EVERY FAMILY
A public health approach to promoting children’s wellbeing.
Brief Report

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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 strategy. Triple P aims to prevent

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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 of 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](image-url)
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 enhances 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.

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)
2.3 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 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](image)

• 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

<table>
<thead>
<tr>
<th>Strength of scientific evidence showing that changing parenting practices through Triple P improves child outcomes</th>
<th>Supporting evidence¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy trials have been conducted using</td>
<td>29 peer-reviewed publications</td>
</tr>
<tr>
<td>i) randomised controlled trial methodology</td>
<td>11 peer-reviewed publications</td>
</tr>
<tr>
<td>ii) a series of single case experiments</td>
<td>9 peer-reviewed publications</td>
</tr>
<tr>
<td>Effectiveness trials have been conducted under conditions of usual service delivery that demonstrate positive outcomes for children and parents</td>
<td>6 peer-reviewed publications</td>
</tr>
<tr>
<td>Dissemination trials have been conducted demonstrating successful transfer of skills to service providers</td>
<td>4 peer-reviewed publications and 8 technical reports²</td>
</tr>
<tr>
<td>Independent replication studies of main findings across sites and investigators have established the robustness of the findings</td>
<td>4 peer-reviewed publications</td>
</tr>
<tr>
<td>Positive intervention effects have been demonstrated with parents from diverse sociodemographic backgrounds</td>
<td>4 peer-reviewed publications</td>
</tr>
<tr>
<td>Evidence is available concerning the preintervention characteristics of children and parents that predict clinical outcomes</td>
<td>4 peer-reviewed publications</td>
</tr>
<tr>
<td>No known negative side effects of intervention have been reported</td>
<td>40 peer-reviewed publications</td>
</tr>
<tr>
<td>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)</td>
<td>17 peer-reviewed publications</td>
</tr>
<tr>
<td>Follow up data demonstrate the durability of outcomes</td>
<td>29 peer-reviewed publications</td>
</tr>
<tr>
<td>Evidence concerning cost effectiveness is available</td>
<td>1 peer-reviewed publication</td>
</tr>
<tr>
<td>Evidence concerning effectiveness of dissemination method</td>
<td>4 peer-reviewed publications</td>
</tr>
</tbody>
</table>

For a comprehensive list of the scientific evidence base supporting Triple P see Appendix 1.

¹ Supporting evidence is demonstrated by publications showing positive effects and the absence of studies showing adverse effects.

² 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), 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.

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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
<th>Parent Resource</th>
<th>Practitioner Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Triple P (Level 1)</td>
<td>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).</td>
<td>Media promotion kit (clips from print, radio and television)</td>
<td></td>
</tr>
<tr>
<td>Selected Triple P (Level 2)</td>
<td>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.</td>
<td>48 tip sheets (including 3 Seminar Series tip sheets)</td>
<td>Facilitator’s manual PowerPoint presentation</td>
</tr>
<tr>
<td>Primary Care Triple P (Level 3)</td>
<td>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.</td>
<td>Level 2 resources 1 booklet</td>
<td>Practitioner’s manual 1 consultation flip-chart 1 wall-chart 1 Every Parent video/DVD*</td>
</tr>
<tr>
<td>Group Triple P (Level 4)</td>
<td>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.</td>
<td>1 workbook*</td>
<td>Practitioner’s manual 1 video/DVD* PowerPoint presentation</td>
</tr>
<tr>
<td>Enhanced Triple P (Level 5)</td>
<td>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.</td>
<td>1 workbook*</td>
<td>Practitioner’s manual 2 Triple P videos/DVDs*</td>
</tr>
<tr>
<td>Stepping Stones Triple P (Level 5)</td>
<td>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</td>
<td>1 workbook*</td>
<td>Practitioner’s manual 1 video/DVD*</td>
</tr>
</tbody>
</table>

* 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 2: The roll out: Making Triple P available

Figure 4 shows the range and growth of program activities areas in targeted (high intensity) communities over the course of the trial.

Figure 4 Triple P activity coordinated by the Every Family team

Indices of increased program availability to extend usual service delivery were measured over two years from August 2003 to September 2005:

- Increased media coverage on parenting issues. Every Family staff contributed to or were involved in 55 newspaper articles, 36 radio interviews and 30 television programs (magazine, news or current affairs programs)
- 121 Triple P large group seminars were conducted
- 35 intensive parenting groups were conducted
- 7 workplace Triple P groups for teachers were conducted
- Access to Triple P trained telephone counsellors through Parentline (7 days per week, 8am to 10pm)

The section below documents the effectiveness of activities undertaken to ensure adequate availability of Triple P in the target catchment areas.

Three additional pieces of evidence were gathered during Every Family to show that Triple P, as delivered in Every Family had the desired effect on both parents and their children. The following questions were examined: 1) How effective were the Triple P parenting seminars?; 2) How did consumers evaluate the seminars?; and 3) To what extent was Group Triple P effective, when delivered as an intensive one-day program? Does it produce outcomes comparable to the 8 week program used in other Triple P studies?
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 as pre-intervention.

![Figure 5 Total behavioural and emotional difficulties at pre- and post-intervention by condition](image)

- 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.
Figure 6 Total inappropriate parenting at pre- and post-intervention by condition

Study 4: What did parent consumers think of the Triple P seminar series?

This study examined overall consumer satisfaction in a larger sample (N=1156) of parents attending the three Positive Parenting Seminars (Seminar 1: Power of Positive Parenting, Seminar 2: Raising Confident, Competent Children, and Seminar 3: Raising Resilient Children). Results indicated that the majority of parents were very satisfied with:

- Quality of the seminar presentation (85%)
- Content of the seminar presentation (90%)
- Opportunities for questions during the seminar (88%)
- Clarity of examples provided to illustrate parenting ideas during the seminar (91%)
- Knowledge and information gained to facilitate implementation of the parenting advice offered (86%)
- Understanding gained of how to help their child learn new skills and behaviour (88%)
- Usefulness of the parenting tip sheet provided (94%)

Additionally, the overwhelming majority of parents attending the seminars indicated that they intended to implement the parenting advice received (96%).

Parent satisfaction ratings on various aspects of the Triple P Seminar Series appear in Figure 7. Satisfaction ratings were made on a seven point scale. Parents who had ratings of 5 (satisfied) or above appear below. Overall, there was a high level of parent satisfaction with the seminars.
Figure 7 Parent satisfaction rating of the Triple P Seminar Series

Study 5: How effective was Group Triple P as delivered in Every Family?

Group Triple P, in its original format, has been extensively trialled previously and shown to be an effective intervention. Thus, we did not attempt to replicate earlier findings. However, during Every Family it became apparent that many parents were looking for an intervention with less time commitment. As such the Group Triple P intervention was offered to parents in both the usual 8-week format and in a condensed one-day workshop version, followed by three optional telephone consultations. We decided to track the clinical outcomes of a sample of groups conducted in this way (N=49) to gauge the feasibility and impact of this method of program delivery compared with published clinical trial outcomes. A study evaluating the short-term intervention effects of Every Family Group Triple P confirmed the efficacy of the program in improving parenting variables implicated in the development and maintenance of child internalizing and externalizing disorders and enhancing parenting variables considered to be protective factors.

Specifically, it was found that after completion of Group Triple P there was:

- A significant reduction in parents’ level of inappropriate parenting practices including laxness, overreactivity and verbosity
- A significant improvement in parents’ satisfaction in their relationship with their partner
- A significant improvement in parents’ confidence in managing problem child behaviour
- A significant reduction in parents’ levels of anxiety and stress
- Movement from the clinical range of depression prior to the intervention to the non-clinical range in the majority of parents
Moreover, the study also demonstrated improvements in behavioural problems of children whose parents participated in Group Triple P. After completion of Group Triple P there was:

- A significant reduction in parents’ ratings of children’s conduct problems
- A significant reduction in parent’s ratings of children’s total emotional and behavioural difficulties
- A high level of parents’ satisfaction with the program

The effects obtained with the intensive one day program were similar to those obtained with the eight week version of Group Triple P in prior research.

**Study 6: Case studies**

Three case examples were developed to highlight important process issues and organisational factors that needed to be addressed in delivering the program. These studies showed that different communities adopted *Every Family* in various ways.

- The driving force in delivering Triple P varied between schools, health professionals and family day care centres.
- The establishment of networks and referral pathways was important in improving the reach of *Every Family*.
- Adoption of *Every Family* was related to the level of support from practitioners and parents in the community.
- *Every Family* activity spread to surrounding schools when it had been effectively implemented in one location.
- The provision of Triple P resources was an important factor in the promotion of *Every Family*.
- *Every Family* Project Officers played a significant role in the development of networks and were able to facilitate relationships to share the delivery of Triple P, e.g. three schools combined to offer Groups and Seminars.

**3.1.6 Criterion 6: Having an effective training and dissemination system available**

The implementation of Triple P in *Every Family* as a public health intervention requires that service providers have access to appropriate training to deliver the intervention and be adequately supported following initial training. Two studies were conducted that provided evidence concerning the efficacy of the training and dissemination process employed.

**Study 7: How effective was the professional training provided to deliver Triple P?**

A total of 375 practitioners serving the high intensity catchment areas participated in Triple P training courses conducted as part of *Every Family*. Twenty one training courses were conducted. These courses included 2-5 day training programs, depending on the specific course completed. Training was provided by Triple P International for five different levels. These were Selected Triple P, Primary Care Triple P, Group Triple P, Stepping Stones Triple P, and Enhanced Triple P. Practitioners undertaking the training were assessed before and after completing the course of the training and then again after completing accreditation. The main findings were:

- In all training conducted for the five levels of intervention there was a significant increase from pre- to post- training in the level of practitioner self efficacy across a wide range of targeted skills relevant to that specific level of training.
• Practitioners reported high levels of satisfaction with the quality of the training they received during both training and accreditation sessions (6.3 and 6.5 respectively on a scale with a maximum score of 7 indicating high satisfaction).
• There were similarly high ratings for the quality of presentation, level of active participation, workshop content, and whether the training equipped them with the skills they needed to implement Triple P in both training and accreditation workshops.
• 73% of practitioners who completed Module 1 of the training completed Module 2 and were subsequently accredited.
• Practitioners who attended the accreditation days reported a high level of satisfaction with the training.

Overall, the evaluations of the professional training courses by participants showed they were considered to be very high quality. Hence, these findings suggest that the criterion of having an effective training system was met.

Study 8: What factors were associated with provider use of Triple P subsequent to training?

The provision of quality initial training does not guarantee that professionals will use an intervention in the manner intended or in a manner that is likely to produce a good clinical outcome. Therefore, Every Family provided an opportunity to examine factors that might help us understand when and under what circumstances practitioners implement Triple P interventions with families. To accomplish this, practitioners who participated in Triple P training were contacted to participate in a structured telephone interview to assess the amount of time practitioners devoted to learning Triple P, the extent of their use of Triple P with families, and to identify factors that might have functioned as facilitators of or barriers to program use. Data have been collected from 102 practitioners and this study will be completed in the next month. The preliminary findings from this sample were:

• The majority of practitioners (79%) reported using Triple P subsequent to initial training.
• On average it took practitioners 27 hours including attending training and accreditation, course preparation and reading to learn Triple P skills.
• On average practitioners spent 5.94 hours per week in parent consultation with about a quarter of that time devoted to Triple P (27%).
• The majority of practitioners used Triple P in a relatively brief 15-30 minute consultation reflecting the large number of trained practitioners working in a primary care context.
• Practitioners reported using Triple P with an average of 56 families over the implementation period.
• The majority of practitioners (52%) reported there were no barriers or only minor barriers to program use.
• The main barrier to program use among practitioners who reported never or rarely using Triple P related to organisational factors such as lack of time due to competing workload commitments.
• The majority of practitioners (79%) reported being confident in their use of Triple P.
• Most practitioners were satisfied with the level of support provided by the project.
• The factors that were rated most highly by practitioners as being helpful in their use of Triple P were attending the Triple P training (52%) and Triple P resources (50%).
• Approximately 71% of practitioners rated the quality of parenting services in their community as adequate or better.
• The majority (53.8%) of practitioners considered that Every Family had improved the availability of parenting support and advice in their community.
3.1.7 Criterion 7: Tracking outcomes at a population level

To conclude that a public health intervention reduced the prevalence rates for a target problem, some form of population level auditing or survey of parents is needed to assess whether parental concerns about children’s behavioural and emotional problems have decreased, whether there has been an increase in parents use of positive parenting methods and a decrease in dysfunctional parenting practices. Changes in parent participation rates in parenting programs, and access to formal and informal support should also have changed. *Every Family* used the CATI methodology to provide data on the impact of the initiative at a population level.

The population level effects of *Every Family* will be reported following the completion of this survey, which commences in February, 2006.

4 MAIN FINDINGS

4.1 There is a clear need for a population level parenting intervention

The baseline prevalence survey established widespread concerns amongst Australian parents about children’s behavioural and emotional problems. A large proportion of parents reported using parenting strategies that are likely to contribute to conduct problems and emotional difficulties. Only a minority of parents had sought professional help or had participated in a parenting program. These findings provide further justification for seeing parenting difficulties as a significant public health problem and indicate the need for a coordinated, multilevel, whole of population approach to the problem.

4.2 Large-scale parenting interventions are feasible and accepted by the community

The feasibility of mounting such a large-scale population level mental health promotion intervention targeting parenting was demonstrated. This resulted in a considerable increase in the availability of parenting support to parents in high intensity (full exposure) areas. Many parents benefited from involvement in *Every Family* and reported significant benefits as a result of their involvement.

4.3 The capacity of the workforce to deliver evidence-based parenting programs was strengthened

*Every Family* equipped and resourced a workforce to employ an evidence-based parenting intervention to promote better mental health outcomes for children. These workers included teachers, general practitioners, social workers and other Queensland Health, Education Queensland and Parentline staff. Professionals serving the target communities as a result of *Every Family* experienced increased capacity to handle child behavioural and emotional problems more effectively. Further a significant number reported becoming more receptive to other evidence-based programs.

4.4 *Every Family* helped create a shared vision across sectors about the value of parenthood preparation

The initiative showed that a committed management team comprising different organisations could come together for the common purpose of promoting better parenting for children.
4.5 The Triple P-Positive Parenting Program is effective as a multilevel public health approach to strengthening parenting in the community

This project provided further evidence of the effectiveness of Triple P as a parenting intervention and taken together with other evidence from previous clinical trials on the program it has established the viability of implementing Triple P as a multilevel public health approach to promoting positive parenting in the Australian community. Results from the eight sub studies conducted as part of the evaluation show that Triple P is a cost effective way of producing a range of positive child and parent mental health outcomes at a key phase in a child’s development, namely the transition to school period. Improved family functioning, reduced stress and depression in parents in turn reduce children’s vulnerability to becoming depressed and developing other serious mental health problems.

*Every Family* has been an effective vehicle for increasing the capacity of service providers in a range of settings to deliver evidence-based parenting interventions.

Table 3 below demonstrates how *Every Family* met each criterion necessary to classify it as a successful intervention.

**Table 3 Evidence that *Every Family* meets the criteria to classify it as a successful public health intervention**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Meets criteria</th>
<th>Evidence relating to each criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Knowledge about base prevalence rate of target child problems</td>
<td>YES</td>
<td>2 peer-reviewed publications</td>
</tr>
<tr>
<td>2. Knowledge about base prevalence rates of family risk and protective factors available</td>
<td>YES</td>
<td>2 peer-reviewed publications</td>
</tr>
<tr>
<td>3. Knowledge that changing risk and protective factors improves child outcomes</td>
<td>YES</td>
<td>44 peer-reviewed publications</td>
</tr>
<tr>
<td>4. Effective interventions are available</td>
<td>YES</td>
<td>15 videos 17 practitioner manuals</td>
</tr>
<tr>
<td>5. Intervention can be made widely available</td>
<td>YES</td>
<td>4 peer-reviewed publications</td>
</tr>
<tr>
<td>6. Effective training and dissemination system is available</td>
<td>YES</td>
<td>3 peer-reviewed publications</td>
</tr>
<tr>
<td>7. Tracking of outcomes at population level is feasible</td>
<td>YES</td>
<td>1 peer-reviewed publication</td>
</tr>
</tbody>
</table>

For further information about publication sources please refer to a more detailed analysis in the Technical Report.

5  **KEY LESSONS LEARNED**

An important aim of *Every Family* was to gain a greater understanding of practical and logistical aspects of rolling out a large scale population level parenting initiative. Key learnings from each phase of the project are discussed below.

5.1 Lessons learned from the planning phase

- The importance of establishing clear population targets for parental participation.
Prior research had evaluated different levels of the Triple P intervention but no study had examined the effects of delivering all levels concurrently. The consequence of this was that it was unknown how the concurrent availability of alternative delivery modalities would affect the demand for participation in a specific modality (e.g., Group Triple P). Although ideally all parents should be offered an opportunity to complete Triple P, it is useful to know how many parents need to receive a Triple P intervention to be able to detect a meaningful reduction in the number of children with behavioral or emotional problems. To achieve a 5%, 10%, and 15% reduction at a population level in child behavioral and emotional problems, the respective parent participation rates are 33%, 66%, and 99% respectively.

**Figure 8** Population reach of Triple P needed to achieve a desired reduction in prevalence of behavioral and emotional problems

- **The need for an evaluation plan that informs the delivery as well as reports on outcomes**

The evaluation of a large scale population trial is a complex process. The original design selected was a cluster evaluation design that involved a comparison of three sociodemographically equivalent catchment areas using a CATI survey to evaluate the impact of implementing Triple P. During the course of the trial a number of additional evaluation opportunities arose (studies 2-8) that helped to inform how to deliver *Every Family* in the future.

- **Recruitment of schools**

Schools eligible to participate in *Every Family* were selected on the basis of random assignment in South Brisbane to the high intensity catchment area. With this design, the consultation and liaison at local school level could only begin with the implementation phase. An alternative method for initial recruitment of schools might have included a self-selection or tendering process that involved schools being accountable for their own targets and performance goals, in relation to parenting services. It might also involve schools receiving discrete allocated funding to address implementation obstacles (e.g., reimbursement for teacher release time).
• **Availability of trained providers to deliver programs**

All participating agencies and service providers agreed to have staff involved in the project and to undertake training. Competing demands and other priorities made delivery of Triple P groups difficult in some settings. Greater commitment could potentially be gained prior to training, by putting into place a formal agreement for implementation requirements post training. For example, have a written contractual agreement with the organisations sending staff to training to ensure that only those staff committed to actually implementing the program attended training. This would improve the cost efficiency of the training and potentially reduce the number of staff that need to be trained.

More formalized contractual agreements were in fact implemented in the latter phase of the project (2005), when additional Level 4 training places were offered to independent schools. These schools “self-selected” into training on the basis that they would be expected to conduct a minimum number of parenting groups per school term. A contract, clearly describing the commitment expected from both parties, (and support needs identified by practitioner) was signed by both practitioner and school principal. Regular supervision was provided to practitioners by the project manager and some of these practitioners worked together in teams to deliver parenting groups, thereby establishing their own peer support networks.

• **The need to address organisational barriers such as perceptions of “core business” within schools and where parenting programs fit within the framework of school agendas and priorities**

Integration into school business plans may be one strategy. Strong advocates in the education sector are required to progress initiatives such as *Every Family* and to provide leadership and policy direction. Schools may also need incentives to “pick up the parenting agenda”, in an environment where they are constantly juggling community expectations.

• **Ensuring sufficient personnel to plan and organise parenting seminars and groups.**

Originally it was envisaged that many schools would want to plan and organise their own seminars and groups for parents. As time progressed it became apparent that a central booking system coordinated by the project management team was needed to support schools with this task. An administrative assistant to respond to telephone inquiries about *Every Family* and to organise and book venues was needed. Once this occurred there was a significant increase in school-based delivery of programs.

• **The importance of group-based delivery**

The Triple P system has a number of flexible delivery modalities including group, individual, telephone assisted and self directed to ensure adequate population reach of the intervention. Most parents participating in Triple P in this trial attended parenting groups. Group-based delivery of the program through the Triple P seminar series and Group Triple P are the most cost efficient ways of engaging large numbers of parents.

• **Role of General Practice**

Issues around privacy legislation and business competition between GPs were noted by other health and school staff as potential barriers to the development of better communication and referral pathways. In the future a voluntary list of consenting GPs trained in Triple P along the lines used by beyondblue to allow identification of GPs with additional Level 1 training under the Better Outcomes in Mental Health Strategy in the management of depression would be useful.
There is a need to explore additional strategies for improving the communication and referral links between GPs and other Triple P service providers in a community.

5.2 Lessons learned about engaging parents

5.2.1 Creating a “new” tradition of preparation for parenthood

The idea of parents undertaking parenting programs to support their child at school is not new; however it is not the norm and is new to many parents and schools. Once it becomes better established and the benefits to parents, children and schools become clear, parents themselves become strong advocates and word of mouth creates a kind of “social contagion”.

The project demonstrated that, in some schools, it was possible to gain the support of key administrators and school staff in “fast tracking” acceptance of parenting programs as the norm. One Brisbane South school decided early in the project to focus on increasing promotional efforts with their preschool parents, and introduced an active school policy of universal parental participation in Triple P programs. This included all preschool and year one parents receiving Triple P information at student intake interviews, in addition to regular advertising of seminars and groups and tip sheet displays. This school trained all their key staff including preschool teacher, principal, deputy, guidance officer, Advisory Visiting Teacher (AVT) and Special Education Development Unit (SEDU) staff.

In the wider roll out of Triple P through schools, liaison and consultation is desirable with peak professional bodies such as the Australian Primary Principals Association, the Australian Principals Associations Professional Development Council, Association of Heads of Independent Schools of Australia and Association of Principals of Catholic Schools of Australia.

5.2.2 The use of the media to increase public awareness of Triple P

Over the course of the trial the communication and social marketing strategy used promoted much greater public awareness of Triple P and increased parental awareness of the availability of the program. A media and communication strategy that involved building relationships with the media meant the strategy needed to be dynamic, and responsive to current affairs and news events related to children and families that the media were interested in. Every Family showed it was possible to gain considerable positive media coverage without paid advertising campaigns. At different stages of the roll out different media strategies were used to combat negative media stories about children and families. Some of the most effective media in producing parental engagement were through school newsletters. However, the use of mainstream media (radio and television) helped promote a culture of acceptance that parenthood preparation is a normal and healthy thing for a parent to do. Recent evidence, from a controlled trial funded by the Home Office in the UK that evaluated the impact of an ITV documentary series on Triple P with British families, “Driving Mum and Dad Mad”, showed how television can be used to promote positive parenting in the community.

5.2.3 The importance of timing outreach efforts

The success of any population level parenting intervention rests on its capacity to engage a sufficient number of parents who complete the program. The social marketing efforts to get parents involved were most successful in the first two terms of the school year and least successful in term four. Also, newsletters from schools and preschools were the most productive ways of parents finding out about Triple P. Evening seminars and weekend (Saturday) groups proved to be the most popular times in terms of parental attendance.
5.2.4 Understanding the priorities and competing demands of parents

Although parents of young children are generally interested in parenting programs, many have competing work and family responsibilities that interfere with their capacity to commit to and complete parenting programs. This highlights the importance of focussing on strengthening processes to engage parents.

Several strategies were introduced to support parents and maintain flexibility in program delivery, and these were successful in engaging parents. These included the establishment of a central enrolment process, reminder letters, rescheduling of parents into programs, option for enrolment via a website and seminars/groups simultaneously offered across multiple sites.

5.3 Lessons learned about project management

5.3.1 Having sufficient staff to manage a large scale roll out of Triple P

This population level trial was managed with limited staff resources that included a full-time project management position (shared by two staff), three part-time project officers and one part-time research officer. This level of funding necessitated the project team seeking further funding support to assist with both program implementation and evaluation.

Project officers with a sole responsibility for *Every Family* are needed. Key skills that proved to be valuable within the project team included knowledge of school systems and previous experience working within schools. Location of the project team located within the same organisation, with lines of management authority clearly outlined would enhance communication and cohesiveness within the project team.

5.3.2 The need for an appropriate governance structure

The governing structures put in place to guide the design, implementation and evaluation of the initiative, were a necessary component of the project. This included establishment of a National Management Committee and Reference Group. The reference group provided a forum for key stakeholders to maintain engagement in the project and for project managers to receive advice and direction on project activities. The inclusion of a parent consumer representative and representation from indigenous and non-English speaking parents is needed.

5.3.3 Flexible provision of training

As the project proceeded it became apparent that there was a need for regular, ongoing practitioner training to be available. A greater proportion of the overall budget could have been devoted to running additional training courses in all three years of *Every Family*.

5.3.4 Being responsive to feedback from providers

Practitioners experienced in working with particular communities have a lot of local knowledge of the client population and how to motivate parents. Over the life of *Every Family*, we received much useful feedback and advice (both solicited and unsolicited) from participating practitioners regarding all aspects of the project. Seeking and responding to this kind of feedback in a timely manner is important to ensure an effective roll out of the program.

5.3.5 Managing differences in parental uptake across catchment areas

Strategies that are effective with some areas required tailoring to work with others. Creative local solutions were needed to maximise parental involvement. More socioeconomically disadvantaged areas had slower uptake. Strategies that worked well in these initially low uptake areas included a focus on building personal relationships with parents, involvement of a broad range of
community service providers to deliver parenting interventions and delivery of parenting messages via television.

5.3.6 The importance of support for trained service providers

The provision of training to prepare service providers to implement Triple P is essential to ensure that practitioners have the knowledge, skills and confidence to use the intervention with a reasonable level of program fidelity. The training was well received and rated highly by the vast majority of participants. However, a practitioner's capacity to utilise the training is also affected by workplace factors and is only one of a number of steps that need to be undertaken to ensure ongoing support. Project officer support, practitioner workshops, practitioner newsletters, access to website, and supportive telephone calls to practitioners were useful support strategies.

5.3.7 Building the Every Family website

The Every Family website (www.pfsc.uq.edu.au/everyfamily) was established to facilitate communication between the project staff, service providers and the public. The establishment of a website to support a specific intervention such as Triple P is increasingly seen as a low cost vehicle for ongoing communication with practitioners and parents. The further development of a comprehensive internet site for supporting the delivery of specific parenting interventions such as Every Family has an added function of alleviating administrative burden and allowing for a more effective allocation of available resources. The implementation of a reliable internet-based resource can provide an additional degree of flexibility in the delivery of an intervention and increase the likelihood of reaching and engaging a population of interest.

5.4 Lessons learned about aids and obstacles to program use

All interventions occur within a broader sociopolitical and organisational context that can both facilitate and obstruct the effective implementation of a program. In the area of parent education, there are no quality standards relating to the professional competencies required of service providers to counsel or advise parents about parenting issues.

5.4.1 Make training ongoing

Training for professionals in Triple P needs to be regular and ongoing. This would help deal with the issue of high staff turnover. As new staff were appointed or heard about the initiative, training opportunities would still be available.

After completion of initial training, practitioners need timely opportunities to practise and build their confidence before running parenting programs individually. To ensure this occurs, parenting groups and seminars need to be scheduled shortly after training and/or accreditation has been completed. Newly trained practitioners should be encouraged to observe or cofacilitate at these programs.

5.4.2 Involve a wider range of community organisations

Partnerships and having a shared vision are crucial to the overall success of a population health approach. In addition to Reference Committee meetings, regular discussions with key stakeholders concerning the direction of the initiative would be useful. Careful coordination of the implementation, training, and research was necessary. While it worked well to have the implementation, training, and research teams based in separate organisations, it did not work as well to have the implementation team itself split across different organisations. For such a large initiative, splitting the implementation team carries risk of compromising the communication lines and consequently the clear direction for the project.
5.5 Lessons learned about working together

The parties involved in Every Family had pre-existing relationships relating to parenting and family mental health. The model of intervention involved seeking to engage a range of services and agencies potentially in a position to deliver Triple P. However, not all agencies are in a position to deliver the program and decisions need to be made regarding readiness, capacity and level of commitment to being involved. Specific assessment tools to gauge agency readiness would be useful to ensure cost efficient implementation.

5.5.1 Determining who to involve

In a public health application of Triple P, a wide range of organisations including schools, local health services, and a range of community organisations (e.g. NGOs) could deliver the program. Earlier in the program it was decided to concentrate the outreach on schools, health services and general practitioners. There may also be potential to involve others including pharmacies, child care centres and antenatal care services, as part of the mix.

A number of criteria need to be met by a lead organisation /partnership managing the program, to maximize the effectiveness of program delivery. These include the ability to coordinate linkages across a broad spectrum of community agencies, including links with the primary health and education sectors; experience in implementing research projects and evaluation methodologies; and clearly defined organisational priorities that acknowledge the importance of population health and mental health promotion objectives.

5.5.2 Developing a shared understanding between key agencies

A formalized process, such as the development of a Memorandum of Understanding, involving key agencies such as Queensland Health, Education Queensland, Divisions of General Practice (and possibly local councils) is beneficial in clarifying roles and expectations at a service delivery level and in providing support and direction to individual schools and child health services.

6 POLICY IMPLICATIONS OF EVERY FAMILY

When the findings from the present project and prior research are taken together it is clear that Triple P can effect change in a range of important family risk and protective factors related to the development of children’s mental health problems including depression. These changes are directly relevant to not only beyondblue's early intervention policy framework concerning reducing depression and other mental health problems, but to a number of other Commonwealth policy initiatives relating to the health and well being of children and young people. These include the National Mental Health Strategy focusing on mental health promotion, prevention and early intervention, National Suicide Prevention Strategy (e.g. Mind Matters and the Primary Schools initiative), the Youth Mental Health initiative, Better Outcomes in Mental Health Care and the National Illicit Drugs Strategy. Triple P has been designed as a mental health promotion strategy within a public health framework and its goals, methods and conceptual basis are most clearly relevant to a health policy framework. The findings relating to Triple P are also relevant to a number of other government departments (Education and Training, Families and Communities, Attorney General's), and specific policy initiatives such as the Stronger Families and Communities Strategy, and the National Crime Prevention Program. In each of these key policy domains evidence-based parenting or family interventions have been identified as a useful target for intervention.
Recommendation 1: The Commonwealth Government in partnership with other relevant stakeholders should fund a staged national roll out of Every Family throughout Australian States and Territories.

The cumulative strength of evidence concerning the efficacy of the Triple P system of intervention is substantial. This evidence provides a sound basis for government investment in a well researched, evidence-based program that has potential to change a range of important risk and protective factors related to increased risk of children developing serious mental health problems and the burden of these problems on children, their families and carers, schools and the wider community. This public health initiative could be funded as a whole of government approach under one or more of the following programs beyondblue, the National Suicide Prevention Strategy (as part of Mind Matters or the Primary Schools Strategy), a downward extension to include younger children of the Youth Mental Health Strategy or through the Better Outcomes in Mental Health Strategy.

Recommendation 2: Develop an appropriate governance structure to manage the implementation process

The national implementation strategy of Every Family will require a governance structure to ensure that the program is implemented appropriately, with fidelity and in a manner consistent with other policy initiatives of the Commonwealth Government. The key stakeholders in such an endeavour should include beyondblue, the Department of Health and Ageing, the University of Queensland’s Parenting and Family Support Centre, the Australian Divisions of General Practice and Triple P International. The project will need a Board of Management and an Advisory Board comprised of key Government, non-government stakeholders and key consumer groups.

Recommendation 3: Implement Every Family so as to optimise population level benefits

It is recommended that a wider roll out concentrate on group-based delivery of Every Family through the Triple P Seminar Series and Group Triple P. Group and individual forms of the intervention are comparable in their effects. However, group-based delivery has the capacity to reach more parents in a cost-effective manner. This would maximise program reach, would enable the largest numbers of parents to participate, while containing implementation costs. We conservatively estimate that when Triple P is offered universally a 5% reduction (23% to 18%) in the number of 4-7 year olds in the population with clinically elevated behaviour or emotional problems can be achieved when approximately 33% of all families (at least one parent or carer per family) participate in the intervention. To achieve a 10% reduction (23% to 13%), 66% of parents would need to participate.

Recommendation 4: Fund specific research examining the engagement of indigenous and culturally and linguistically diverse populations

Although there is evidence showing that Triple P is effective with a range of cultural groups further scientific work is needed to evaluate the impact of strategies to enhance parental engagement in parenting programs for specific high need groups.

Recommendation 5: Further develop the media and communication strategy used in Every Family
The Triple P media and communication strategy used in Every Family can be enhanced further by developing the Every Family website for parents and practitioners. This website could be linked, as appropriate, to other policy relevant websites concerned with early intervention, mental health and families.

**Recommendation 6: Develop a national television series on parenting**

One of the most useful and wide reaching vehicles for communicating information on parenting involves the use of television. There have now been several controlled trials showing that Triple P when delivered through the medium of free to air broadcast television can be effective in changing parenting practices. It can also rate highly with viewers. Two types of television programs have been evaluated: 1) An infotainment genre television series (“Families” TV3 in New Zealand) on parenting that combined entertainment, and quality information on parenting based on Triple P; 2) An observational documentary series “Driving Mum and Dad Mad” ITV in the UK). The ITV series when shown on TV in March and April was the second most popular UK show in its primetime spot for the previous 12 months. For some parents television will be the only medium through which they will access parenting information.

**Recommendation 7: Seek the support of the private sector**

There is likely to be considerable interest in the private sector in supporting a positive community initiative such as Every Family focusing on strengthening parenting skills. It has considerable potential benefit to employers, due to the costs and loss of productivity associated with family conflict and parenting problems. Workplace Triple P as an employee assistance strategy has been shown in earlier research to reduce occupation stress and increase satisfaction with work. As a strategy to support teachers dealing with other parents children, as well as their own it is likely to be particularly useful.

**Recommendation 8: Establish an appropriate evaluation framework for a national rollout of Every Family**

A carefully thought through evaluation framework is needed from the outset so that the next phase of implementation can generate further knowledge about the impact a population approach to parenting intervention. This framework should aim to use rigorous methods of public health evaluation appropriate to a staged roll out.

### 8 CONCLUSION

Every Family involved the combined efforts of a large number of people committed to improving the mental health and well being of children and their families. The translation of research findings that have established the efficacy and effectiveness of Triple P into an implementation plan involving a public health model was a major undertaking. Every Family is an example of how such an implementation process can take place. The results of the trial to date show the feasibility and acceptance by the community of the approach. The blending of evidence based strategies developed from clinical research trials, with a dissemination strategy that increased the capacity of professionals to deliver Triple P in a manner suited to conditions. Finally, Triple P appears to be a useful vehicle for concurrently improving a range of risk factors linked to mental health problems in both children and parents. From a child’s perspective fewer conduct problems, and less anxiety should reduce vulnerability to depression, later conduct disorders, relationship difficulties and other mental health problems in adolescence and adulthood. From an adult’s perspective when parents are less coercive, indulgent, inconsistent and more confident with their children, have less marital conflict, and are less stressed and depressed there is a significant improvement in emotional well being and quality of life.