



Community-wide implementation of a parenting program: the South East Sydney Positive Parenting Project

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Abstract

This paper provides a description and evaluation of a community-wide implementation of a parenting program - the group version of Triple P - in South Eastern Sydney. The implementation was undertaken in partnership with a range of public health services and community agencies that participated on a voluntary basis. A number of strategies were shown to development the capacity of services and professionals to deliver the Triple P program to parents. Parent evaluations at the conclusion of the program demonstrated a reduction in disruptive child behaviour, lower levels of dysfunctional parenting, reduction in conflict between parents over child-rearing, and gains in parental mental health. Gains in all of these domains were maintained at 6 and 12 month follow-up. The results of the study indicate that it is possible to take a population health approach to parenting, successfully involve multiple services and professionals in the delivery of the program, and maintain the effectiveness of the parenting intervention in a community-wide implementation.

Keywords

parenting, prevention, dissemination, family intervention, parent management training, capacity building

Introduction

Prevalence studies in Australia report that around 14% of children and adolescents experience a mental health disorder in any 6 month period (Sawyer, Arney, Baghurst et al., 2000). In addition, it is estimated that 10-15% of pre-school children have mild to moderate behavioural problems, and another 10-15% experience moderate to severe behavioural problems (Marshall & Watt, 1999). As young children with behavioural problems are at increased risk of later developing more severe and long-lasting mental disorders, early

intervention for these children should be a priority in a population approach to children's mental health (Sanders & Markie-Dadds, 1996).

Population studies have found that coercive or inconsistent styles of parenting are linked to higher rates of mental health problems, whilst encouraging parental styles are associated with lower rates of mental health problems in children (Silburn, Zubrick, Garton et al., 1996). Research has shown that prevention and early intervention strategies targeting parenting are amongst the most effective strategies for preventing chronic problems (Webster-Stratton, 1997). Parent

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management training (PMT) based on social learning models (Patterson, 1982) has been found to be an efficacious intervention for children with behaviour disorders (Kazdin, 1997). Typically, PMT teaches parents to increase their positive interactions with their children, whilst reducing coercive and inconsistent interactions.

However, reducing children's mental health problems within the population will require a strategy that takes PMT from the clinical treatment setting and makes it available widely to parents in the community. In order to address the need for population based parenting and family interventions, Sanders and colleagues have developed the Triple-P Positive Parenting Program (Sanders, 1999).

The Triple P Program aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. It promotes nurturing, safe, engaging, non-violent, and low conflict environments for children. It also aims to promote children's social, emotional, language and behavioural competencies through positive parenting practices (Sanders, 1999). This program has five levels of intervention, on a continuum of increasing strength and narrowing reach, which are designed to be used according to the needs of the families being targeted. The Triple P Program has been found to be an efficacious treatment in a range of controlled randomised trials (Sanders, 1999; Sanders, Markie-Dadds, Tully & Bor, 2000).

A group version of Triple P is available, which is an intensive program focusing on parent-child interaction and the application of parenting skills to a broad range of behaviours (Turner, Markie-Dadds & Sanders, 1998). This program is typically delivered over 8 sessions to groups of 10–12 parents, and hence has the potential to provide a cost-effective intervention. This version of Triple P has been tested in a large-scale population trial in East Perth in Western Australia. Preliminary data from this study showed that parents who received this intervention reported reduced rates of child disruptive behaviour compared to a non-

intervention comparison group. Parents in the intervention group also reported reductions in dysfunctional parenting practices, marital conflict, parental stress, and depression (Williams, Silburn, Zubrick & Sanders, 1997).

In 2000, the Mental Health Service of the South Eastern Sydney Area Health Service (SESAHS) launched a project to promote positive parenting practices throughout the community. The group version of Triple P was implemented, similar to the work conducted in Perth.

The geographical area served by the SESAHS had a population of 769,402 at the 2001 Census, of whom 83,567 were aged less than 10 years. The region has a high migrant population (31%), the majority of who were born in a non-English speaking country. The population averages for the area show a higher level of educational achievement and family income than the NSW averages. The SESAHS provides a broad range of public health services to the population, including community and hospital services.

The South East Sydney Positive Parenting Project was conducted by the Mental Health Service of SESAHS over three years from 2000–2002. The project involved mental health services, as well as primary health care teams, other government departments and non-government organisations. The broad aim was to increase the capacity of a range of health and non-health services to provide evidence-based parenting interventions across the community, both during the project and after its completion.

The project adopted strategies to build the capacity of services to implement Triple P groups within the community, based on the work of O'Hanlon, Kosky, Martin et al. (2000). The authors draw upon the NSW Department of Health (1998) strategic framework for capacity building in regard to health promotion activities. The strategies within this framework are: workforce development (eg training of staff, support and supervision), organisational development (e.g. developing strategic plans, ensuring management support and commitment) and resource allocation (e.g. financial and human resources, administrative support). In addition, O'Hanlon et al. (2000) believe that partnerships

and networks are vital for building and sustaining capacity.

The South East Sydney Positive Parenting Project was evaluated during the last six months of the project and is presented here as two studies. Study 1 examined the strategies used in building the capacity of participating services to provide the group Triple P program to parents in the community. The aims were to:

1. Improve the knowledge and skills of SESAHS staff and partners in positive parenting practices;
2. Increase opportunities for parents to learn about positive parenting practices;
3. Strengthen links and develop partnerships within SESAHS, with non-government organisations and other government departments; and
4. Ensure organisational support to facilitate change.

Study 2 evaluated the effectiveness of the Triple P group program from the point of view of the parents. This evaluation was important as the program was delivered in a naturalistic service delivery context, as opposed to the more controlled conditions of a research study.

Study 1. Implementing Group Triple P across a community and public health service setting

Method

Participants

Seventy four professionals working within the South East Health region participated in the Triple P training. They included nurses, social workers, psychologists, preschool teachers, teachers and welfare workers. Forty-six participants were from South East Health Services, including Child and Family Health Nursing Teams, Child & Adolescent Mental Health Teams, the Child Protection Service and Adult Mental Health. The other 28 participants worked in community agencies such as Family Support Services, preschools, church counselling and welfare services, and the Department of Education and Training. One part-time Area

Mental Health staff member was employed as a project coordinator.

Measures

A questionnaire was developed from two focus groups conducted by an independent facilitator with 15 of the participants. The questionnaire assessed how the strategies used in the project contributed to the capacity of individuals and services to implement the parenting program. The questionnaire included Yes/No items, Likert-style questions, and free response questions. It was sent to all participants still working in the area in the final six months of the project.

Other measures of the program's success were the number of participants who conducted at least two Triple P groups with parents, the number of participants who later received Triple P accreditation, the extent to which recommendations were adopted by the services, and the extent to which Triple P groups were still being conducted in each service at the conclusion of the project.

Procedure

Seventy-four participants were trained to deliver Level 4 Group Triple P. The training and program resources were provided free of charge. Fifteen workshops were conducted to help participants overcome problems in facilitating groups, to promote networking amongst the facilitators, and to provide practice sessions prior to each Triple P accreditation day.

Group Triple P was promoted widely across the community as a universal parenting program. The 74 participants trained in Triple P were each asked to conduct at least two Triple P groups with parents. To strengthen partnerships between services involved with the families, participants co-facilitated their initial groups with a person from another health team or agency. Workshops conducted by the project coordinator also promoted networking amongst the participants.

To promote organisational change and enhance the sustainability of the program, the project coordinator worked closely with service

management to develop local systems of administration and planning for Triple P group programs. In each sector, a central booking system was established and enquiries were dealt with locally, with sector-based planning and organisation of the groups. The need to appoint a local coordinator in each sector was emphasised.

Evaluation occurred during the final six months of the project via participant questionnaires. Data on the number of participants who conducted at least two groups, and who achieved Triple P accreditation, were collected after the conclusion of the project.

Results

Aim 1. To improve the knowledge and skills of SESAHS staff and partners in positive parenting practices

Seventy participants (95%) met the requirement to conduct at least two Triple P groups with parents, and many conducted more than the required two groups. With support from the project, forty-five (61%) of the participants have since become accredited Group Triple P providers.

Evaluation questionnaires were sent to 68 of the 74 participants, and 47 were returned (69% response rate). Thirty seven (88%) participants intended to conduct further Triple P groups in the future. Forty-one respondents had attended at least one Triple P workshop conducted by the project coordinator and rated the value of the workshops very highly. Fifty-two percent stated that they had changed referral patterns as a result of the project, dealing with more presenting problems rather than referring clients to other services.

Aim 2. To increase opportunities for parents to learn about positive parenting practices

By the end of the project in 2002, 122 Triple P group programs had been conducted with approximately 1000 parents in a range of community venues across the area. The course was made available to parents on a self-referring basis, or with professional referral, and was run at a low cost to parents.

Aim 3. To strengthen links and develop partnerships within SESAHS, with non-government organisations and other government departments

Results of the project questionnaire indicated that the program was successful in promoting networking within SESAHS staff and between health service staff and other government and non-government organisations. Participants were asked about the benefits of co-facilitation, using a 7-point Likert Scale (1-not very worthwhile to 7-very worthwhile). Forty three percent of participants responded favourably with a rating of 4 to 6, and 45% gave a rating of 7. Only 3 respondents reported no benefit. The most commonly reported benefits were: sharing the load, networking, learning new skills, and mentoring.

Aim 4. Ensure organisational support to facilitate organisational change

Ninety one percent of participants stated that they had been given adequate resources to conduct the groups. Most of the facilitators rated the support of the project coordinator very highly, that is, 5, 6 or 7 on a Likert scale (7-very useful, 1-not very useful).

As management support is integral to the success of implementing change into a service, the questionnaire asked participants if they felt they had received adequate support from their managers to conduct the groups. Twenty-eight stated that they had received adequate support, 8 said they had not, 5 answered both yes and no and 3 said this was not applicable to them.

Further evidence of the project's success in supporting organisational change is the degree to which local systems of administration were developed during the course of the project. At the time of writing, the central booking system established during the project continues to operate in two of the three sectors. In one sector, this booking system ceased to operate due to the relocation of community health services. All sectors have recognised the need to appoint a local coordinator. Currently, two of the three sectors have a staff member in this role.

Study 2. Measuring the success of the Level 4 Group Triple P program in changing parenting style and child behaviour patterns

Method

Participants

Participants were 560 parents from the South East Health Area who had at least one child aged 2 to 10 years. Approximately half reported having a child with significant behavioural problems when they enrolled for Triple P.

Five hundred and eight families were invited to complete the pre- and post- group measures, and 330 (65%) of the families provided a full set of pre and post data. One hundred and forty two families were asked to complete the 6 month follow-up and 110 (77%) families returned these questionnaires. A different 78 families were invited to complete 12 month follow-up questionnaires, and 52 families (67%) returned them. The numbers of mothers and fathers who participated in each phase of the study are shown in Table 1.

Table 1. The numbers of mothers and fathers participating in each phase of the project

Completed questionnaires	Pre-group	Post-group	6mo follow up	12 mo follow up*
Mothers	446	303	102	48
Fathers	114	60	12	15
Total	560	363	114	63
Total families involved	508	330	110	52
Response Rate	100%	65%	77%	67%

*The families in the 12 month follow-up were not the same families that participated in the 6 month follow up.

The post-group and follow-up samples were compared with the pre-group sample on the basis of their demographic profile and initial problem status (as measured by the Eyberg Child Behaviour Inventory Intensity Scale; see below). There were no significant differences between the samples on marital status, household income,

employment status, and cultural background. The only significant difference in education level was found in the 6 month follow-up group of mothers, where there were more in the middle education levels than in the lower and upper levels ($\chi^2 = 11.79$, $p < .05$).

Measures

Parents were asked to complete pre-group, post-group and follow-up questionnaires about the same child, namely, the child they felt had the most significant behaviour problems. The following instruments, other than the satisfaction questionnaires, were administered at each time point.

The Eyberg Child Behavior Inventory (ECBI). The Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999) is a 36-item measure of parental perceptions of disruptive behaviour in their child. It incorporates a measure of the frequency of disruptive behaviours rated on 7-point Likert scales ('Intensity' - the sum of the 36 ratings circled by the parent) and a measure of the number of disruptive behaviours that are a problem for parents ('Problem' - the number of times 'yes' is circled). Intensity Scale scores can range from 36 to 252. A score of 132 and above is considered to lie within the clinical range for problem intensity. Problem Scale scores can range from 0 to 36, with scores of 15 and above usually considered to be in the clinical range (Eyberg & Pincus, 1999).

The Parenting Scale (PS). The Parenting Scale (Arnold, O'Leary, Wolff & Acker, 1993) is a 30-item questionnaire measuring three dysfunctional discipline styles in parents: Laxness (permissive discipline); Over-reactivity (authoritarian discipline, displays of anger, meanness and irritability); and Verbosity (overly long reprimands or reliance on talking). For this analysis only the Total Score (an overall measure of dysfunctional parenting styles) has been used. The mean Total Score for a non-clinic sample is considered to be 2.6 (standard deviation 0.6) and for a clinic sample a mean of 3.1 (standard deviation of 0.7).

The Parent Problem Checklist (PPC). The Parent Problem Checklist (Dadds & Powell, 1991) is a 16-item scale measuring inter-parent conflict over child rearing. It rates parents' ability to cooperate and work together in family management. Six items explore the extent to which parents disagree over rules and discipline for child misbehaviour, six rate the amount of open conflict over child-rearing and four items assess the extent to which parents undermine each other's relationship with their children. The score on this checklist is the total number of items that cause problems between the parents (scores range from 0-16). Those scoring 5 or more are considered to have clinically significant levels of inter-parent conflict over child-rearing. Only two parent families were asked to complete this questionnaire.

The Depression-Anxiety-Stress Scale (DASS). The DASS (Lovibond & Lovibond, 1995) is a 42-item questionnaire assessing symptoms of depression, anxiety and stress in adults. Each scale has a range of 0-42. Scores considered in the normal range are 0-9 for depression, 0-7 for anxiety and 0-14 for stress. Scores above these ranges indicate the degree of problem from mild through to extreme.

Client Satisfaction Questionnaire (CSQ) – Post-group only. The CSQ is an adaptation of the Therapy Attitude Inventory developed by Eyberg (1993). It consists of 13 questions each scored on a 7-point Likert Scale (1 being the lowest and 7 the highest on each item). The total score range is from 13 to 92.

Follow-up Client Satisfaction Questionnaire (FCSQ) – Follow-up only. The FCSQ consisted of seven questions taken from the post-group survey (rated on a scale of 1-7) together with two open-ended questions. The total satisfaction score based on the initial 7 questions can range from 7 to 49.

Procedure

Participants from Study 1 conducted Level 4 Group Triple P with groups of 5 to 14 parents. Pre-group, post-group and follow-up questionnaires were mailed to parents along with

a reply-paid envelope. One reminder was sent to parents who did not respond to the initial mail-out.

Results

Given the number of measures used, a Bonferroni adjusted probability was set at $p < .05/7$ or $p < .007$. Unless otherwise stated, results reported here are significant at this adjusted level. Because different subsets of participants completed 6 month versus 12 month follow-ups, data for pre, post and follow-up was analysed separately for each follow-up sample. Only follow-up data for mothers was analysed due to the small number of fathers who completed follow up questionnaires.

Pre-post group changes

Table 2 shows the means, standard deviations and results of related samples t-tests for pre- and post-group measures on the ECBI, DASS, PPC and PS. There were significant improvements for mothers and fathers on all of the measures, except the fathers' DASS Anxiety Scale score (which was not significant at the Bonferroni-adjusted level, $p = .04$).

The clinical significance of the changes in the ECBI Intensity Scale were assessed by comparing the proportion of participants who rated above the cut-off score of 132 on pre-group and post-group ECBI. Forty nine percent of mothers and 40% of fathers rated their child's behaviour as falling within the clinical range at pre-group but this fell to 20% (mothers) and 26% (fathers) at post-group. A Chi-Square analysis showed that this shift was significant for mothers ($n = 277$, $\chi^2 = 90.18$ $p < .05$) and fathers ($n = 53$, $\chi^2 = 3.87$ $p < .05$).

Client Satisfaction Questionnaire

Post-group data for the CSQ indicated high levels of satisfaction with the program for the mothers ($n = 303$, mean = 71.8) and the fathers ($n = 59$, mean = 70.5).

Table 2. Means and standard deviations for pre and post-group measures for mothers (M) and fathers (F)

Measure	Parent	N	Pre-group		Post-group		Sig
			Mean	SD	Mean	SD	
ECBI							
Intensity Scale	M	277	128.9	26.9	109.9	26.4	*
	F	53	123.9	25.2	109.9	26.6	*
Problem Scale	M	277	14.1	6.8	7.7	6.6	*
	F	53	11.9	7.3	7.3	7.2	*
DASS							
Depression Scale	M	295	5.9	7.7	3.3	5.2	*
	F	60	5.1	8.0	2.8	5.8	*
Anxiety Scale	M	295	2.6	4.2	1.7	3.2	*
	F	60	2.6	6.5	2.0	6.3	n.s.
Stress Scale	M	295	11.4	8.6	7.5	6.7	*
	F	60	9.8	8.4	6.1	7.4	*
Parent Problem Checklist	M	236	3.8	3.6	2.1	2.7	*
	F	47	2.9	2.6	1.7	2.1	*
Parenting Scale Total Score	M	299	3.3	0.6	2.7	0.7	*
	F	57	3.2	0.6	2.7	0.7	*

* $p < .007$ (Bonferroni adjustment)

Six month follow-up evaluation (mothers only)

Table 3 shows the means and standard deviations for each measure for mothers who completed the 6 month follow up.

Eyberg Child Behaviour Inventory. Related samples t-tests comparing the means for mothers at the 3 points of time revealed, for both the Intensity and Problem Scales, a significant decrease from pre-group to post-group and from pre-group to follow-up, and no difference between post-group and follow-up.

Depression, Anxiety, Stress Scale. For Depression, there was a significant decrease from pre-group to post-group and from pre-group to follow-up. There was no change from post-group to follow-up, indicating maintenance of the change. For Anxiety, the decrease from pre-group to post-group was significant and there was no significant difference from post to follow-up, however, the decrease in Anxiety from pre-group to follow-up was not significant at the Bonferroni-adjusted level ($p = .018$). For Stress, the decreases from pre-group to post-group and from pre-group to follow-up were

significant. There was no significant difference from post to follow-up, indicating maintenance of the change.

Parent Problem Checklist. There was a significant decrease pre- to post-group, and pre-group to follow-up. There was no significant change from post-group to follow-up.

Parenting Scale. Related samples t-test comparisons of the mean scores on the PS found a significant decrease from pre-group to post-group. There was then a significant increase from post-group to follow-up, but the decrease from pre-group to follow-up was still significant.

Follow-up Client Satisfaction Questionnaire (mothers and fathers). The potential range of scores on the FCSQ was from 7 to 49. The total mean satisfaction score was 36.7 for mothers and 37.7 for fathers.

Table 3. Means and Standard deviations at pre, post and follow-up for mothers who completed the 6 month follow-up evaluation

Measure	Pre-group		Post-group		6 mo followup	
	Mean	SD	Mean	SD	Mean	SD
ECBI (n=92)						
Intensity Scale	128.7	25.6	108.4	26.9	107.4	24.8
Problem Scale	14.6	6.8	7.8	6.2	7.9	6.7
DASS (n=97)						
Depression Scale	5.2	7.3	3.0	5.8	2.7	3.0
Anxiety Scale	2.6	3.8	1.4	3.0	1.8	3.0
Stress Scale	10.7	8.2	6.8	7.1	6.7	6.3
Parent Problem Checklist (n=74)	3.2	3.0	1.7	2.2	2.0	3.2
Parenting Scale Total Score (n=100)	3.3	0.6	2.6	0.7	2.8	0.6

Table 4. Means and standard deviations at pre, post and follow-up for mothers who completed the 12 month follow-up evaluation

Measure	Pre-group		Post-group		12 mo followup	
	Mean	SD	Mean	SD	Mean	SD
ECBI (n=43)						
Intensity Scale	132.1	29.8	113.6	31.5	114.9	30.1
Problem Scale	13.8	7.5	8.1	7.5	8.2	8.0
DASS (n=47)						
Depression Scale	5.0	6.7	3.1	4.2	3.3	5.9
Anxiety Scale	2.0	2.4	1.4	2.3	1.5	2.1
Stress Scale	10.9	8.1	7.9	5.9	7.3	7.1
Parent Problem Checklist (n=39)	3.6	3.4	1.4	1.7	1.7	2.6
Parenting Scale Total Score (n=48)	3.3	0.7	2.6	0.6	2.7	0.6

12 month follow-up evaluation (mothers only)

Table 4 shows the means and standard deviations at pre, post and follow-up for mothers who completed the 12 month follow-up evaluation.

Eyberg Child Behaviour Inventory. Results for the 12 month follow-up for both scales of the EBCI replicated those for the 6 month follow-up. That is, significant improvements on both the Intensity and the Problem Scales were maintained at follow-up.

Depression Anxiety and Stress Scale. Related samples t-tests were used to compare the means at the 3 points of time for each scale of the DASS. For Depression, neither the decrease from pre-group to post-group nor from pre-group to follow-up, were significant at the Bonferroni-adjusted level ($p=.02$ and $p=.05$ respectively). There was no significant difference from post to

follow-up. Similarly, for Anxiety there were no significant changes between any of the time points. For Stress, the decrease from pre-group to post-group was significant. There was no significant difference from post to follow-up, indicating maintenance of the change at the end of the group. There was also a significant decrease in Stress from pre-group to follow-up.

Parent Problem Checklist. Results for the PPC at the 12month follow-up replicated those for the 6 month follow-up, with improvements maintained at follow-up.

Parenting Scale. Results for the PS at 12 month follow-up replicated those for the 6 month follow-up with the exception that the increase in scores from post-group to follow-up was not significant at the Bonferroni-adjusted level ($p=.02$).

Client Satisfaction Questionnaire (mothers and fathers). The results for the CSQ at 12 months were almost identical to those obtained at the 6 month follow-up: mean scores were 36.5 for mothers (n=48) and 37.9 for fathers (n=15).

Discussion

Taken together, the results of Study 1 and 2 indicate the success of the South East Sydney Positive Parenting Project in implementing an evidence-based group parenting program in the community, and in facilitating the service changes required within a range of public health and community agencies to deliver such a program.

The results of Study 1 indicated that the project was successful in increasing the knowledge and skills of SESAHS staff and partners in positive parenting practices, and in increasing opportunities for parents to learn about positive parenting practices. By the end of the project in 2002, 122 Triple P group programs had been conducted across the South East Sydney area, with approximately 1000 parents. Seventy four professionals had been trained in Group Triple P and 45 had become accredited Group Triple P providers. After the initial two groups, many of the staff had continued to conduct Triple P groups within their service as part of their normal duties. As 88% of participants stated that they intended to run Triple P groups in the future, the increased opportunities for parents in the region to learn about positive parenting practices could be expected to continue beyond the conclusion of the project.

The project also strengthened links and developed partnerships within SESAHS and with external agencies. Co-facilitation of the initial two groups was used to promote partnerships between services and to assist inexperienced facilitators gain confidence and skills from working together. Most facilitators found co-facilitation of their initial groups worthwhile, and reported benefits relating to networking, learning skills, mentoring and a sharing of the workload.

The project also promoted and supported the organisational change required to enable services to continue to deliver the program after the end of the project period. The central booking system continued to operate in two of the three sectors. Two sectors have appointed a staff member to act as a local coordinator, and the third sector has also recognised the need to implement this change.

The benefits of being involved with the Triple P project for staff appeared to extend beyond developing the skills to conduct this program. Facilitators reported that it had positively impacted on their other work with families, providing them with additional confidence and skills in teaching parenting skills, and this was reflected in a change in their referral patterns.

The results of Study 2 indicate that the Level 4 Group Triple P was successful in increasing parents' knowledge and use of positive parenting practices, and that this, in turn, resulted in improvements in their children's behaviour. Parents reported a significant decrease in disruptive child behaviour after attending the groups. For both the 6 and 12 month follow-up samples, the decrease in disruptive child behaviour evident at the conclusion of the program was maintained.

The use of dysfunctional parenting practices decreased for both mothers and fathers following the program. At follow-up, some slipping back to more dysfunctional practices was noted in the mothers in the 6 and 12 month follow-up samples. However, at 12 months, mother's use of dysfunctional parenting practices remained at lower levels than pre-intervention.

Parental conflict over child-rearing was found to have decreased at post-intervention, according to both mothers and fathers. This reduction in parental conflict remained evident at both the 6 and 12 month follow-ups (data from mothers only). Attendance at a Triple P group also had apparent benefits for parental mental health, as evidenced by lower scores on the Depression-Anxiety-Stress Scale at post-group and at 6 and 12 month follow-ups.

The results of Study 2 also lend support to previous research (Sanders et al., 2000) indicating that parents find the Triple P program a satisfying and worthwhile experience. Both mothers and fathers reported a high level of satisfaction with the program at post-group and at 6 and 12 month follow-ups.

As the project was conducted using existing services within the public health and community sector, the results of this project are likely to be generalisable to other geographical areas. A broad range of health and other community agencies were found to be willing to become involved in the delivery of parenting programs to the community.

Most of the group facilitators were inexperienced in delivering parenting interventions, yet they were able to achieve positive outcomes. This supports the robustness of the Triple P program. The program has previously been found to be an efficacious treatment in a range of controlled randomised trials (Sanders, 1999; Sanders et al., 2000) and preliminary results are available from one population health model intervention (Williams et al., 1997). Thus, the results of the current project are important in providing evidence for the effectiveness of Group Triple P when presented within many different community settings, by a variety of facilitators and when attended by a broad range of parents.

Study 2 indicates that the project was successful in reaching the families it was designed to help. Prior to attending the program, almost half of the parents who participated in Study 2 reported having a child with disruptive behaviour within the clinical range on the Eyberg Child Behaviour Inventory Intensity Scale. Given that the program was advertised widely throughout the community and parents could self-refer, it was evident that parents with more concerns about child behaviour self-selected to attend. This can be seen as another indication of the project's success, both in terms of the promotion of the groups within the community, and in terms of meeting parents' needs through a public health model.

The success of the project was aided by several factors. Firstly, all services were provided with free training and resources, which was important for service participation. Also, a project coordinator was made available to assist the group facilitators. As group facilitators came from a wide range of professional backgrounds and levels of experience in addressing parenting issues, workshops were conducted throughout the project, in addition to the initial Triple P group program training and accreditation workshop. These workshops were attended by almost all the facilitators and were rated by them as being very useful. New group facilitators were also supported by informal contact with the project coordinator and most facilitators saw this support as being very valuable. Another factor in the success of the project may have been the efforts made by the project coordinator to build sustainability into the model by working with sector management to develop local systems of administration and planning for Triple P group programs.

Despite the success of the project, several limitations were evident, some of which suggest changes within the health service organisation are needed to enhance the availability of a program such as Triple P. For example, some facilitators who participated in Study 1 did not feel that they had received adequate management support for implementing change in their service. The most commonly cited comments related to inadequate management support for after hours groups. Because most parents work, this matter must be addressed to be able to effectively deliver a program like Triple P.

A limitation of Study 2 was the lack of a control group - a common limitation of research undertaken in a service delivery context. Another limitation was that the families who participated were not entirely representative of the population for South East Health. Although there were some participants from non-English speaking or Aboriginal backgrounds, these groups were under-represented in the sample. Future research could investigate more specific approaches to meet the needs of these parents.

Conclusion

The South East Sydney Positive Parenting Project had a significant impact on the availability of parenting programs for parents of young children in the South Eastern Sydney Area. The project was responsible for increasing the capacity of professionals and services to better meet the needs of parents for assistance with their parenting. These services included a range of health teams (both at a primary and secondary health level) and other community agencies involved with children and families. The project also contributed to improved links between public health services and between health and other community agencies.

The Triple P group program was shown to be an acceptable and effective program for families in South Eastern Sydney. The benefits seen in parenting practices, child behaviour, marital harmony and parental mental health are clear and long lasting. There is, however, some concern that without the area-wide coordination provided, the gains achieved may erode over time.

Overall, the project has demonstrated that it is possible to take an evidence-based intervention program, such as Triple P, which has been developed and evaluated within controlled settings, and successfully incorporate it into service delivery in a range of health and community services. At the same time it is possible to demonstrate that the program can retain its effectiveness and produce positive outcomes which remain evident one year later.

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