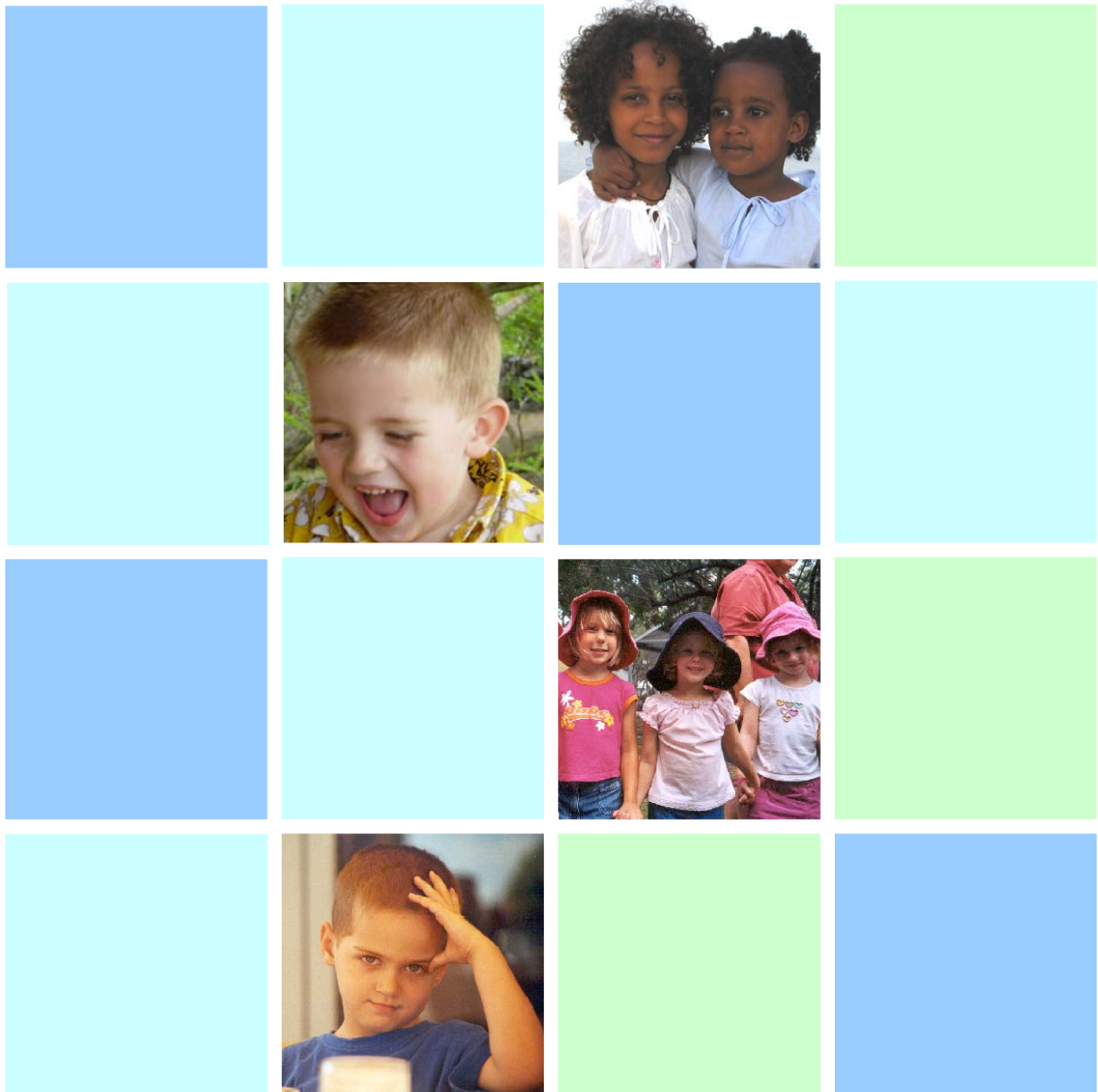


Every Family: *A public health approach to promoting children's wellbeing*

Brief Report



Matthew R. Sanders, Alan Ralph, Rachel Thompson, Kate Sofronoff, Paul Gardiner
Parenting and Family Support Centre, The University of Queensland
and
Kerry Bidwell, Sarah Dwyer
Queensland Divisions of General Practice

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1 INTRODUCTION

1.1 Background context

A substantial body of evidence shows that the quality of parenting children receive has a major effect on their development. Family risk factors such as poor parenting, family conflict and marriage breakdown strongly influence children's risk of developing mental health problems. Specifically, a lack of a warm positive relationship with parents; insecure attachment; harsh, inflexible or inconsistent discipline practices; inadequate supervision of and involvement with children; marital conflict and breakdown; and parental psychopathology (particularly maternal depression) increase the risk that children will develop major behavioural and emotional problems, including depression and conduct problems.

1.2 *beyondblue* and prevention

Every Family is one of a series of projects funded by *beyondblue*: the national depression initiative, as part of its policy framework on prevention and early intervention. The three specific priority areas addressed by *Every Family* are: 1) developing prevention and early intervention approaches; 2) better training for service providers; and 3) support for depression-related research.

2 WHAT IS EVERY FAMILY?

2.1 Aims of *Every Family*

Every Family represents the largest population health trial of a parenting intervention focusing on the prevention of serious behavioural and emotional problems in children in Australia. The central question examined was whether the Triple P-Positive Parenting Program could successfully improve parent-child relationships and thereby, reduce the prevalence of behavioural and emotional problems in children making the transition to school. By reducing early conduct problems and anxiety and by promoting positive family relationships children would be less vulnerable to developing later serious emotional problems such as depression or conduct disorders. *Every Family* aimed to:

- Reduce the prevalence of common emotional and behavioural problems in children, including conduct problems and anxiety as precursors to later depression.
- Increase parents' confidence and competence in their parenting role.
- Decrease the prevalence of parental distress (depression, anxiety and stress) associated with parenting.
- Refine pathways to different levels of mental health care for children and their families.
- Evaluate the impact of a community-based model for mental health promotion, prevention and early intervention that could be adapted for implementation in other parts of Australia.

2.2 Why the Triple P model of intervention?

The Triple P-Positive Parenting Program was selected as the model of parenting intervention to use due to its extensive evidence base. It is also the only multi-level system of parenting and family support specifically developed as a population level strategy¹. Triple P aims to prevent

¹ Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review*, 2, 71-90.

severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength (see Figure 1) for parents of children and adolescents from birth to age 16. The program adopts the concept of a “family friendly” environment to support and empower parents. Interventions target everyday social contexts that influence parents including the mass media, primary health care services, preschool, child care and school systems, worksites, religious organisations, and the political system.

Triple P applies principles and strategies derived from social learning theory to increase parents’ self efficacy in raising their children. It targets five core parenting principles. These are 1) creating a safe engaging environment for children, 2) creating a positive learning environment, 3) assertive discipline, 4) reasonable expectations and 5) looking after oneself as a parent. Parents in turn learn how to encourage children to develop a variety of social and emotional skills to succeed at school and in relationships. Children learn how to communicate and get on with others, manage their feelings, be independent, and solve problems for themselves.

2.3 How does Triple P work at a community level?

Figure 1 depicts the differing levels of intensity and reach of the Triple P system, as applied in *Every Family*. Level 1, a universal parent information strategy, provides all interested parents with access to useful information about parenting through a coordinated media and promotional campaign using print and electronic media, as well as user-friendly parenting tip sheets and videotapes which demonstrate specific parenting strategies. This level of intervention aims to increase community awareness of parenting resources, receptivity of parents to participating in programs, and to create a sense of optimism by depicting solutions to common behavioural and developmental concerns. Level 2 is a brief, one- to two-session individual primary care intervention or a one- to three-session large group seminar program providing early anticipatory developmental guidance to parents of children with mild to moderate behaviour difficulties. Level 3, a four-session intervention, targets children with moderate behaviour difficulties and includes active skills training for parents. Level 4 is an intensive eight-to-ten session individual or group parent training program for children with more severe behavioural difficulties and Level 5 (which is deployed in conjunction with Level 4) is an enhanced family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. marital conflict, parental depression, or high levels of stress).

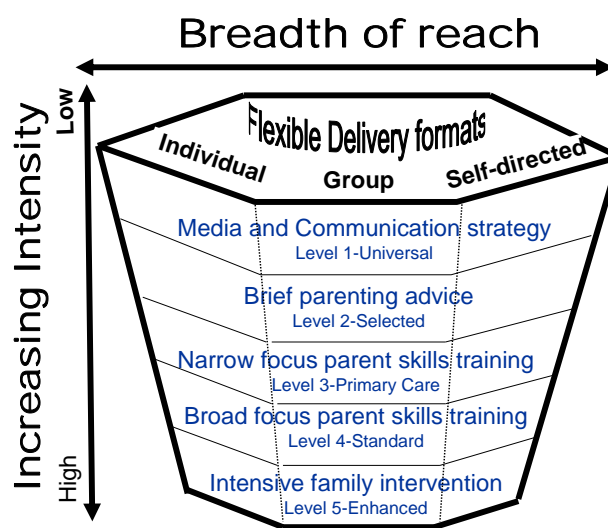


Figure 1 The Triple P model of graded reach and intensity of parenting and family support services

The rationale for this tiered multi-level strategy is that there are differing levels of behavioural and emotional disturbance in children, and parents have different needs and preferences regarding the type, intensity and mode of assistance they require. The multi-level strategy is designed to maximize efficiency, contain costs, avoid over-servicing, and to ensure the program has wide reach in the community. Also the multi-disciplinary nature of the program involves the better utilization of the existing professional workforce in the task of promoting competent parenting by enskilling service providers with flexible, evidence-based consultation tools in working with parents. The program targets five different developmental periods from infancy to adolescence. In *Every Family* two developmental periods associated with the transition to school were targeted (preschool and primary school age). Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). This flexibility enables practitioners to determine the scope of the intervention given their own service priorities. *Every Family* emphasises the importance of links and pathways between the different sectors and service providers who come into contact with children and families. By working to improve communication and referral processes between these organisations, this initiative aims to build community capacity, and enhance the sustainability of interventions.

Figure 2 shows the ecological model of the intervention used to support parents and children. To maximise parents' ability to access positive parenting services, a range of delivery formats were used across different settings to enable better tailoring to suit the needs of families.

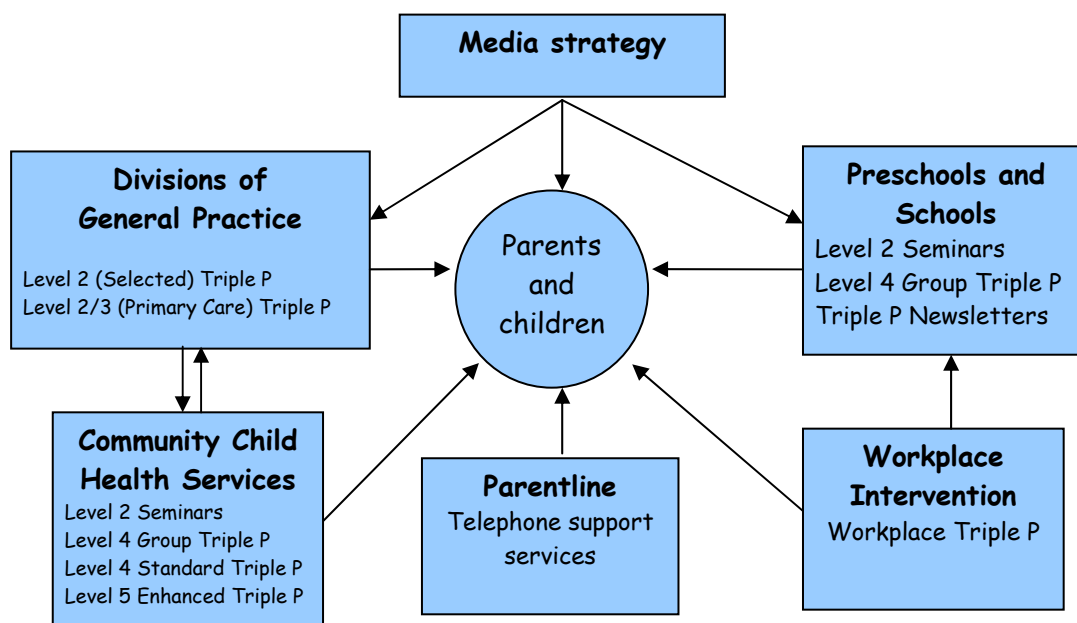


Figure 2 An ecological model for the delivery of parenting and family support services

These intervention options included:

- Co-ordinated media strategy about Positive Parenting, including print, radio, and television media
- Series of three 90-minute parenting seminars (through schools, community centres and Child Health Centres)
- Positive parenting newsletters through schools
- 8-hour parenting groups (through schools and Child Health Centres)
- Tip sheets on parenting (through schools, libraries, GPs, Child Health Centres)

- GPs trained in Primary Care Triple P
- Telephone counselling (through Parentline counsellors trained in Triple P)
- Specialist interventions (through Community Child Health Centres)
- Workplace Triple P for teachers

2.4 Scope of Brief Report

Overall, *Every Family* employed a randomised, cluster experimental design involving 30 socio-demographically matched school catchment areas. Twenty geographical areas were in Southern Brisbane, five areas were in Sydney, and five areas were in Melbourne, with each area comprising one to five suburbs. Of the twenty Brisbane areas, 10 were allocated to the high intensity intervention condition (full exposure) and 10 to the medium intensity intervention condition (partial exposure), with all 10 areas in Sydney and Melbourne forming the low intensity intervention condition (usual care). The sub-studies reported in this document pertain to interventions carried out in the *Every Family* high intensity areas in Southern Brisbane.

3 OVERVIEW OF EVALUATION

The evaluation framework used to assess the impact of *Every Family* involved a blend of quantitative and qualitative methods. As the project was a public health intervention it was necessary to evaluate the extent to which *Every Family* was able to meet seven core criteria that are commonly considered necessary if an intervention is to be effective. This report therefore documents the project outcomes against each of these criteria.

3.1 The criteria that need to be met for a population level strategy to work

Although no single set of agreed upon criteria has been developed to assess the value of public health interventions focusing on prevention of mental health problems, evidence-based approaches require both stringent methodological and dissemination criteria to be met. These are discussed below.

3.1.1 Criterion 1: Knowledge of the prevalence of child problems being targeted

The success of a population health prevention program depends on demonstrating there are improved developmental and/or mental health outcomes in children whose parents have been exposed to the intervention. This means having knowledge of the base rates of behavioural and emotional problems in the target geographical catchment areas before the intervention begins.

Study 1a: What was the prevalence of targeted child behaviour problems?

A Computer Assisted Telephone Interview (CATI) of 4501 parents was completed between July 2003 and February 2004 to establish the prevalence rates of child and parent targets of the intervention. This survey was conducted with parents of 4-7 year old children in socio-demographically matched suburbs of Brisbane, Sydney and Melbourne. The survey included questions about the extent to which children had emotional problems, conduct problems, hyperactivity, peer relationship difficulties and their prosocial behaviour. The main findings were:

- A substantial number of parents reported significant concerns about their child's adjustment.
- 29% of parents reported their child had behavioural or emotional problems in the six months prior to the survey.
- Parent responses indicated 23% of children had total emotional or behavioural difficulties.
- 24% of children were reported to have emotional problems.



- 32% of children were reported to have conduct problems.
- 28% of children were described as hyperactive.
- 25% of children were reported to have problems with peers.
- Parents reported more problems with boys (61%) than girls (39%).

Although the largest proportion of parents of children with clinically-elevated levels of emotional or behavioural difficulties were in the lowest income group, the majority of children with such problems do not come from families in the lowest income band, suggesting a whole-of-population approach is needed for a prevention approach.

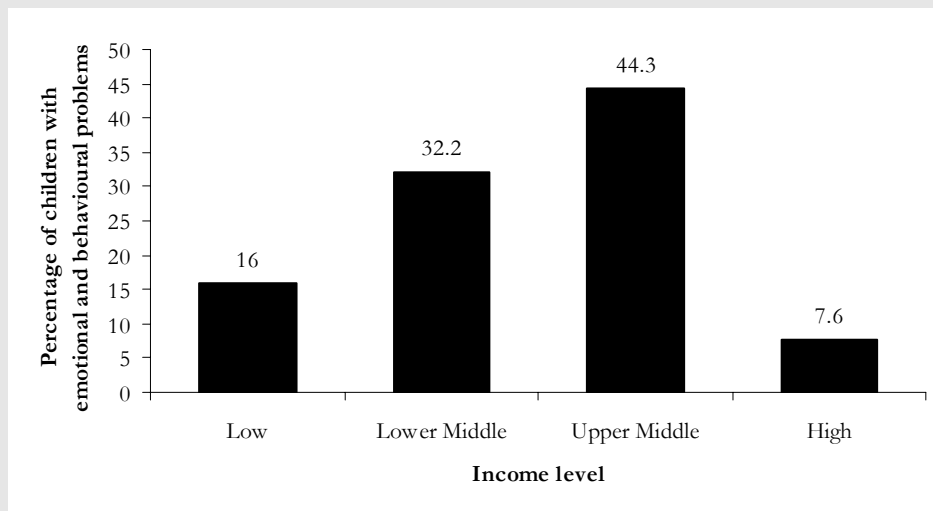


Figure 3 Percentage of children with clinically-elevated levels of emotional or behavioural difficulties in each family income band

- Parents who were depressed were more likely to have children with clinically elevated levels of conduct problems, emotional problems and total behavioural and emotional difficulties.

These findings highlight the large number of children making the transition to start school whose parents are reported to be concerned by behavioural and emotional problems.

3.1.2 Criterion 2: Knowledge of the prevalence of parent risk and protective factors

A second criterion is knowing the prevalence of potentially modifiable parenting and family factors that influence children's behaviour and adjustment. Factors that place a child at risk of developing behavioural and emotional problems include exposure to a harsh, inconsistent parenting style, low parental self efficacy in undertaking the tasks of raising children, mental health problems in parents including depression and anxiety, high marital or partner conflict and low levels of parenting support.

Protective factors that reduce children's risk of developing problems include exposure to evidence-based parenting programs, access to professional support for children's emotional and behavioural problems, and having high levels of social and emotional support from significant others.

Study 1b: What was the prevalence of targeted parenting and family factors?

Every Family sought to reduce the number of children in the community exposed to parenting practices that contribute to the development or maintenance of behavioural and emotional

problems. The second part of the CATI survey provided base rate information about typical parenting practices and other family factors that might be subsequently affected by *Every Family*.

- Over half of parents reported using discipline strategies for dealing with children's misbehaviour that are considered ineffective or coercive (56%).
- Many parents also reported using parenting strategies that may inadvertently encourage children to avoid confronting or facing up to their fear (e.g. avoidance 57%).
- Many parents reported experiencing high levels of personal stress (52%).
- Many parents reported being depressed (23%).
- 31% had sought professional help for their child's behavioural or emotional problems.
- Only a minority of parents (14%) had completed a parenting program.
- Some parents (26%) felt unsupported in their parenting role.
- Triple P was the most widely known parenting program (58%) but was still accessed by only a small proportion of parents (5%).
- Parents who were depressed were more likely to be stressed and less likely to feel supported in their parenting.

These findings showed that a substantial number of parents use parenting practices that potentially contribute to the development of behavioural and emotional problems in children, have high level of personal stress and only a small minority of parents had participated in any formal parenting program prior to *Every Family*.

3.1.3 Criterion 3: Knowledge that changing risk and protective factors improves child outcomes

Parenting interventions have the potential to change important family based risk and protective factors that contribute to children developing serious behavioural and emotional problems.

A public health intervention targeting parenting should be considered for broader dissemination when there is sufficient good quality evidence that demonstrates that the intervention is effective.

The selection of the Triple P system as the parenting intervention to implement in *Every Family* was based in part on the existence of a large number of well controlled outcome studies that show the intervention is effective in reducing early behavioural and emotional problems in children (see the Technical Report for a list of evaluations of Triple P).

Scientific proof that changing inappropriate or dysfunctional parenting practices improves children's mental health and well being comes from numerous clinical trials showing that increasing positive parenting practices and reducing ineffective discipline practices produces better mental health outcomes in children than comparison conditions such as care as usual, no treatment, or waitlist control conditions.

The strength of evidence can be further established by showing that intervention effects can be replicated under conditions of usual service delivery, and similar results are achieved across independent investigators, sites, different ethnic and cultural groups and countries. Other relevant evidence includes having information available on the cost effectiveness of the intervention, and having an effective training and dissemination system to allow for broader roll out of the intervention.



Table 1 Scientific evidence base for the Triple P system

Strength of scientific evidence showing that changing parenting practices through Triple P improves child outcomes	Supporting evidence^a
Efficacy trials have been conducted using	
i) randomised controlled trial methodology	29 peer-reviewed publications
ii) a series of single case experiments	11 peer-reviewed publications
Effectiveness trials have been conducted under conditions of usual service delivery that demonstrate positive outcomes for children and parents	9 peer-reviewed publications
Dissemination trials have been conducted demonstrating successful transfer of skills to service providers	6 peer-reviewed publications
Independent replication studies of main findings across sites and investigators have established the robustness of the findings	4 peer-reviewed publications and 8 technical reports ^b
Positive intervention effects have been demonstrated with parents from diverse sociodemographic backgrounds	4 peer-reviewed publications
Evidence is available concerning the preintervention characteristics of children and parents that predict clinical outcomes	4 peer-reviewed publications
No known negative side effects of intervention have been reported	40 peer-reviewed publications
Robustness of intervention has been demonstrated through evaluation of programs with specific high risk populations (e.g. parents of children with developmental disabilities, clinically depressed parents)	17 peer-reviewed publications
Follow up data demonstrate the durability of outcomes	29 peer-reviewed publications
Evidence concerning cost effectiveness is available	1 peer-reviewed publication
Evidence concerning effectiveness of dissemination method	4 peer-reviewed publications

For a comprehensive list of the scientific evidence base supporting Triple P see the full report.

^aSupporting evidence is demonstrated by publications showing positive effects and the absence of studies showing adverse effects.

^b The Triple P system has been disseminated internationally to 13 countries comprising New Zealand, Singapore, Hong Kong, Japan, Iran, England, Scotland, Germany, Switzerland, The Netherlands, Belgium, Canada, and the United States. Large scale implementation of Triple P has taken place in several of these countries.

A large number of studies has been conducted employing randomised clinical trial methodology. According to National Health and Medical Research Council (1999)¹, this type of evaluation is considered to provide the strongest scientific evidence (Levels I and II on the 6 point rating system). Evidence supporting the efficacy of the Triple P system is summarised in Table 1. It demonstrates that there is sufficient pre-existing evidence showing that the intervention is effective in changing risk and protective factors related to children's behavioural and emotional problems, therefore meeting the third criterion.

3.1.4 Criterion 4: Having effective interventions available

For an intervention to be usable as a public health strategy it needs to be readily available for use by service providers serving a catchment area or population. This means having appropriate materials and resources that can be used as part of the intervention ready for use and access to a professional training process that equips service providers to deliver the program with fidelity. An extensive range of high quality parent and professional resources are available as part of the Triple P system.

¹ National Health and Medical Research Council (1999). *A guide to the development, implementation and evaluation of clinical practice guidelines*. Canberra: Commonwealth of Australia.

Table 2 Description of levels of Triple P and resources used in *Every Family*

Intervention	Description	Parent Resource	Practitioner Resource
Universal Triple P (Level 1)	A coordinated information campaign using print and electronic media and other health promotion strategies to promote awareness of parenting issues and normalise participation in parenting programs such as Triple P. May include some contact with professional staff (e.g. via telephone).		Media promotion kit (clips from print, radio and television)
Selected Triple P (Level 2)	Provision of specific advice on how to solve common child developmental issues (e.g. toilet training) and minor child behaviour problems (e.g. bedtime problems). May involve face-to-face or telephone contact with a practitioner (about 20 minutes over 2 sessions) or (90 minute) seminars.	48 tip sheets (including 3 Seminar Series tip sheets)	Facilitator's manual PowerPoint presentation
Primary Care Triple P (Level 3)	A brief program (about 80 minutes over four sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage a discrete child problem behaviour (e.g. tantrums, fighting with siblings). May involve face-to-face or telephone contact with a practitioner.	Level 2 resources 1 booklet	Practitioner's manual 1 consultation flip-chart 1 wall-chart 1 Every Parent video/DVD ^a
Group Triple P (Level 4)	An 8-session group program made up of 4 x 2 hour sessions followed by 3 x 20 minute telephone consultations and a final 2 hour closure session. A generic program designed for a range of families including those with children exhibiting longer term behaviour problems.	1 workbook ^b	Practitioner's manual 1 video/DVD ^a PowerPoint presentation
Enhanced Triple P (Level 5)	An intensive individually tailored program (up to 11 sessions) for families with child behaviour problems and family dysfunction. Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, partner support skills, attribution retraining and anger management.	1 workbook ^b	Practitioner's manual 2 Triple P videos/DVDs ^a
Stepping Stones Triple P (Level 5)	This is a broad focus 10 session program that includes adaptations for parents of preadolescent children who have a disability. This program includes Triple P parenting training methods and introduces additional strategies drawn from disability research literature. Involves individual consultation with parents	1 workbook ^b	Practitioner's manual 1 video/DVD ^a

^a The videos/DVDs have been designed for use by practitioners as part of a Triple P intervention, however many parents utilise them as well. There are a total of three videos in the Every Parent Series and seven in the Triple P Series.

^b Workbooks are provided to practitioners as part of their kit but are also available to be used by parents.

This availability criterion was considered to be met by *Every Family* by making use of Triple P program resources that have been developed for parents and practitioners. Table 2 lists the various resources used in each level of the intervention. The resources used included practitioner manuals, parent tip sheets, wall charts and workbooks, videos and DVDs, advertising and promotional material, parent and practitioner newsletters. For each level of intervention there is a Trainer's Kit that consists of a trainer's guide, participant notes, training video and PowerPoint presentation.

3.1.5 Criterion 5: Making interventions widely available

In public health interventions, evidence-based programs need to be made widely available and barriers to parent's participation reduced or eliminated to ensure adequate program reach. To meet this criterion *Every Family* made extensive use of different delivery modalities to enable as many parents as possible to participate. The intervention increased parental exposure to positive parenting through a coordinated media strategy, by conducting large group Triple P seminars and parenting groups, brief primary care interventions, intensive individual programs, telephone assisted programs and self directed programs. This approach ensured flexibility in how parents could access parenting information.



Study 3: How effective was the Triple P Seminar series in changing parenting practices?

Community seminars on parenting are a cost efficient way of communicating messages about positive parenting strategies to large numbers of parents. A study into the effectiveness of the Triple P Seminar series was conducted. A randomised controlled trial compared three intervention conditions: Condition 1 (Introductory seminar exposure, N=34) vs Condition 2 (Full seminar exposure, N=34) vs Condition 3 (Waitlist control, N=41) on a number of parenting and child variables. Results indicated that:

- Parents with both introductory and full seminar exposure reported significantly lower levels of inattention/ hyperactivity and total emotional and behavioural difficulties (see Figure 5 below) in their children at post intervention than did waitlist controls, after controlling for differences in scores at pre-intervention.
- Parents with full seminar exposure reported significantly lower levels of total anxiety in their children at post intervention than did parents with introductory seminar exposure or waitlist controls, after controlling for differences in scores at pre-intervention.

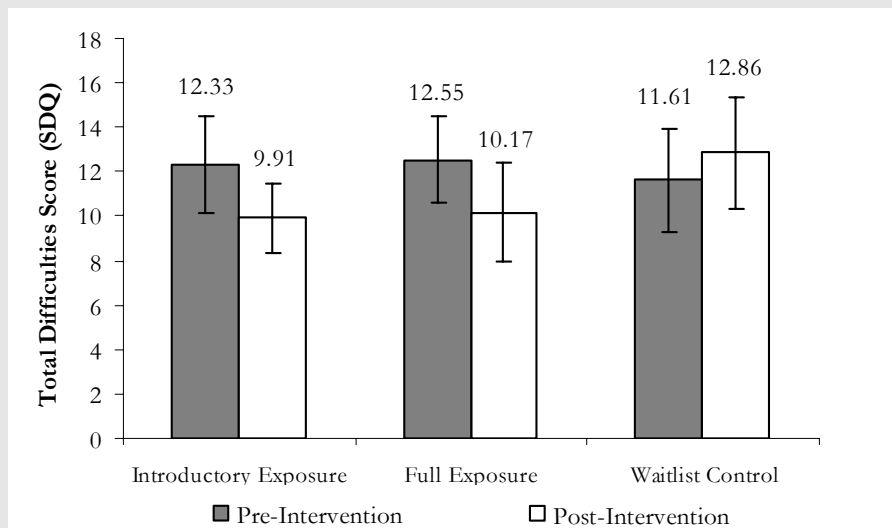


Figure 5 Total behavioural and emotional difficulties at pre- and post-intervention by condition

- Parents with full seminar exposure reported significantly lower levels of the inappropriate parenting practices of laxness (permissive discipline) and verbosity (overly long reprimands or reliance on talking) than did parents with introductory or no exposure to seminars.
- Parents with both introductory and full seminar exposure reported significantly lower levels of overreactivity (authoritarian discipline; displays of anger, meanness and irritability) and total inappropriate parenting (see Figure 6 below) than did waitlist controls.
- Parents with full seminar exposure reported significantly lower levels of parental conflict than did parents with introductory or no seminar exposure.
- Overall both versions of the seminar series were effective in reducing inappropriate parenting with the full seminar program producing the best outcomes.

