (n=2)	none (groups pooled in analysis)	Eyberg Child Behavior Inventory, Parenting Scale, Parenting Sense of Competence scale, The Depression, Anxiety, Stress Scale, Parent Problem Checklist, Consumer satisfaction questionnaire	Pre/Post program intervention data reviewed	45% of children were found to be in the clinical range for child behaviour problems before intervention. Following the parenting program only 12% of children were reported by their parents to be in the clinical range. Significant improvements were also noted in measures of parental style, sense of competence, depression, anxiety, stress, and couple conflict.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Group and Standard Triple P (L:4)	H. Rogers, W. Cann, D. Cameron, L. Littlefield & V. Lagioia (2003) (Victoria, Australia)	Uncontrolled Evaluation of BFI program. Data reported are a subset of ongoing evaluation of the Family Intervention Service (FIS): Metropolitan Project	83 children aged 2-15 years diagnosed with ADHD (clients of the Victorian Parenting Centre (FIS)	none	The Eyberg Child Behavior Inventory, Depression Anxiety Stress Scale, The Parenting Scale, Parent Sense of Competence Scale, The Parenting Problem Checklist, a parent program satisfaction questionnaire	Pre/Post test data examined	Significant reduction in problem behaviour scores of children perceived to have a high frequency of typical of ADHD behaviours. Reduced maternal depression, anxiety and stress, increased feelings of satisfaction and competency in parenting, less negative parenting behaviour, reduction in parental conflict and high levels of satisfaction with the program. Parents who indicated high level of child behaviours associated with ADHD reported reductions in child problem behaviour, positive changes in parenting style, improved confidence in parenting, reduced inter-parental conflict, and less depression, anxiety and stress following involvement in the FIS program.
Telephone Supported Self-Directed Triple P (L:4)	Hahlweg, K., Heinrichs, N., Kuschel, A., & Feldmann, M. (2008). (Germany)	RCT	69 parents of children aged 3-6.	Waitlist control	Parent Problem Checklist, Parenting Scale, Fragebogen zur Lebenszufriedenheit [General Life Satisfaction Questionnaire], Center for Epidemiological Studies - Depression Scale, Abbreviated Dyadic Adjustment Scale, Child Behavior Checklist, Strengths and Difficulties Questionnaire	Pre/Post 6 Mo-FU	Mothers in intervention group reported significant reductions in externalizing child behavior problems and improved maternal parenting style; maintained at follow-up. No significant differences for depression, general life satisfaction or marital quality. This study found the number of chapters read significantly correlated with the within group effect size of improvements in dysfunctional parenting but not for child behavior or emotional problems. Fathers reported only marginal changes.
Self-Directed and Telephone Supported Self-Directed Triple P (L:4)	Morawska, A., & Sanders, M. R. (2006a). (Brisbane, Australia)	RCT	126 self selected parents expressing concern about the behaviour of their child/ren ages 1-3 SD (n=33) TSSD (n=39) WL (n=37)	Waitlist Control	Parenting Scale, Depression Anxiety Stress Scale, Eyberg Child Behavior Inventory, Toddler Care Questionnaire, Parental Anger Inventory, Relationship Quality Scale, The Family Observation Schedule	Pre/Post 6 Mo-FU	Significant short-term reductions in reported child behavior problems and improvements in maternal parenting style, parenting confidence, and anger. Families who received minimal therapist assistance made more clinically significant gains compared with families who completed the program with no therapist assistance. The intervention effects were maintained at 6-month follow-up.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Telephone Supported Self -Directed Triple P (L:4)	Morawska, A., & Sanders, M. R. (2006b). (Australia)	Uncontrolled (repeated measures design, comparison across three time periods)	110 self selected parents expressing concern about the behaviour of their child/ren ages 1-3	none	Parenting Scale, Depression Anxiety Stress Scale, Eyberg Child Behavior Inventory, Toddler Care Questionnaire, Parental Anger Inventory, Relationship Quality Scale	Pre/Post 3 Mo-FU	Significant short-term effects in terms of child behaviour problems and parenting style, parenting confidence and anger. Improvements in mother's personal adjustment, and lower levels of parenting conflict. Intervention effects maintained at 3-month follow-up.
Telephone Supported Self-Directed Triple P (L:4)	W. Cann, H. Rogers & G. Worley (2003) (Victoria, Australia)	One group pre-test post-test design	73 families with children ages 1-11 years (age 5) participating in The Family Intervention Service (Isolated Rural Project) in	none	Eyberg Child Behavior Inventory, Parenting Scale, Parenting Sense of Competence Scale, The Depression Anxiety Stress Scale, the Parent Problem Checklist, Abbreviated Dyadic Adjustment Scale A consumer satisfaction measure was administered post-intervention.	Pre/Post (10 week interven-tion)	Significant improvements were noted in child behaviour, parenting style, parental depression, anxiety, and stress, inter-parent conflict, and parent satisfaction and efficacy.
Telephone Supported Self-Directed Triple P (L:4)	S. Connell, M. R. Sanders, C. Markie-Dadds (1997) (Queensland, Australia)	RCT	24 preschool children and their families (children aged 2-6,age 4) S-DTP (12 families) WL (11 families)	Waitlist Control	Eyberg Child Behavior Inventory , Parenting Scale, Parent Daily Report Daily Checklist. Parenting Sense of Competence Scale, Depression Anxiety Stress Scale. A consumer satisfaction measure was administered post-intervention.	Pre/Post (6 week in-tervention)4 Mo-FU	Significant reduction in ECBI intensity scores and significantly lower level of disruptive child behaviour from pre to post treatment in S-DTP condition only. Changes generally maintained at 4 month follow up. Mothers in treatment group gained greater sense of competence and parental satisfaction than WL mothers. Mothers reported significantly lower levels of anxiety, stress and depression in S-DTP group; however both fathers in treatment group and WL demonstrated no significant change.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Individual & Self-Directed Triple P (L:4) behavioral family intervention (BFI)	Nicholson, J., & Sanders, M. R. (1999). (Australia)	RCT	60 parents in stepfamilies of children aged 7-12 with an ECBI score >40, or 5 ODD [3 CD] symptoms in previous 6 months	Waitlist Control	Parent Problem Checklist, Child Behavior Checklist, Parent Daily Report, Child Manifest Anxiety Scale, Coopersmith Self-Esteem Inventory child form	Pre/Post	No significant differences for self-directed vs. therapist directed (individual) Triple P. Families receiving BFI reported significantly greater reductions in child behavior problems and couple conflict over parenting, and were more likely to show clinically significant and statistically reliable improvements on a range of family and child measures than control families.
Self- Directed Triple P (L:4)	C. Markie-Dadds & M. R. Sanders (2006) (Australia)	Randomized group comparison design	63 families with a preschool-age child, age 3.6 S-DTP (n=32) WL (n=31)	Waitlist control	Eyberg Child Behavior Inventory, Parent Daily Report, Parenting Scale, Parenting Sense of Competency Scale, Parent Problem Checklist, Depression Anxiety Stress Scales, The Client Satisfaction Questionnaire	Pre/Post 6 Mo-FU	S-DTP was associated with significantly lower levels of disruptive child behaviour and dysfunctional parenting strategies, and significantly higher parenting confidence in comparison to WL controls. No differences found on parent adjustment measures. Intervention results were maintained at 6-month follow-up, with the exception of parenting confidence, which had decreased significantly from post.
Standard Triple P & Self-Directed Triple P (L:4) Enhanced Triple P (L:5)	M. R. Sanders, W. Bor & A. Morawska (2007) (Australia)	RCT	Original Study: 305 preschoolers at high risk of developing conduct problems (Brisbane) 3 year follow-up: ETP (n=48) STP (n=50) S-DTP (n=41) (did not reassess waitlist condition)	Enhanced Triple P, Standard Triple P & Self-Directed Triple P	Family Background & Diagnostic Interview Schedule for Children–Parent version, Observation of Mother and Child Behavior, Beck Depression Inventory, Child Abuse Potential Inventory, Eyberg Child Behavior Inventory, Parent Daily Report, Parenting Scale, Parenting Sense of Competence Scale, Parent Problem Checklist, Abbreviated Dyadic Adjustment Scale, Depression Anxiety Stress Scales, Client Satisfaction Questionnaire, Sutter–Eyberg Student Behaviour Inventory	3 Yr-FU of Sanders, Markie-Dadds, Tully & Bor (2000)	At 3-year follow-up (n= 139), each condition showed a similar level of maintenance of intervention effects regardless of which Triple P intervention parents received. Approximately 2/3 of preschoolers who were clinically evaluated on measures of disruptive behaviour at pre-intervention moved from the clinical to the non-clinical range. Across conditions, there was a comparable preventive effect for each intervention for these high-risk children. Similarly, there were sustained improvements on mothers' observed negative behaviour, in the parental reports of child behaviour, dysfunctional discipline, parenting sense of competence, marital adjustment, marital conflict, or negative affect, but no significant condition by time interaction effects.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Self- Directed and Enhanced Self- Directed Triple P (L:4) (L:5)	C. Markie-Dadds & M. R. Sanders (2006) (Australia)	Randomized group comparison design	41 families in rural Western Australia with a child aged between 2 and 6 years ,age 3.9 S-DTP (*n*=15) Enhanced S-DTP (*n*=14) WL (*n*=12)	Comparison to enhanced self-directed triple P with telephone sessions and waitlist control	Eyberg Child Behavior Inventory, Parent Daily Report, Parenting Scale, Parenting Sense of Competency Scale, Parent Problem Checklist, Depression Anxiety Stress Scales, The Client Satisfaction Questionnaire,	Pre/Post 6 Mo-FU	Both S-DTP interventions were associated with significantly lower levels of mother reported disruptive child behaviour in comparison to WL, with the telephone-assisted group significantly more improved than the standard group. Significantly less dysfunctional parenting (laxness) and higher parental confidence in the telephone-assisted group in comparison to S-DTP and WL. No differences were found on measures of parent adjustment or parenting conflict. Results for the telephone-assisted condition were generally maintained at 6-month follow-up.
Standard Triple P (STP) (L:4) Enhanced (ETP) (L:5)	W. Bor, M. R. Sanders & C. Markie-Dadds (2002) (Australia)	Randomized group comparison design 2 treatment groups; standard & enhanced, and waitlist	87 families with preschoolers (age 3.4) with co-occurring disruptive behaviour & ADD/ ADHD STP (*n*=29) ETP (*n*= 26) WL (*n*=32)	Enhanced Triple P (ETP) and a waitlist (WL) control condition	Family background interview, diagnostic interview based on DSM –IV , observation of mother child behaviour coded with the Revised Family Observation Schedule, parent-report measures (Beck depression inventory, Child abuse Potential Inventory, Eyberg Child Behavioural Inventory, Parent Daily Report, Parenting Scale, Parenting sense of Competency Scale, Parent Problem Checklist, Depression Anxiety Stress Scale, The client Satisfaction Questionnaire)	Pre/Post at 15-17 weeks, 12 Mo-FU	Both STP and ETP were associated with significantly lower parent reported child behaviour problems, lower levels of dysfunctional parenting and significantly greater parenting confidence than WL control. Both interventions produced significant reductions in children's co-morbid disruptive behaviour and attention problems. ETP was associated with significantly less observed disruptive child behaviour than the WL control. Gains were maintained at 1-year follow-up. ETP was not shown to be significantly superior to STP at post assessment or follow-up.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Individual Triple P (L:4) (L:5) Behavioral Family Intervention (BFI)	Sanders, M. R., & McFarland, M. (2000). (Australia)	Random Assignment	47 mothers diagnosed with major depression who are parents of children ages 3-9 diagnosed with ODD or CD	Level 4 as compared to Level 5	The Family Observation Schedule, Beck Depression Inventory, Automatic Thought Questionnaire, Parent Sense of Competence, Child Behavior Checklist, Parent Daily Report	Pre/Post 6 Mo-FU	Both treatments were equally effective in reducing mothers' depression and child disruptive behavior on observational and self-report. A 6-month follow-up more families in Individual (53%) compared to Enhanced Triple P (13%) experienced concurrent clinically reliable reductions in maternal depression and child disruptive behavior. These findings support the value of Enhanced triple P (CBFI) in reducing depression in mothers of children with disruptive behavior problems.
Standard Triple P & Self-Directed Triple P (L:4) Enhanced Triple P (L:5)	M. R. Sanders, C. Markie- Dadds, L. Tully & W. Bor (2000) (Brisbane, Australia)	RCT	305 preschoolers at high risk of developing conduct problems, age 3.4 ETP (n=76) STP (n=77) S-DTP (n=75) WL (n= 77)	Enhanced Triple P, Standard Triple P & Self-Directed Triple P compared to waitlist control	Family Background Interview, Observation, Beck Depression Inventory, Child Abuse Potential Inventory, Eyberg Child Behavior Inventory, Parent Daily Report, Parenting Scale, Parenting Sense of Competence Scale, Parent Problem Checklist, Abbreviated Dyadic Adjustment Scale, Depression Anxiety Stress Scales, Client Satisfaction Questionnaire	Pre/Post 12 Mo-FU	Children in the three intervention conditions showed greater improvement on mother-reported disruptive behaviour than the WL control. Only participants in the ETP and STP conditions showed significant improvement on observed disruptive child behaviour and father reports. No intervention effects were found for observed mother negative behaviour toward the child or for parent adjustment, conflict or relationship satisfaction. Mothers in all three-intervention conditions reported greater parenting confidence than controls. At 1-year follow-up, children receiving S-DTP had made further improvements on observed disruptive behaviour and all intervention groups were comparable on measures of child behaviour and parenting style.
Stepping Stones Triple P	K. Whittingham, K. Sofronoff, J. Sheffield & M. R. Sanders (2009)	RCT Mixed within-between-subjects design and a wait-list control group.	59 families with a child with ASD ages 2 to 9 Intervention (n=29) Wait-list (n=30)	Waitlist control Participants matched for functioning and parent-reported language development	Semi-structured diagnostic interview based on DSM-IV, Family Background Questionnaire, Eyberg Child Behaviour Inventory (ECBI), Parenting Scale, Being a Parent Scale	Pre/Post 6 Mo-FU	A significant reduction in parent reported childhood behaviour problems for the treatment group in comparison to the wait-list group (ECBI). Significant reduction in dysfunctional parenting styles for the treatment group. Parental over reactivity and parental verbosity maintained at follow-up 6 months later. Significant improvements in parental satisfaction and conflict about parenting as well as a sleeper effect for parental efficacy.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Stepping Stones Triple P (L:4) Enhanced Stepping Stones (L:5)	K. M. Plant & M. R. Sanders (2007) (Australia)	RCT	74 preschool-aged children with developmental disabilities,age 4.6 SSTP-E (n = 24) SSTP-S (n = 26) WL (n = 24)	SSTP-S: standard parent training intervention SSTP-E: enhanced parent training intervention combing parenting skills and care-giving coping skills WL: waitlist control	Family background questionnaire, Vineland Adaptive Behavior Scale, 30 min videotaped home observation of parent-child interaction, Eyberg Child Behavior Inventory, Developmental Behavior Checklist—Parent Version, Care-giving Problem Checklist, Care-giving Problem Checklist, Parenting Scale, Parenting Sense of Competence Scale, Depression, Anxiety and Stress Scales, Abbreviated Dyadic Adjustment Scale, The Client Satisfaction Questionnaire	Pre/Post (10 sessions) 12 Mo-FU	At post-intervention, both programs were associated with lower levels of observed negative child behavior, reductions in the number of care-giving settings where children displayed problem behavior, and improved parental competence and satisfaction in the parenting role as compared with the waitlist condition. Gains attained at post-intervention were maintained at 1-year follow-up. Both interventions produced significant reductions in child problem behavior, with 67% of children in the SSTP-E and 77% of children in the SSTPS showing clinically reliable change from pre-intervention to follow-up. Parents reported a high level of satisfaction with both interventions.
Stepping Stones Triple P	C. Roberts, T. Mazzucchelli, L. Studman & M. Sanders (2006) (Australia)	RCT	48 preschool children aged 2-7 age 4.3 with developmental disabilities Intervention (n=27) Waitlist (n=20)	Waitlist Control	Stanford-Binet Intelligence scale (4th ed). , Vineland Adaptive Behaviour Scale, Developmental Behaviour checklist, Family Observation Schedule-Revised III, Parenting Scale, Depression-Anxiety-Stress Scale, Client Satisfaction Questionnaire	Pre/Post 6 Mo-FU	Children in intervention condition showed fewer behaviour problems as reported by mothers and independent observers. Intervention group showed significantly improved maternal and paternal parenting style, and decreased maternal stress. All results maintained at 6 month follow-up.
Stepping Stones Triple P (L:4)	K. Whittingham, K. Sofronoff, J. K. Sheffield (2006) (Australia)	Mixed method. Series of multiple regression analyses on single treatment group plus focus group.	42 parents of children with Autism (age 5.9) 4 parents attended the focus group	none	Family background questionnaire, attribution and control questionnaire, parenting strategies questionnaire, follow up questionnaire	Pre/Post 2 wk -FU via phone	Parent's responses to the program were positive. Attribution of the child's behaviour to uncontrollable factors was found to predict higher ratings of usability. The focus group suggested that extra resources be included in the Stepping Stones program. These included, social stories, teaching children how to read facial expressions, relaxation training, using special interests as rewards and information for parents on medication.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Level 5: Enhanced Triple P / Pathways Triple P							
Enhanced Group Triple P (L:5)	M. R. Sanders, A. M. Pidgeon, F. Gravestock M. D. Connors, S. Brown & R. W. Young (2004) (Queensland, Australia)	Repeated-measures randomized group comparison design	98 parents experiencing significant difficulties in managing their own anger in their interactions with their preschool-aged children (ages 2-7) clients from Families, Youth and Community Care Queensland EGTP (n=35) SBIP (n=39)	Standard behavioral family intervention program (SBIP)	Family background interview, Observation of child behavior, Parent's Attributions for Child's Behavior, State-Trait Anger Expression Inventory, Parental Anger Inventory, Child Abuse Potential Inventory, Parent Opinion Questionnaire, Parenting Scale, Parent Sense of Competence, Depression-Anxiety-Stress Scales, Parent Problem Checklist, Eyberg Child Behavior Inventory, Parent Daily Report Checklist, Home and Community Problem Checklist, Client Satisfaction Questionnaire	Pre/Post 6 Mo-FU	At post-intervention, both conditions were associated with lower levels of observed and parent-reported disruptive child behavior, lower levels of parent-reported dysfunctional parenting, greater parental self-efficacy, less parental distress, relationship conflict and similarly high levels of consumer satisfaction. EGTP showed a significantly greater short-term improvement on measures of negative parental attributions for children's misbehavior, potential for child abuse and unrealistic parental expectations than SBFI. At 6-month follow-up both conditions showed similarly positive outcomes on all measures of child abuse potential, parent practices, parental adjustment, and child behavior and adjustment; however, EBFI continued to show greater change in negative parental attributions.
Enhanced Group Triple P	F. E. Hoath & M. R. Sanders (2002) (Australia)	RCT	21 parents of children ages 5-9 (age 7.7) diagnosed with ADHD	Waitlist Control	Child disruptive behaviour and attention problems, parenting style, parental adjustment, parenting conflict and relationship satisfaction.	Pre/Post 3 Mo-FU	EGTP demonstrated a clinically significant and reliable decrease in the level of child disruptive and impulsive behaviours in both home and school environments at post intervention. Significant change in child behaviour and parenting practices within individual families; decrease in child impulsivity and disruptive behaviours at home and school environments, increases in parental competence and satisfaction levels, decrease in family dysfunction maintained at 3-month follow-up. Levels of parental conflict, maternal stress, anxiety and depression were not statistically lower in treatment group.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Related Research							
Predicting Utilization of Triple P	M. R. Sanders, R. J. Prinz, C. J. Shapiro (2009)	Based on findings of a population level RCT of Triple P (Prinz and Sanders 2007)	Service providers with Triple P training (n=611)	none	Structured Interview: level of post-training program use, facilitators and barriers to program use, sociodemographic characteristics of providers, confidence in parent consultation skills, adequacy of training in parent consultation skills, self-efficacy in Triple P.	Structured interview 6 months following training Exploratory analyses, series of binary logistic regressions	High utilization factors: Practitioners who received training in Group Triple P, received positive client feedback, had experienced only minor barriers to implementation, and had consulted with other Triple P practitioners following training. Low utilization factors: lower levels of confidence in delivering Triple P and in consulting with parents in general, had difficulties in incorporating Triple P into their work, and where there was low workplace support.
Socio-Ecological Predictor Model of Parental Intention to Participate in Triple P	Y. Matsumoto, K. Sofronoff, M.R. Sanders (2009)	Multiple regression analyses was used to evaluate the Socio-Ecological Predictor Model	222 families (Japan)	none	Eyberg Child Behaviour Inventory, Strengths and Difficulties Questionnaire, Parenting Scale, Parent Problem Checklist, Relationship Quality Index, Problem Setting and Behaviour Checklist, Depression Anxiety Stress Scale, Family Background Questionnaire, Parental Intention Questionnaire	Survey, single wave	Findings indicate that the Socio-Ecological Predictor Model increases the predictive power of parental intention to participate (PIP) and accounts for 50% of the variance in PIP. Most significant predictor was program features, which accounted for 30% of the variance. Child, parent, sociodemographic, and program variables were significantly related to PIP. Knowledge about participation, including awareness of specific services and the perceived effectiveness of specific programs, was the strongest and most direct predictor of participation. Further predictive findings discussed in detail in full article.
All 5 levels Employed	M. R. Sanders, A. Ralph, K. Sofronoff, P. Gardiner, R. Thompson, S. Dwyer, K. Bidwell (2008)	Large-scale population trial. Non-Equivalent Groups Design	Primary care givers living in Brisbane, Sydney or Melbourne with a child aged 4-7. 2999 parents surveyed at Pre-intervention 3004 parents at follow up	Care as usual (CAU) comparison communities.	Validated parent report measures assessing known risk and protective factors. Strengths and difficulties questionnaire, recent parental and child mood rated, parental consistency, self-efficacy, parenting practice, social support, awareness of Triple P	Pre-test : Computer-assisted telephone interview of a random sample of households in each community 24 Mo-FU	At post-intervention there were significantly greater reductions in the Triple P communities in the number of children with clinically elevated and borderline behavioral and emotional problems compared to the CAU communities. Parents reported a greater reduction in the prevalence of depression, stress and coercive parenting. Findings show the feasibility of targeting dysfunctional parenting practices in a cost-effective manner and the public acceptance of an approach that blends universal and targeted program elements.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Triple P cost effectiveness	C. Mihalopoulos, M. R. Sanders, K. M.T. Turner, M. Murphy-Brennan & R. Carter (2007)	Threshold analysis was undertaken together with a limited cost-effectiveness analysis.	For the costs of Triple P, the base population of interest is the number of families in Queensland who have children aged 2-12 years of age. For the effectiveness of Triple P, the base population of interest is the number of children aged 6 -12 years who meet the criteria for conduct disorder.	N/A	Calculation of Triple P costs requires assumptions regarding the relevant proportions of the population to whom the intervention is applied. The cost associated with conduct disorder is estimated by way of published international literature.	N/A	The Triple P Positive Parenting Program is a dominant intervention; that is, it costs less than the amount it saves, until the reduction in prevalence falls below 7% where net costs become positive. The prevalence cost of implementing Triple P in Queensland to 572 701 children aged between 2 and 12 years of age (315 378 families) is $19.7 million (Level 1, $240 000; Level 2, $5.8 million; Level 3, $5.7 million; Level 4, $4 million; Level 5, $3.6 million) with an average cost of $34 per child.
Evaluation of Triple P program (All 5 Levels employed)	M. R. Sanders & M. L. Woolley (2004) (Queensland, Australia)	Post test only Non-Equivalent Groups Design	124 mothers of 2- to 8-year-old children with conduct problems. Clinic mothers recruited through involvement in the Triple P- Program at the Parenting and Family Support Centre, (PFSC) University of Queensland. (n=45) Non-clinic mothers from the community (n = 79).	Non-clinic community sample	The Family Background Questionnaire, social support cumulative risk index, Eyberg Child Behaviour Inventory, The Parenting Scale, The General Self-Efficacy scale, Parenting Sense of Competence Scale, The Parenting Tasks Checklist, The Behavioural Self-Efficacy subscale, The Setting Self-Efficacy subscale, Depression and Stress subscales of the Depression Anxiety Stress Scale	Post test only	Triple P mothers reported significantly lower self-efficacy than non-clinic mothers for all but one of the parenting tasks assessed. Clinic mothers rated themselves as significantly less confident than non-clinic mothers in handling 27 of the 28 child behaviours and settings assessed. Both groups of mothers reported lowest self-efficacy for similar parenting tasks. Authors suggest that parents seeking assistance for child behaviour problems are likely to have low self-efficacy in the daily tasks of parenting. These findings support the emphasis of interventions such as Triple P that aim to increase parental self-efficacy through teaching parents the skills they need to manage specific problems behaviours and pre-emptive or antecedent strategies that enable parents to plan, anticipate, select appropriate activities and encourage desirable behaviour at high-risk times.

PPP Program	Author / Date	Design	Sample	Comparison Group	Measures	Measure Times	Outcome
Triple P television segments	M. R. Sanders, D. T. Montgomery & M. L. Brechman-Toussaint (2000) (Australia)	RCT	56 mothers with children aged between 2 and 8 years ,age 4.6 TV condition (*n*=28) WL (*n*=28)	Waitlist Control	Eyberg Child Behavior Inventory, The Parenting Scale, Parenting Sense of Competence, Depression-Anxiety-Stress Scales, Parenting Problem Checklist, Abbreviated Acceptability Rating Profile	Pre/Post (Intervention watching 2 sessions/ week for 6 weeks) 6 Mo-FU	Mothers in the TV intervention condition reported significantly lower levels of disruptive child behaviour and higher levels of parenting confidence than controls following intervention. No changes were found on parenting strategies, conflict or parental adjustment. Results for the intervention group were maintained at 6-month follow-up.

Triple P Positive Parenting Program: Findings not published or not available in English

Triple P Program	Design	Sample	Comparison Group	Measures	Measure Times	Citation
(L:1-4) not discernable	Quasi-experimental field study	731 mothers and fathers (Switzerland)	Waitlist Control	Parenting Scale, Eyberg Child Behavior Inventory	Pre/Post 6 Mo-FU 12 Mo-FU	Cina, A., Ledermann, T., Meyer, J., Gabriel, B., & Bodenmann, G. (2004). *Triple P in der Schweiz: Zufriedenheit, Akzeptanz und Wirksamkeit (No. 162)* Institute for Family Research and Counseling, University of Fribourg, Switzerland.
Telephone Supported and Group Triple P (L:4)	Uncontrolled	508 parents who reported child behaviour problems, (community with >30% immigrants, high education) children aged 2-10 years. (Australia)	none	Parenting Scale, Parent Problem Checklist, Depression Anxiety Stress Scale, Eyberg Child Behavior Inventory	Pre/Post 6 Mo-FU 12 Mo-FU	Dean, C., Myors, K., & Evans, E. (2003). Community-wide implementation of a parenting program: The south east Sydney Positive Parenting Project. Australian e-Journal for the Advancement of Mental Health, 2. [journal no longer available]
Telephone Supported and Group Triple P (L:4)	RCT	(n=1174) Representative sample, higher weight for deprived quarters, child age 6.8 (Switzerland)	control group	Social behaviour Questionnaire, Alabama Parenting Questionnaire	Pre/Post 12 Mo-FU	Eisner, M., Ribeaud, D., Juenger, R., & Meidert, U. (2007). Fruehpraevention von Gewalt und Aggression. Ergebnisse des Zuercher Praeventions- und Interventionsprojektes an Schulen. Zuerich: Rueegger Verlag.
Self-Directed and Group Triple P (L:4)	RCT	(n=69) universal focus (Germany)	Waitlist Control	Parenting Scale, Fragebogen zum Erziehungsverhalten, Abbreviated Dyadic Adjustment Scale, Fragebogen zur Erfassung Partnerschaftlicher Kommunikationsmuster, Child Behavior Checklist, Strengths and Difficulties Questionnaire	Pre/Post	Feldmann, M., Heinrichs, N., Hahlweg, K., & Bertram, H. (2007). Bibliotherapie zur Verbesserung elterlicher Erziehungskompetenz: Eine randomisierte Evaluationsstudie. Verhaltenstherapie, 17, 26–35.

Triple P Program	Design	Sample	Comparison Group	Measures	Measure Times	Citation
Telephone Supported and Group Triple P (L:4)	Quasi-Experimental	219 parents of children aged 2–6 years (Germany)	Waitlist Control	Parenting Scale, Fragebogen zum Erziehungsverhalten, Abbreviated Dyadic Adjustment Scale, Child Behavior Checklist, Depression Anxiety Stress Scale	Pre/Post 12 Mo-FU	Heinrichs, N., Hahlweg, K., Bertram, H., Kuschel, A., Naumann, S., & Harstick, S. (2006). Die langfristige Wirksamkeit eines Elterntrainings zur universellen Praevention kindlicher Verhaltensstoerungen: Ergebnisse aus Sicht der Muetter und Vaeter Zeitschrift fuer Klinische Psychologie und Psychotherapie, 35, 72–86
Telephone Supported and Group Triple P (L:4)	RCT	(n=150) (Switzerland)	Waitlist control	Parenting Scale, FDCT: measure of relationship quality, Kommunikationsfragebogen Fragebogen zum Psychischen und Physischen Befinden, Eyberg Child Behavior Inventory	Pre/Post 6 Mo-FU 12 Mo-FU	Ledermann, T., Cina, A., Meyer, J., Barbara, G., & Bodenmann, G. (2004). Die Wirksamkeit zweier Praeventionsprogramme zur Verbesserung elterlicher Kompetenzen und kindlichen Befindens (No. 163) Switzerland: Institute for Family Research and Counseling, University of Fribourg.
Telephone Supported and Group Triple P (L:4)	RCT	54 self selected parents expressing concern about the behaviour of their child/ren ages 2-10. (Japan)	Waitlist Control	Parent Problem Checklist, Parenting Scale, Problem Setting and Behavior Checklist, Relationship Quality Scale, Depression Anxiety Stress Scale, Eyberg Child Behavior Inventory, Strengths and Difficulties Questionnaire	Pre/Post 6 Mo-FU	Matsumoto, Y., Sofronoff, K., & Sanders, M. R. (under review). Triple P- Positive Parenting Program in Japanese society: Comparison between effectiveness and efficacy trials.
Individual Triple P (L:2/3)	Quasi-experimental	34 self selected parents expressing concern about the behaviour of their child/ren, average age 4.6 (Germany)	Waitlist Control	Parenting Scale, Parenting Sense of Competence scale	Pre/Post	Neumann, S. (2003). Evaluation der praeventiven "Triple Pkurzberatung" (Positive Parenting Program): Veraenderungen im elterlichen Erziehungsverhalten [Evaluation of preventative brief Triple P counseling: Changes in parenting behavior]. Muenster, Germany: Westfaelische Wilhems-University. [in Winker, 2006]

Triple P Program	Design	Sample	Comparison Group	Measures	Measure Times	Citation
Individual Triple P (L:2/3)	Quasi-experimental	34 self selected parents expressing concern about the behaviour of their child/ren, average age 4.6 (Germany)	Waitlist Control	Strengths and Difficulties Questionnaire	Pre/Post	Nielebock, A. (2003). Evaluation der praeventiven "Triple Pkurzberatung" (Positive Parenting Program): Veraenderungen im kindlichen Verhalten [Evaluation of preventative brief Triple P counseling: Changes in child behavior]. Muenster, Germany: Westfaelische Wilhems-University [in Winker, 2006]
Telephone Supported and Group Triple P (L:4)	Uncontrolled	(n=29) (Germany)	none	Parenting Scale, Eyberg Child Behavior Inventory	Pre/Post	Penthin, R., Schrader, C., & Mildebrandt, N. (2005). Erfahrungen mit der deutschen Version des Triple-P-Elterntrainings bei Familien mit und ohne ADHS-Problematik [Experiences with the German version of Triple P parent training with families with and without ADHS problems]. Zeitschrift fuer Heilpaedagogik, 5, 186–192.
Telephone Supported and Group Triple P (L:4) Workplace Triple P (L:4)	RCT	123 parents of children age 1-16 reporting work-home management distress (Australia)	Waitlist Control	Depression–Anxiety–Stress Scale, Parenting Scale, Parenting Task Checklist, Work Stress Scale, Eyberg Child Behavior Inventory, Job Satisfaction Scale, Work Commitment Questionnaire, Work and Life Attitudes Survey,	Pre/Post 12 Mo-FU	Sanders, M. R., & Stallman, H. (under review). Workplace Triple P: A controlled evaluation of a parenting intervention for working parents.
Info Campaign (L:1) Telephone Supported (L:2)	Quasi-exparimental field study	(n=1336) (Switzerland)	Waitlist Control	Resilienzskala [Resilience Scale], Depression–Anxiety–Stress Scale, Relationship Assessment Scale, INCOPE II, Parenting Scale, Strengths and Difficulties Questionnaire, Problem Setting and Behavior Checklist,	Pre/Post 4 Mo-FU	Schmid, H., Anliker, S., Bodenmann, G., Cina, A., Faeh, B., Kern, W., et al. (2007). Empowerment in family and school (EIFAS): A randomised controlled trial. Unpublished report.
Telephone Supported Self-Directed Teen Triple P (L:4)	RCT	51 parents expressing concern about behaviour of child/ren aged 11-14. (Australia)	Waitlist Control	Parenting Scale Adolescent Version, Parent Problem Checklist, Relationship Quality Scale, Depression–Anxiety–Stress Scale	Pre/Post 3 Mo-FU	Stallman, H., Ralph, A., & Sanders, M. R. (2005). Evaluation of self-directed Teen Triple P: A behavioural family intervention to reduce risk factors for adolescent behavioural and emotional problems. Unpublished manuscript.

Triple P Program	Design	Sample	Comparison Group	Measures	Measure Times	Citation
Triple P (L:3)	RCT	48 parents expressing concern about behaviour of child/ren aged 2-8, including 26 participants from another RCT	Waitlist Control	Parenting Scale, Parent Sense of Competence, , Strengths and Difficulties Questionnaire	Pre/Post	Winkler, N. (2006). Veraenderungen im elterlichen Erziehungsverhalten, im Kompetenzgefuehl von Eltern und im kindlichen Verhalten durch die Teilnahme an einer Kurzberatung. Eine Evaluation der Ebene 3 der Triple P-Elternberatung (Positive Parenting Program) Muenster: Westfaelische Wilhelms-Universitaet Muenster [Changes in parenting behavior, parental feelings of competence, and child behavior through participation in a brief counseling. An evaluation of level 3 Tripe P].

Appendix B

supported parenting survey

Family and Disability Studies

UNIVERSITY OF ALBERTA

parentLINKcentre

Thank you for taking the time to complete this survey. The information you provide will help us better understand parents' information and support needs, and help us improve services for families in the community.

The survey includes questions about you, the health and wellbeing of your child and family, the challenges and rewards involved in parenting, and the information and support you have received from your Parent Link Centre.

Once you have completed the survey, please return it to us, together with the signed consent form, in the postage paid envelope provided. If you have any questions, you may call: Dr David McConnell at 780 492 7475.

Most of the questions in this survey ask you to choose from a list of possible answers, such as "I agree", or "I disagree". You select your answer by filling in the corresponding circle. For example

Question: Do you live in Canada?

● Yes ○ No

This first section of the questionnaire asks about the support and services you have received from your **Parent Link Centre**.

1 **What kind of support have you received from your Parent Link Centre?** Please fill all that apply.

- ○ Information, education and/or training (e.g. tip sheets, parenting skills)
- ○ Emotional or moral support (e.g. understanding & encouragement)
- ○ Good company (e.g. opportunity to do fun things with people you like)
- ○ Practical help (e.g. toy lending, clothing exchange, transport, help with filling out forms etc.)

2 **In the last three months, did you receive any of the following supports or services from your Parent Link Centre?** Please fill all that apply.

- ○ Information, including handouts or 'tip sheets'
- ○ Individual (one to one) parent education
- ○ Group-based (with other parents) parent education
- ○ Family support (for example: collective kitchen, toy lending, clothing exchange)
- ○ Child development screening
- ○ 'Drop-in' playgroup activities for you and your child
- ○ Other (please describe)

3 **When did you first visit your Parent Link Centre?**

- ○ Sometime in the past three months
- ○ Earlier this year (January-March)
- ○ Sometime last year, 2008
- ○ Before 2008

4 **In the last three months, how many times have you been down to your Parent Link Centre and/ or attended a Parent Link Centre program/event?**

- ○ Just once
- ○ No more than two or three times
- ○ Four or five times
- ○ More than five times
- > How many times would you say (e.g. 7 times)? ☐

5 **Have you ever received Triple P parent education?** (including Triple P tip sheets, one-to-one or group-based Triple P parent education)

○ Yes ○ No ○ Don't know

6 **In the last three months, did you receive Triple P parent education?** (including Triple P tip sheets, one-to-one or group-based Triple P parent education)

○ Yes ○ No ○ Don't know

7a **In the last three months did you receive any support from your Parent Link Centre with issues to do with your relationship with your partner?**

○ Yes ○ No ○ Not applicable

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7b **In the last three months did you receive any support from your Parent Link Centre with issues to do with your baby/infant?**

○ Yes ○ No ○ Not applicable

If Yes, what specific issues?

○ Sleep patterns

○ Crying or irritable baby

○ Separation anxiety

○ Development

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7c **In the last three months did you receive any support from your Parent Link Centre with issues to do with your toddler?**

○ Yes ○ No ○ Not applicable

If Yes, what specific issues?

○ Sharing

○ Tantrums

○ Hurting others

○ Listening/obedience

○ Bedtime problems

○ Toilet training

○ Language development

○ Whining

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7d **In the last three months did you receive any support from your Parent Link Centre with issues to do with your pre-school age child?**

○ Yes ○ No ○ Not applicable

If Yes, what specific issues?

- ○ Separation problems
- ○ Nightmares and night terrors
- ○ Mealtime problems
- ○ Listening/obedience
- ○ Fighting and aggression
- ○ Going shopping

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7e **In the last three months did you receive any support from your Parent Link Centre with issues to do with your elementary school age child?**

○ Yes ○ No ○ Not applicable

If Yes, what specific issues?

- ○ Behaviour at school
- ○ Being bullied
- ○ Bedwetting
- ○ Self esteem
- ○ Listening/obedience
- ○ Lying or stealing
- ○ Homework
- ○ Fears
- ○ Chores
- ○ Attention Deficit Hyperactivity Disorder (ADHD)

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7f **In the last three months did you receive any support from your Parent Link Centre with issues to do with your teenager?**

○ Yes ○ No ○ Not applicable

If Yes, what specific issues?

- ○ Friends and peer relationships
- ○ Coping with anxiety or depression
- ○ Drug or alcohol use
- ○ Sexual activity and dating
- ○ Rudeness and disrespect
- ○ Truancy / skipping school
- ○ Fads and fashions
- ○ Smoking

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7g **In the last three months did you receive any support from your Parent Link Centre with personal issues?**

○ Yes ○ No ○ Not applicable

If Yes, what specific issues?

- ○ Feeling depressed
- ○ Coping with stress
- ○ Feeling alone
- ○ Balancing work and family
- ○ Being a parent

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

7h **In the last three months did you receive any support from your Parent Link Centre with any other issues?**

○ Yes ○ No ○ Not applicable

If Yes, please describe?

If Yes, do you now feel more confident in dealing with these issues?

○ Not at all confident ○ A little more confident ○ A lot more confident

8 **In the last three months, did you get the type of help you wanted from your Parent Link Centre?**

①	②	③	④	⑤	⑥	⑦
Definitely not		No, not really		Yes, generally		Yes, definitely

9 **In the last three months, to what extent did the Parent Link Centre meet your needs as a parent?**

①	②	③	④	⑤	⑥	⑦
No needs have been met		Only a few have been met		Most needs have been met		Almost all needs have been met

10 **In the last three months, did your Parent Link Centre help you to deal more effectively with your child's behaviour?**

①	②	③	④	⑤	⑥	⑦
No, it made things worse		No, it has not helped much		Yes, it has helped somewhat		Yes, it has helped a great deal

11 **In the last three months, did your Parent Link Centre help you to deal more effectively with problems that arise in your family?**

①	②	③	④	⑤	⑥	⑦
No, it made things worse		No, it has not helped much		Yes, it has helped somewhat		Yes, it has helped a great deal

Please tell us a little about your child. If you have more than one child, please tell us about **the child you are most concerned about** (i.e. who is the most challenging?)

12 **Child's gender**

○ Male ○ Female

13 **Child's age** (years and months):

14 **What is your relationship to this child?**

○ Mother (biological or adoptive)
○ Step mother
○ Foster mother
○ Father (biological or adoptive)
○ Step father
○ Foster father
○ Other (please describe)

15 **In general, would you say this child's health is:**

Poor	Fair	Good	Very good	Excellent
①	②	③	④	⑤

16 **Does this child have any of the following long-term conditions which have been diagnosed by a health professional?** Please fill all that apply.

○ Vision impairment
○ Hearing impairment
○ Intellectual disability (mental handicap)
○ Asthma or severe allergies
○ Heart condition or disease
○ Kidney condition or disease
○ Diabetes
○ Epilepsy
○ Cystic Fibrosis
○ Autism Spectrum Disorder
○ Fetal Alcohol Spectrum Disorder
○ Cerebral palsy
○ Spina Bifida
○ Muscular Dystrophy
○ Down syndrome
○ Missing or malformed arms, legs, fingers or toes
○ Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)
○ Emotional, psychological or nervous difficulties
○ Complex medical care needs
○ Other condition/s (please describe)

If this child is **three years of age or older,** please go to question 17 on the next page.

If this child is **less than three years of age,** please go to question 42 on page 9.

Please tell us more about this child's behavior over the last six months. Answer all items as best you can even if you are not absolutely certain.

		Not True	Somewhat True	Very True
17	**Considerate of other people's feelings**	①	②	③
18	**Restless, overactive, cannot stay still for long**	①	②	③
19	**Often complains of headaches, stomach-aches or sickness**	①	②	③
20	**Shares readily with other children (treats, toys, etc.)**	①	②	③
21	**Often has temper tantrums or hot tempers**	①	②	③
22	**Rather solitary, tends to play alone**	①	②	③
23	**Generally obedient, usually does what adults request**	①	②	③
24	**Many worries, often seems worried**	①	②	③
25	**Helpful if someone is hurt, upset or feeling ill**	①	②	③
26	**Constantly fidgeting or squirming**	①	②	③
27	**Has at least one good friend**	①	②	③
28	**Often fights with other children or bullies them**	①	②	③
29	**Often unhappy, down-hearted or tearful**	①	②	③
30	**Generally liked by other children**	①	②	③
31	**Easily distracted, concentration wanders**	①	②	③
32	**Nervous or clingy in new situations, easily loses confidence**	①	②	③
33	**Kind to younger children**	①	②	③
34	**Often lies or cheats**	①	②	③
35	**Picked on or bullied by other children**	①	②	③
36	**Often volunteers to help others (parents, teachers, other children)**	①	②	③
37	**Thinks things out before acting**	①	②	③
38	**Steals from home, school or elsewhere**	①	②	③
39	**Gets along better with adults than with other children**	①	②	③
40	**Many fears, easily scared**	①	②	③
41	**Sees tasks through to the end, good attention span**	①	②	③

42 **Do you use any kind of child care service for this child?**

○ Yes ○ No

If Yes, which of the following kinds of child care services are you using for this child?

○ Childcare centre

○ Before or after school care program

○ Private home day care

○ Parent/child drop-in program

○ Child drop-off centre for occasional use

○ Paid arrangement with a caregiver

○ Unpaid arrangement with a caregiver

○ Nursery school

○ Toy library

○ Playgroup

○ Other (please describe)

43 **Approximately how many hours each week, on average, would this child be cared for by others** (including for example, child care services and/or grandparents)**?**

○ less than 6 hours ○ 6-12 hours ○ 12-18 hours ○ 18-24 hours ○ more than 24 hours

44 **Given the choice, would you like to use less, the same number, or more hours of childcare?**

○ Less ○ Same number of hours ○ More

The following questions are about your parenting style. If you have more than one child, please think *again* about the child you are most concerned about or who is the most challenging.

		Not applicable	Never	Less than half the time	About half the time	More than half the time	All the time
45	**If there is a parenting decision to be made** (i.e. rules to be set, child misbehaving, school decisions)**, how often do you and your spouse/partner agree on what to do?**	○	①	②	③	④	⑤

If this child is **12 years of age or older** please go to question 71 on page 13.

		Never	About once a week or less	A few times a week	One or two times a day	Many times each day
46	**How often do you praise this child, by saying something like "Good for you!" or "What a nice thing you did!", or "That's good going!" ?**	①	②	③	④	⑤
47	**How often do you and this child talk or play with each other, focusing attention on each other for five minutes or more, just for fun?**	①	②	③	④	⑤
48	**How often do you and this child laugh together?**	①	②	③	④	⑤
49	**How often do you get annoyed with this child for saying or doing something he/she is not supposed to?**	①	②	③	④	⑤
50	**How often do you tell this child that he/she is bad or not as good as others?**	①	②	③	④	⑤
51	**How often do you do something special with this child that he/she enjoys?**	①	②	③	④	⑤
52	**How often do you play sports, hobbies, or games with this child?**	①	②	③	④	⑤

		Never	Less than half the time	About half the time	More than half the time	All the time
53	**Of all the times that you talk to this child about his/her behavior, what proportion is praise?**	①	②	③	④	⑤
54	**Of all the times that you talk to this child about his/her behavior, what proportion is disapproval?**	①	②	③	④	⑤

If this child is **less than two years of age** please go to question 81 on page 14.

		Not applicable	Never	Less than half the time	About half the time	More than half the time	All the time
55	**When you give this child a command or order to do something, what proportion of the time do you make sure that he/she does it?**	○	①	②	③	④	⑤
56	**If you tell this child he/she will get punished if he/she doesn't stop doing something, and he/she keeps doing it, how often will you punish him/her?**	○	①	②	③	④	⑤
57	**How often does this child get away with things for which you feel he/she should have been punished?**	○	①	②	③	④	⑤
58	**How often do you get angry when you punish this child?**	○	①	②	③	④	⑤
59	**How often do you think that the kind of punishment you give this child depends on your mood?**	○	①	②	③	④	⑤
60	**How often do you feel you are having problems managing this child in general?**	○	①	②	③	④	⑤
61	**How often is this child able to get out of a punishment when he/she really sets his/her mind to it?**	○	①	②	③	④	⑤
62	**How often when you discipline this child, does he/she ignore the punishment?**	○	①	②	③	④	⑤
63	**How often do you have to discipline this child repeatedly for the same thing?**	○	①	②	③	④	⑤

When this child breaks the rules or does something that he/she is not supposed to, how often do you...

		Never	Rarely	Sometimes	Often	Always
64	**tell this child to stop?**	①	②	③	④	⑤
65	**ignore it or do nothing?**	①	②	③	④	⑤
66	**raise your voice, scold or yell at this child?**	①	②	③	④	⑤
67	**calmly discuss the problem with this child?**	①	②	③	④	⑤
68	**use physical punishment?**	①	②	③	④	⑤
69	**describe alternative ways of behaving that are acceptable?**	①	②	③	④	⑤
70	**take away privileges or send this child to their room?**	①	②	③	④	⑤

If this child is **less than twelve years of age** please go to question 81 on page 14.

People often disagree with each other. The following sentences describe situations. How often do you and this child do the following things?

		Not at all	A little	Sometimes	Pretty often	Almost all the time
71	**We disagree and fight.**	①	②	③	④	⑤
72	**We make up easily when we have a fight.**	①	②	③	④	⑤
73	**We bug each other or get on each other's nerves.**	①	②	③	④	⑤
74	**We yell at each other.**	①	②	③	④	⑤
75	**When we argue, we stay angry for a very long time.**	①	②	③	④	⑤
76	**When we disagree, I refuse to talk to this child.**	①	②	③	④	⑤
77	**When we disagree, this child stomps out of the room, house, or yard.**	①	②	③	④	⑤
78	**When we disagree about something, we solve the problem together.**	①	②	③	④	⑤
79	**When we disagree about something, I give in just to end the argument.**	①	②	③	④	⑤
80	**When we disagree another person comes in to settle things or find a solution.**	①	②	③	④	⑤

The following questions are about how you feel as a parent. In answering these questions, please think again about the child you are most concerned about or who is the most challenging. Choose the response which best describes your feelings. **Your first reaction** to each question should be your answer.

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
81	**I often have the feeling that I cannot handle things well.**	①	②	③	④	⑤
82	**I find myself giving up more of my life to meet my children's needs than I ever expected.**	①	②	③	④	⑤
83	**I feel trapped by my responsibilities as a parent.**	①	②	③	④	⑤
84	**Since having this child I have been unable to do new and different things.**	①	②	③	④	⑤
85	**Since having a child I feel that I am almost never able to do the things that I like to do.**	①	②	③	④	⑤
86	**I am unhappy with the last purchase of clothing I made for myself.**	①	②	③	④	⑤
87	**There are quite a few things that bother me about my life.**	①	②	③	④	⑤
88	**Having a child has caused more problems than I expected in my relationship with my spouse/partner.**	①	②	③	④	⑤
89	**I feel alone and without friends.**	①	②	③	④	⑤
90	**When I go to a party I usually expect not to enjoy myself.**	①	②	③	④	⑤
91	**I am not as interested in people as I used to be.**	①	②	③	④	⑤
92	**I don't enjoy things as I used to.**	①	②	③	④	⑤

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
93	**My child rarely does things for me that make me feel good.**	①	②	③	④	⑤
94	**Most times I feel that my child does not like me and does not want to be close to me.**	①	②	③	④	⑤
95	**My child smiles at me much less than I expected.**	①	②	③	④	⑤
96	**When I do things for my child I get the feeling that my efforts are not appreciated very much.**	①	②	③	④	⑤
97	**When playing, my child doesn't often giggle or laugh.**	①	②	③	④	⑤
98	**My child doesn't seem to learn as quickly as most children.**	①	②	③	④	⑤
99	**My child doesn't seem to smile as much as most children.**	①	②	③	④	⑤
100	**My child is not able to do as much as I expected.**	①	②	③	④	⑤
101	**It takes a long time and it is very hard for my child to get used to new things.**	①	②	③	④	⑤

102 **I feel that I am ...**

- ○ not very good at being a parent
- ○ a person who has some trouble being a parent
- ○ an average parent
- ○ a better than average parent
- ○ a very good parent

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
103	**I expected to have closer and warmer feelings for my child than I do and this bothers me.**	①	②	③	④	⑤
104	**Sometimes my child does things to bother me just to be mean.**	①	②	③	④	⑤
105	**My child seems to cry or fuss more often than most children.**	①	②	③	④	⑤
106	**My child generally wakes up in a bad mood.**	①	②	③	④	⑤
107	**I feel that my child is very moody and easily upset.**	①	②	③	④	⑤
108	**My child does a few things which bother me a great deal.**	①	②	③	④	⑤
109	**My child reacts very strongly when something happens that my child doesn't like.**	①	②	③	④	⑤

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
110	**My child gets upset easily over the smallest thing.**	①	②	③	④	⑤
111	**My child's sleeping or eating schedule was much harder to establish than I expected.**	①	②	③	④	⑤

112 **I have found that getting my child to do something or stop doing something is...**

- ○ much harder than I expected
- ○ somewhat harder than I expected
- ○ about as hard as I expected
- ○ somewhat easier than I expected
- ○ much easier than I expected

113 **Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.**

○ 10+ ○ 8-9 ○ 6-7 ○ 4-5 ○ 1-3

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
114	**There are some things my child does that really bother me a lot.**	①	②	③	④	⑤
115	**My child turned out to be more of a problem than I had expected.**	①	②	③	④	⑤
116	**My child makes more demands on me than most children.**	①	②	③	④	⑤

The next section of the questionnaire asks about you, your health and your wellbeing.

117 **What is your age?** (in years)

118 **What is your gender?**

○ Male ○ Female

119 **What is your marital status?**

○ Married ○ Living with a partner
○ Single – never married ○ Widowed
○ Separated ○ Divorced

120 **Were you born in Canada?**

○ Yes ○ No

If "no", where were you born?

And, how many years have you now been in Canada?

121 **What language do you most often speak at home?**

○ English
○ French
○ Other (please specify)

122 **To which ethnic or cultural groups do you and your family belong?**

○ Inuit
○ Métis
○ North American Indian
○ Other (please specify)

123 **What is the highest level of education you have completed?**

- ○ Less than grade 10
- ○ Grade 10 or 11
- ○ Grade 12
- ○ Trade / Apprenticeship
- ○ College certificate / diploma
- ○ University undergraduate Degree (Bachelor's)
- ○ University postgraduate Degree (Master's or PhD)

124 **Did you receive any special support with learning at school?** (e.g. were you ever in a special class or attend a special school for children with learning difficulties)

○ Yes ○ No

125 **How would you rate your general ability to learn new things?**

Poor	Below average	Average	Good	Excellent
①	②	③	④	⑤

126 **Do you receive a disability support pension or benefit?**

○ Yes ○ No

If yes, what is your disability? (Please describe)

127 **Are you currently employed?**

○ Yes ○ No

If yes, about how many hours per week?

128 **If yes to question 127, which of the following best describes the hours you usually work?**

- ○ Regular daytime schedule or shift
- ○ Regular evening shift
- ○ Regular night shift
- ○ Rotating shift (for example, change from days to evenings to nights)
- ○ Split shift (for example, some hours in the day and the remainder in the evening or night)
- ○ On call
- ○ Irregular schedule

129 **Do you have any diagnosed long term health condition?**

○ Yes ○ No

What specific condition? (Please fill all that apply)

- ○ Heart condition ○ Asthma
- ○ Diabetes ○ Epilepsy
- ○ Kidney disease
- ○ Emotional, psychological or nervous difficulties
- ○ Other (please describe)

130 **In general, would you say your health is:**

Poor	Fair	Good	Very good	Excellent
①	②	③	④	⑤

131 **Over the past two weeks, have you felt down, depressed, or hopeless?**

○ Yes ○ No

132 **Over the past two weeks, have you felt little interest or pleasure in doing things?**

○ Yes ○ No

The next few questions are about your support network.

133 **How many people are so close to you that you can count on them if you have serious problems?**

None	1 or 2	3 to 5	6 to 10	More than 10
○	○	○	○	○

134 **How supportive has your partner been towards you over the last six weeks?**

Not applicable	Not at all	Slightly	Moderate	Very	Extremely
○	①	②	③	④	⑤

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
135	**If something went wrong, no-one would help me.**	①	②	③	④	⑤
136	**I have family and friends who help me feel safe, secure and happy.**	①	②	③	④	⑤
137	**There is someone I trust whom I would turn to for advice if I were having problems.**	①	②	③	④	⑤
138	**There is no one I feel comfortable talking about problems with.**	①	②	③	④	⑤
139	**I lack a feeling of closeness with another person.**	①	②	③	④	⑤
140	**There are people I can count on in an emergency.**	①	②	③	④	⑤
141	**I feel part of a group who shares my attitudes and beliefs.**	①	②	③	④	⑤
142	**There is no one who shares my interest and concerns.**	①	②	③	④	⑤

Thinking now about your family and household ...

143 **How many people live in your household?** ☐

144 **How many of them are under the age of 6?** ☐

145 **How many are 6 to 12 years of age?** ☐

146 **How many are 13 to 17 years of age?** ☐

147 **Including yourself, how many of them are 18 years of age or older?** ☐

148 **How many children in your household have a long-term physical condition, mental condition, learning or health problem that reduces the amount or kind of activities they can do?** ☐

149 **How many bedrooms do you have in your home?** ☐

150 **Which best describes your household?**

- ○ Original family (both biological or adoptive parents present)
- ○ Blended family (two parents, with at least one being a step parent)
- ○ Sole parent family
- ○ Other (please describe)

The following statements are about how you get along together as a family.
For each one, please choose the response that best describes your family.

		Strongly disagree	Disagree	Agree	Strongly agree
151	**Planning family activities is difficult because we misunderstand each other.**	①	②	③	④
152	**In our family we feel accepted for what we are.**	①	②	③	④
153	**Making decisions is a problem for our family.**	①	②	③	④
154	**In times of crisis we can turn to each other for support.**	①	②	③	④
155	**We cannot talk to each other about sadness we feel.**	①	②	③	④
156	**Individuals (in the family) are accepted for what they are.**	①	②	③	④
157	**We avoid discussing our fears or concerns.**	①	②	③	④
158	**There are lots of bad feelings in our family.**	①	②	③	④
159	**We are able to make decisions about how to solve problems.**	①	②	③	④
160	**We don't get along well together.**	①	②	③	④
161	**We confide in each other.**	①	②	③	④
162	**We express feelings to each other.**	①	②	③	④
163	**Drinking is a source of tension or disagreement in our family.**	①	②	③	④

The next questions are about how your family is doing financially:

164 **In the next three months, how often do you think that you and your family will experience bad times such as poor housing or not having enough food?**

- ○ Almost never
- ○ Once in a while
- ○ Sometimes
- ○ A lot of the time
- ○ Almost always

165 **In the next three months, how often do you expect that you will have to do without the basic things that your family needs?**

- ○ Almost never
- ○ Once in a while
- ○ Sometimes
- ○ A lot of the time
- ○ Almost always

166 **Thinking back over the past three months, how much difficulty have you had paying your bills?**

- ○ No difficulty at all
- ○ A little difficulty
- ○ Some difficulty
- ○ Quite a bit of difficulty
- ○ A great deal of difficulty

167 **Thinking again over the past three months. Generally, at the end of the each month did you end up with:**

- ○ More than enough money left
- ○ Some money left
- ○ Just enough money left
- ○ Somewhat short of money
- ○ Very short of money

168 **Over the last 12 months, what was your total household income?**

- ○ Less than $20,000
- ○ $20,000 to $29,999
- ○ $30,000 to $39,999
- ○ $40,000 to $49,999
- ○ $50,000 to $59,999
- ○ $60,000 to $69,999
- ○ $70,000 to $79,999
- ○ $80,000 to $89,999
- ○ $90,000 to $99,999
- ○ $100,000 to $149,999
- ○ More than $150,000

169 **In your own words, please describe how your Parent Link Centre has helped you and your family**

Thank you so much for assisting us with this important project.

To thank you for your valuable contribution, and the time you put into this project, we would like to pay you $30.00. To do this we will need your name and mail address. Please print carefully.

Please note that as soon as we receive this questionnaire back from you we will remove this page and store it separately so no one will know that this questionnaire came from you. The information you have given us will remain strictly confidential.

Name:

Address:

Supporting parents is arguably the most effective way of supporting children: Parents can be their children's primary source of support and/or their primary source of vulnerability. To improve support for parents and disseminate effective parenting strategies, Alberta Children and Youth Services implemented a pilot of the Positive Parenting Program, known as "Triple P", in selected Parent Link Centres (PLCs) around the province. Triple P International Pty Ltd. was contracted to provide training and accreditation for 60 PLC Staff in Level 2 (provision of parenting advice through seminars and brief consultations with parents) and Level 3 (narrow-focus parent skills training) in 2007-2008. This report details the findings from the evaluation of this pilot. The evaluation had three main aims. The first was to examine the process of integrating Triple P into PLCs, including barriers and facilitators to implementation. The second aim was to determine whether Triple P enhances parent, child and family outcomes compared to PLC services-as-usual. The third aim was to investigate factors that potentially moderate the effects of parent training and support.

Family and Disability Studies
University of Alberta

Creative Services 10996

ISBN: 978-1-55195-268-0