

# **BEST START**

## **Effective Intervention Programs**

### **Examples of Effective Interventions, Programs and Service Models**

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Department of Human Services



## **Acknowledgments**

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## 1. Introduction

### 1.1 Purpose of Report

This report has been prepared by the Centre for Community Child Health and the Victorian Parenting Centre as background reading for the Victorian Government's BEST START project. Best Start is jointly auspiced by the Department of Human Services and the Department of Education, Employment and Training (DEET). Its overall aims are to:

- Improve the social, emotional and physical wellbeing of children (0–8 years)
- Improve the capacity and competency of parents and carers
- Assist communities to become more child friendly.

These aims are to be realised through the development of a more accessible, comprehensive, coordinated and flexible universal service platform. This will demonstrate the value and best practice of a community-based approach to health and wellness promotion, prevention and early intervention for families of young children (pregnancy to age eight years) in socially disadvantaged areas in rural, regional and metropolitan Victoria.

The purpose of this paper is to provide an accurate summary of a range of reputable interventions, programs and service models that have been built on or have contributed to the State, national and international evidence base underlying investment in pre-natal, postnatal, infant and early childhood periods of life. The paper describes interventions, programs and service models targeting the child (0–8 years), their parents/carers (including parents to be), and the communities in which they live. Details are given of the evidence on which they are based and their known effectiveness at individual and/or population levels.

### 1.2 Effective Interventions, Programs and Service Models

The original project brief defines **interventions**, **programs** and **service models** as follows:

- **Interventions** are viewed as specific purposeful activities that may have a particular role to play within a program but can also be viewed as a stand-alone activity in their own right. For example, the provision of information about parent and child wellbeing to all new mothers, transport and support arrangements to enable parents/families to take part in social activities, the provision of playgrounds that are safe for children and families and the provision of family rooms in schools to encourage parental involvement. A range of such activities are known to be effective in contributing to the engagement of high risk families and the making of more child friendly communities.
- **Programs** consist of a number of coordinated interventions that take place or are made available over a period of time . Examples of programs include education and support programs aimed at parenting skill development (for example, Positive Parenting Programs), day programs, assertive outreach programs targeting high risk cohorts and so on . Programs may also be

specific services or parts of services (for example, Maternal and Child Health Services, child care, kindergarten/preschool).

- **Service models** of interest in this project include aggregates of services and programs that have been specifically designed, redeveloped or brought together to support improved service responses to children and their parents/families in the interests of improved child health and wellbeing. They will be needs-based, strongly community-driven and consist of a range of programs constructed to facilitate improved access to, and flexibility of, the universal service platform with particular interest in those known to be at high risk who were previously not accessing these services.

### **1.3 Outline of the Report**

The report begins with two sections that explore the rationale and goals of intervention programs for young children and their families. These are followed by three sections that address the evidence for effective programs. The first of these (Section 4) looks at the types of evidence, while the next two summarise the characteristics of effective programs (Section 5) and some proven effective strategies (Section 6).

The bulk of the report (Section 7) is taken up with a series of descriptions of individual interventions and programs. These include specific parenting programs as well as general intervention programs. Details provided include program background and objectives, description of the program, the evidence base for the program, its strengths and weaknesses, and its availability.

The report concludes with a section outlining what we have learned about effective interventions, programs and service models, and some indications of what we still have to learn.

## 2. Rationale for Intervention with Children and Families

If we are to be successful in supporting young children and their families, we need to have a clear rationale. Why intervene with children and families?

Research has shown that:

what young children learn, how they react to the events and people around them, and what they expect from themselves and others are deeply affected by their relationships with parents, the behavior of parents, and the environment of the homes in which they live (Shonkoff and Phillips, 2000, p. 226).

Even when young children spend most of their waking hours in child care, parents remain the most influential adults in their lives. However, the task of childrearing is by no means easy: in addition to fostering a secure attachment with the child:

...parents must have the personal skills to interact constructively with their children, the organizational skills to manage their lives inside and outside the home, and the problem-solving skills to address the many challenges that children invariably present. Doing this well requires sensitivity to the child and an ability to read, interpret, and anticipate what the child needs and how the child is responding to the world. It also requires supports, like child care and social networks, and resources that come with economic security. (Shonkoff and Phillips, 2000, pp. 238–9).

Childrearing is something for which most parents have no training and although they want to do the best for their children they are often uncertain and even fearful about their capacity to provide optimum care. In earlier generations when families were larger, there were more opportunities to interact with young children. These opportunities meant that new parents were more confident about parenting and had greater familiarity with the needs of infants and young children and with their behaviour. Most new parents these days have come from small families and have not had to care for younger siblings (Ochiltree, 1998).

These days, due to mobility, extended family members often do not live close by and are unable to provide practical support on a regular basis (Ochiltree, 2000). Both men and women are in the workforce and even when family members live in the same city, difficulties with traffic, lack of public transport and so on, create barriers to the amount of support that they are able to provide. The high divorce rate in Australia also decreases the likelihood of family members being readily available to support other family members with young children. Grandparents are often working or may be unable for many reasons, including illness, to provide practical support and/or their advice may be seen as out-of-date. The informal support networks of the past are therefore more difficult to maintain in contemporary society. However, many grandparents do provide some child care, often because the parents cannot afford the costs of formal services, but this can be a 'mixed blessing' due to differences in childrearing practices which can cause intergenerational friction in the family.

A number of studies have shown that it is quite common for women to experience increased isolation in the first year of parenting (Baum, 1990; Tilbury, Moynihan and Siddle, 1990; Brown, Lumley, Small and Astbury, 1994). In some cases isolation is associated with post-natal depression.

Another group at increased risk of social isolation is migrant families who are often separated from their relatives and need support in caring for their infants and young children within what they may perceive as a culturally alien environment. Indigenous families need culturally sensitive support within their own community. Work issues also have an impact on parent's time with each other and with their young children. New mothers may feel particularly isolated if their partner is working long hours and they are at home alone with an infant.

There is an increasing divide in Victoria between the rich and poor and poverty places great stresses on families (Travers, 2001). Poor families and their children are particularly vulnerable and need appropriate support that takes into account their economic situation. There are other vulnerable families with young children and their vulnerabilities are often compounded by low income. These families include: families where there is violence, child abuse and/or neglect; those where there is a problem with gambling, substance or alcohol abuse; families where a parent or child has a disability; families where a parent has a mental illness or where a parent is, or has been, in prison. Teenage parents are also particularly vulnerable and usually need some form of supportive intervention as they grapple with caring for an infant or young child while still working through their own adolescent needs.

Vulnerable families, but especially those marginalised by poverty, are less likely to rely on the informal assistance of friends, family or neighbours than those that are better off, because of the norm of reciprocity which means that favours must be returned (D'Abbs, 1991). Furthermore, families with problems, even minor ones, may not want to expose them to family friends and neighbours and the support that they need may be greater than what these informal supports could meet. Nor can the universal services available in Victoria always meet the needs of these families, which are often greater than simple health or education difficulties. These families often need additional supports that enable them to use existing services.

To summarise, the rationale for providing intervention programs for young children and families:

- Social, economic and demographic changes have placed an increasing number of families with young children in vulnerable and inadequately supported situations.
- The existing universal services are unable to meet all the needs of such families.
- The evidence clearly indicates that, without early intervention and support, the health, educational and developmental outcomes for many of the children from such families will be adversely affected.

Having established a rationale for intervention, we now need to consider what these interventions are designed to achieve, that is, what the goals are.

### 3. Goals of Intervention

Various types of services have been identified, each with distinct aims (Davis, Martin, Kosky, and O'Hanlon, 2000; Dunst, Trivette and Thompson, 1990; Huntington, Lima, and Zipper, 1994; Offord, Kraemer, Kazdin, Jensen, Harrington and Gardner, 1999; Simeonsson, 1991, 1994; Simeonsson and Covington, 1994).

Dunst et al. (1990) distinguish between three modes of intervention—treatment, remediation and promotion:

- **Treatment** involves the management and provision of care or help in order to eliminate or minimise the negative effects of a disorder, disease or problem. Treatment interventions focus on the remediation or amelioration of an aberration or its consequences.
- **Prevention** involves efforts to deter or forestall the occurrence of disorder, disease or problem. Preventive interventions occur prior to the onset of negative functioning and seek to reduce the incidence or prevalence of negative outcomes.
- **Promotion** involves efforts to enhance and optimise positive growth and functioning. Interventions focus on developing and enhancing people's competencies and capabilities.

Dunst et al. (1990) suggest that human services typically begin with a treatment focus and then evolve. Because successful treatment does not guarantee that the problem will not recur, service providers turn to remediation strategies to reduce the occurrence of the problem. And because successful prevention does not guarantee any strengthening of competencies or capabilities, providers eventually turn to promotion strategies.

Another common way of classifying types of prevention strategies is to distinguish between primary, secondary and tertiary prevention (Huntington et al., 1994; Offord et al., 1999; Simeonsson, 1991, 1994; Simeonsson and Covington, 1994; Statham, 1997):

- **Primary prevention** focuses on reducing the incidence (the number of cases) of an identified problem or condition. In a complementary manner, it can also be defined as the primary promotion of health, development and adaptation.
- **Secondary prevention** focuses on reducing the existing number of cases and lowering the prevalence of the manifested problems or condition in the population. From a promotion perspective, the emphasis is on the acquisition of compensatory skills and behaviour.
- **Tertiary prevention** aims to reduce the expression of the sequelae and complications of the diagnosed or identified condition. Programs and services of this kind have a rehabilitative and remedial focus.

Simeonsson (1994) has identified the following assumptions underlying a primary prevention approach:

- Primary prevention and primary promotion are complementary processes.
- The manifestation of a problem or condition is preventable.
- Primary prevention efforts of a universal nature are designed to promote wellbeing in the population at large.
- Primary prevention and primary promotion programs should be based on a proposed causal, or at least sequential, risk chain as a logical foundation on which to base the nature and timing of interventions.
- It is important to intervene early, thereby capitalising on the momentum provided by the developmental forces afforded in childhood.

Evidence for the effectiveness of primary prevention programs has been summarised by Schorr (1991). Among the characteristics of effective prevention programs are:

- They are interdisciplinary in nature
- They minimise bureaucratic boundaries
- They have a strong family and community orientation
- They ensure convenient and ready access to a wide array of services
- They promote relationships based on trust and respect
- They seek to personalise preventive services relative to the extent of risk.

Another way of classifying services is described by Offord et al. (1999) who identify three models or service systems for addressing the developmental health needs of children and families: universal, targeted and clinical. Davis et al. (2000) make the same distinction but use the terms 'universal', 'selective' and 'indicated' services. Offord et al. define these different service types as follows:

- **Universal interventions.** The cardinal characteristics of this type of program are that individual families (and their children) do not seek help and children are not singled out for the intervention. All children in a geographic area or setting (for example, a school) receive the intervention. In the past, the term 'primary prevention' was used.
- **Targeted interventions.** The predominant characteristics of these interventions are that children and their families do not seek help, and certain children are singled out for the intervention, not necessarily because they already have a disorder but because they are at high risk for developing one. In the past, the term 'secondary prevention' was used.
- **Clinical interventions.** The major characteristic of this type of program is that the family with a child who is perceived to have a disorder seeks help and are seen by some type of specialist or clinical service. In the past, the term 'tertiary prevention' was used.

When we combine the service types outlined above, four service models can be distinguished according to their availability and focus:

- **Universal services** which are available everywhere and to everyone.

- **Targeted/universal services** which are targeted to particular at-risk areas (for example, high poverty areas) but are available to everyone in that area.
- **Targeted/eligible services** which are targeted to particular at-risk groups and available only to those who meet certain specified criteria (for example, income level).
- **Clinical services** which are available to those who meet certain criteria (for example, children with disabilities) wherever they live.

These service models are summarised in the following table:

	<b>Location</b>	<b>Eligibility</b>
<b>Universal</b>	Everywhere	Everyone
<b>Targeted/Universal</b>	Selected groups or areas	Everyone
Targeted/ <b>Eligible</b>	Selected groups or areas	Eligible individuals only
<b>Clinical</b>	Everywhere	Eligible individuals only

## 4. Types of Evidence: Evaluating the Evidence Base

Program developers have dealt with the issue of evaluation in different ways. Some have conducted complex and rigorous scientific studies whilst others have not systematically evaluated their programs at all. A program cannot be considered to be evidence-based unless some form of evaluation has been undertaken and the program has been shown to be effective. Determining whether any one particular program is evidence-based requires an understanding of the purpose, nature and context of evaluation.

The kind of methodology adopted in conducting program evaluation depends on the types of questions that the evaluator wishes to ask. Questions can be asked about the outcomes of the program for participants, the conditions or contextual variables that influence whether certain outcomes are achieved, the appropriateness of the program for certain populations, or the perceptions of participants about the program or intervention. However, the one consistent and distinguishable purpose of evaluation work has been to determine the validity of programs, and the degree of confidence we can have about the stated effects a program has on a target population. In a nutshell, the purpose of evaluation is to determine whether a program is successful in achieving its aims.

### Types of Evidence

Evidence for the effectiveness of parenting programs and interventions can come from three different types of studies: **efficacy** studies, **effectiveness** studies and **value** studies. Each type of study produces different levels of empirical evidence ranging from a high level of empirical evidence provided by efficacy studies, to a lower level of empirical support provided by value studies. The term 'empirical' refers to a scientifically accepted standard of evidence. The higher the level of empirical evidence, the more confidence we can have that the program or intervention actually works.

#### ***Efficacy Studies***

A program is said to be "efficacious" if positive outcomes of the program are determined under highly controlled experimental conditions. In order to demonstrate efficacy, this type of evaluation follows a series of scientific guidelines. Either group design studies (randomised controlled trials) or single-case experimental studies are conducted.

In a randomised controlled trial, participants are randomly allocated to two or more groups. Randomisation is used to ensure that the groups are as similar as possible. One group of participants is given one type of intervention, whereas the other group receives a different type of intervention or no intervention at all (in most clinical trials this usually involves a wait list control group who are offered the intervention at a later stage). A series of measures relating to the variables of interest (for example, child behaviour, parenting behaviour, parental attitudes) are undertaken before the intervention and sometimes again after significant time has passed following the intervention. Single-case experimental studies, on the other hand, focus on the study of one particular case or individual. They involve carefully designed observations of the participant's

behaviour before, during and after intervention. Comparing the pre-intervention and post-intervention observations gives the evaluator an opportunity to determine the impact of the intervention.

Efficacy studies are valuable in that they are capable of demonstrating that the program, as opposed to other factors (such as the passing of time or characteristics of the parenting professional) is responsible for any changes observed in parent and/or child behaviour. This is the only type of study that can conclude with any confidence that the program, and not extraneous factors, is producing the specific effects that are observed. Efficacy research is a rigorous approach to evaluation. However, one limitation with efficacy studies is that they often lack ecological validity. For example, in order to achieve comparable groups, strict exclusion criteria are applied in clinical trials; families or children who may present with multiple difficulties are often excluded from the trial because clinical trials are generally established to test the effects of an intervention on a specific problem or variable (for example, a child with a disability might be excluded from a trial evaluating the impact of a program on Attention Deficit Hyperactivity Disorder (ADHD) because of his or her dual diagnosis). In addition, participants in these studies agree to be randomly allocated to treatment conditions, rather than being individually matched to a treatment program, and treatment integrity is tightly maintained to allow comparison of approaches, rather than tailored in content and duration to the individual's needs. Clearly the conditions under which professionals provide services to families are quite different to those that are found in a clinical trial. Thus there is a question about ecological validity, or the issue of how and if the same program outcomes produced under the tightly controlled conditions found in clinical trials will be produced when the intervention is delivered in the community. This problem can, however, be overcome by also conducting 'effectiveness' studies.

### ***Effectiveness Studies***

Effectiveness studies are used to answer the question: 'Does the program work under field conditions?'. A program is said to be 'effective' when it was carried out in the field under natural conditions and produced positive outcomes. Usually effectiveness studies have some, but not all, of the criteria used for establishing efficacy. To conduct an 'effectiveness' study, measurements of the parent's and/or child's behaviour are taken before and after the program, and control groups may or may not be used. The evaluator can then determine whether the program has been effective in changing the parent's and/or child's behaviour by comparing these measurements. Because the methodology used is not as rigorous as that used in efficacy studies, the empirical evidence produced by effectiveness studies is not as strong. However, ecological validity for effectiveness studies tends to be higher than that of efficacy studies, and they are particularly useful in combination with efficacy studies to determine that programs that work in clinical research settings can produce similar outcomes when they are delivered from community-based services.

### ***Value Studies***

It is possible to determine whether parenting programs are potentially effective and have possible value without conducting rigorous evaluation studies like those described above. A program can be said to have 'value' when there are positive

measurable outcomes. Value studies may use simple post-program measurable outcomes, such as consumer satisfaction questionnaires. Systematic collection of data relating to consumer's experience with and acceptance of a program are important to any program evaluation. Because of the lack of a comparison or control groups, or pre and post measures, value studies cannot make firm conclusions about whether a program has worked or not. However, value studies can provide important preliminary evidence that can be used to justify further evaluation of a program's effectiveness and efficacy.

### **Concluding Comments**

In summary, the assessment of the evidence supporting intervention programs is grounded in an understanding of the purpose and nature of evaluation. Program evaluators conduct studies that take a variety of forms, depending on the type and scope of questions asked, and the degree of rigour that is required to answer those questions. Some programs may have potential value if strong consumer acceptability and satisfaction is demonstrated. However, it is important that programs that have been found to have potential value are evaluated more rigorously, not only to provide stronger empirical evidence for the effectiveness of the program, but also to generate further knowledge about the program itself and the conditions under which it does or does not produce positive outcomes. Ultimately, if causal effects are to be drawn between a particular program and outcomes, studies that use randomised control groups are necessary. Needless to say, programs that have not been evaluated at all must be regarded as having no known value, and it is imperative that evaluation studies be conducted.

Clearly, what we are most interested in are examples of interventions and programs that are both efficacious (proven under controlled conditions to have desirable outcomes) and effective (known to work under real conditions). The interventions and programs that are discussed in the remainder of this report meet one or both of these criteria.

## 5. Characteristics of Effective Strategies and Programs

What makes a program or intervention effective? Summary statements of the key features of intervention strategies and programs have been produced by the Committee on the Integration of the Science of Early Childhood (Shonkoff and Phillips, 2000), Fonagy (2001), Halpern (2000), Sanders and colleagues (Triple P Parenting and Family Support Centre), and Schorr (1991).

On the basis of a converging body of knowledge derived from theory, research and practice, Schorr (1997) has identified seven attributes of programs that have proved to be highly effective in supporting families:

- **Successful programs are comprehensive, flexible, responsive and persevering.** No one ever says that this may be what you need but it is not part of my job to help you get it.
- **Successful programs see children in the context of their families.** They know that strong families are the key to healthy children, so they focus on family strengths and work with all generations involved in the household.
- **Successful programs deal with families as parts of neighbourhoods and communities.** Successful interventions cannot be imposed from without, but respond to the needs identified by the community.
- **Successful programs have a long term, preventive orientation, a clear mission, and continue to evolve over time.** They address the preventable risk factors that occur at an early age (for example, during pregnancy), and create an organisational culture that is outcome-oriented rather than rule-bound.
- **Successful programs are managed by competent and committed individuals with clearly identifiable skills.** Effective managers use identifiable management techniques to create a coherent, outcome-oriented organisational culture.
- **Staff of successful programs are trained and supported to provide high quality, responsive services.** The greater the discretion given to front-line staff, the more important it is to provide excellent training, monitoring and supervision to ensure that the mission goals are achieved and services of high quality provided.
- **Successful programs operate in settings that encourage practitioners to build strong relationships based on mutual trust and respect.**

According to the Committee on the Integration of the Science of Early Childhood (Shonkoff and Phillips, 2000), the essential features of effective early interventions are as follows:

- **Individualisation of service delivery:** Effective intervention demands an individualised approach that matches well-defined goals to the specific needs and resources of the children and families who are served. Interventions of this kind have been shown to be more effective in producing desired child and family outcomes than services that provide generic advice and support. Furthermore, programs that directly target the everyday experiences of children appear to be more effective in improving their acquisition of skills

than those that seek to promote child development indirectly by enhancing the general quality of the caregiving environment.

- **Quality of program implementation:** The effectiveness of services is greatly dependent upon the quality of the intervention that is actually delivered and received by target children and families.
- **Timing, intensity, and duration of intervention:** Earlier identification and intervention are more important for some conditions or circumstances than others. However, definitive answers regarding duration and intensity are hard to establish, although duration has been found to be associated with measurable family impacts. The ultimate impact of interventions may be dependent upon the degree to which families are able to incorporate specific intervention techniques into their everyday interactions with their children.
- **Provider knowledge, skills and relationship with the family:** Child care research has shown that having well-trained and qualified staff leads to better child outcomes, particularly for low-income children. While there is no direct evidence for the importance of having well-trained staff working in more specialised early childhood services (such as early childhood intervention), it is clear that working with families of children with special needs demands highly skilled staff and creates a complex challenge for the early childhood field.
- **Family-centred, community-based, coordinated orientation:** These three concepts or principles are firmly embedded in the professional philosophies that guide most early childhood programs.

Halpern (2000) identifies a number of key service delivery principles that can be derived from program developers' and service deliverers' reflections on their experience rather than from the evaluation literature:

- It is important to have an **explicit theoretical framework**, 'addressing such issues as what children need, what is more important about parenting and parent-child relationships, what good helping relationships are about, how they develop, and how they help bring about change' (p. 377). The value of such theoretical frameworks are that they help providers make sense of what they are observing and learning about families and decide how and where to intervene.
- It is also important to have a **clear mission and boundaries**, albeit flexibly implemented. Individual helpers cannot be all things to all people, and there are dangers in spreading oneself or one's service too thin.
- In addition, **interventions have to start where families are at developmentally** – what parents are capable of investing in and contributing to the helping relationship and in their own lives – and should begin with the parents' own experience of their situation and their own perceptions.
- Services should be based on the recognition that **individual growth and change are spurred by, or occur through, relationships**, and an understanding that building good relationships takes time.
- Working from **a strength perspective** does not mean denying or ignoring family vulnerabilities and difficulties, nor does it mean that workers should deny their own complex and not always positive feelings towards their clients.

- In viewing the child in the context of the family, we should not lose sight of the child's individual needs.

Principles of effective parenting skills programs have been identified by Sanders and colleagues (Triple P, Parenting and Family Support Centre):

- **Programs should empower families:** Parenting skills programs aim to enhance families' ability to solve problems for themselves. Programs that promote dependency are destructive. In most instances families have lesser need for support over time.
- **Programs should build on existing strengths of families:** Successful parenting programs build on the existing competencies of family members. It is assumed that individuals are capable of becoming problem solvers, even though their previous attempts to resolve problems may not have been successful.
- **Program goals should address known risk variables:** Parenting skills programs vary according to the focus or goals of intervention. The focus of the intervention depends on the theoretical underpinnings of the approach used. Some programs focus on behavioural change, while others concentrate on cognitive, affective or attitude change. However, a common goal in most effective programs is to improve family communication, problem solving, conflict resolution and specific parenting skills. Interventions that have proven most successful address variables that are known to increase the risk of individual psychopathology.
- **Programs should be designed to facilitate access:** It is essential that programs are delivered in ways that increase, rather than restrict, parents' access to services. Professional practices can sometimes restrict access to services. For example, inflexible clinic hours may prevent working parents from participating in parenting programs. Programs may take place in many different settings, such as clinics, hospitals, homes, kindergartens, preschools, school and worksites. The type of setting should vary depending on the goals of the intervention and the needs of the target group.
- **Programs should be timed developmentally to optimise impact:** Parenting programs should be timed to the age and developmental level of the target group. Programs can be delivered pre-birth, or during infancy, toddlerhood, middle childhood or adolescence. Developmentally targeted programs for particular problems may have a greater impact than if delivered at another time in the life cycle. For example, a prevention program for young children at risk of developing conduct disorders would be more effective than a program for older children or adolescents delivered after the onset of the conduct problems.
- **Programs should emphasise the importance of the therapeutic relationship:** The therapeutic relationship between the clinician and relevant family members is critical to the effectiveness of parenting programs. Clinical skills such as empathy, rapport building, effective communication and session structuring are necessary for establishing a good therapeutic relationship. Such skills are important in programs that involve face to face contact and in models of intervention that involve minimal contact, such as telephone counselling or correspondence programs.

- **Programs should be gender sensitive:** Parenting skills programs have the potential to promote more equitable gender relationships within the family. Interventions should avoid promoting traditional gender stereotypes and power relationships and aim to promote equality between partners.
- **Programs should be based on scientifically validated theories:** Parenting skills programs should be based on coherent and explicit theoretical principles. It is not sufficient just to demonstrate that an intervention results in improvements in family interaction, although this is a necessary first step. The mechanisms purported to underlie the improvement must also be demonstrated to change and be responsible for the observed improvements.
- **Programs should be culturally appropriate:** Programs should be tailored in such a way as to respect and not undermine the cultural values, aspirations, traditions and needs of different ethnic groups. While there is much to learn about how to achieve this objective, there is increasing evidence that sensitively tailored parenting programs can be effective with a variety of cultural groups.

In the mental health area, Fonagy (2001) has summarised some of the principles that, in the light of attachment research and theory and his own judgment, should govern the implementation of prevention programs aimed at reducing adverse developmental outcomes through early intervention.

- Interventions need **a strong theoretical framework** that takes account of the transactional influences between the child and the social environment.
- It follows from the complexity and interactional character of psychosocial risk that **early intervention aimed at a single protective factor is highly likely to be ineffective**. Only comprehensive multiple focus programs work.
- Along the same lines, **it is unlikely that 'off the shelf' prevention programs are pertinent or attractive to every population** and it is clear that even universal early intervention should be specific to the population targeted.
- Evidence as well as common sense suggests that **prevention should be directed not just towards a reduction of negative outcomes but also towards a promotion of competencies (skills) incompatible with the problem behaviour targeted**.
- Empowerment must be a key part of preventive initiatives and **interventions should try to capitalise on (build on the strength of) the individual, family or group at whom the intervention is being addressed**.
- **Interventions should target salient vulnerabilities that are entailed at several levels of a system which generates adverse outcomes**.
- **Prevention should always be looked at in a developmental context** and the success or failure of an intervention must be judged against the appropriate developmental expectations for the outcome under consideration.
- **Acceptability is far more important for prevention than for treatment interventions** and barriers to prevention are even more of a challenge to service providers than those engaged in the provision of treatment. Thus issues such as sensitivity to (sub) cultural attitudes is essential.

- In an ideal world, **prevention should aim only at fostering an intervention that can become self-sustaining.**
- Attempts should be made to provide comparison data, ideally by randomisation or, failing that, by multiple baseline design to provide evidence of effectiveness relative to a control group for any new intervention or new application of an intervention of known effectiveness.

Recommended practices in early childhood intervention have been identified in the US by The Council for Exceptional Children's Division of Early Childhood (McLean and Odom, 1996; Sandall, McLean and Smith, 2000) and the Committee on the Integration of the Science of Early Childhood (Shonkoff and Phillips, 2000). In Australia, Wendi Beamish from Griffith University has surveyed Australian early childhood intervention practitioners to identify recommended practices (Beamish, 1998; Beamish and Bryer, 1999).

The Council for Exceptional Children's Division of Early Childhood identified a number of recommended practices for early childhood intervention services (McLean and Odom, 1996):

- **Research-based or value-based:** Practices should be based on current research or literature demonstrating positive effects for children and families. When it is not possible to support practices empirically, they should be based on clear values.
- **Family-centred:** Practices should be consistent with family-centred philosophy.
- **Multicultural:** Practices should be adaptable for use with children and families who identify themselves ethnically or linguistically as distinct from the mainstream.
- **Cross-disciplinary collaboration:** Practices should be based on interdisciplinary collaboration when assessing and delivering support to children and families.
- **Developmentally and chronologically age appropriate:** Practices should be consistent with developmentally appropriate practice as well as being chronologically age appropriate.
- **Normalisation:** Practices should be provided in ways that make the lives of young children with disabilities as much as possible like the lives of typical children and their families.

Most of the above lists include **family-centred practice** as one of the key features of effective intervention programs. Core practices of a family-centred approach to intervention have been described by Dunst (1997) and Shelton and Stepenek (1994). On the basis of a comprehensive review of the literature, Dunst (1997) identifies the following core principles of family-centred practice:

- Families and family members are treated with dignity and respect at all times.
- Practitioners are sensitive and responsive to family cultural, ethnic, and socioeconomic diversity.
- Family choice and decision making occurs at all levels of family involvement in the intervention process.

- Information necessary for families to make informed choices is shared in a complete and unbiased manner.
- The focus of intervention practices is based on family-identified desires, priorities and needs.
- Support, resources and services are provided in a flexible, responsive and individualised manner.
- A broad range of informal, community and formal supports and resources are used for achieving family-identified outcomes.
- The strengths and capabilities of families and individual family members are used as resources for meeting family-identified needs and as competencies for procuring extra family resources.
- Practitioner-family relationships are characterised by partnerships and collaboration based on mutual trust and respect.
- Practitioners employ competency-enhancing and empowering help-giving styles that promote and enhance family functioning and have family strengthening influences.

To summarise, on the basis of the above accounts, the qualities of effective intervention programs are as follows:

- **Effective programs seek to empower families**, enhancing their ability to solve problems for themselves. Programs that promote dependency are destructive. In many instances families have lesser needs for support over time.
- **Effective programs build on existing strengths of families**, building on the existing competencies of family members. It is assumed that individuals are capable of becoming problem solvers, even though their previous attempts to resolve problems may not have been successful.
- **Effective programs are individualised and responsive to family needs and circumstances**. Families are involved in determining what form services should take, and where and how they are delivered.
- **Effective programs are well coordinated with other programs and designed to make it easy for families to access them**. The needs of families rather than the needs of professionals drive the ways in which services are delivered.
- **Effective programs start where families are at developmentally** – what parents are capable of investing in and contributing in to the helping relationship and in their own lives – and should begin with the parents' own experience of their situation and their own perceptions.
- **Effective programs use a family-centred approach**, based on building a therapeutic alliance or partnership with parents.
- **Effective programs are community-based**, and seek to strengthen community links and utilise community resources to meet the needs of families of young children.
- **Effective programs are sensitive and responsive to family cultural, ethnic and socioeconomic diversity**.

- **Effective programs are based on clear, scientifically-validated theoretical frameworks.**
- **Effective programs are comprehensive and address known risk variables.**
- **Effective programs see the child in the context of the family and address the needs of all family members.**
- **Effective programs are staffed by people who are trained and supported to provide high quality, responsive services.** Staff need both technical training and training in establishing effective working relationships with parents.

The key principle underlying all these is that **how** programs are delivered is as important as **what** is delivered.

## **6. Effective Strategies**

This section describes five general strategies that are known to be effective in working with families.

### **6.1 Information Strategies**

There is an increasing demand in the community for reliable parenting advice and information. Ergon-Rowe, Ichinose and Clark (1991) have argued that informal sources of information and advice on raising children, such as that provided by extended family or close friends, has diminished as a result of changes in modern lifestyles. Providing timely, practical and easy to understand information on topics related to children's behaviour and development is therefore an efficient and effective way of providing parental support. This section details a number of innovative and effective ways that information strategies can be used to enhance the confidence and competence of parents, together with the available evidence supporting their effectiveness.

#### **Effectiveness of Information Provision**

There are some factors that influence the effectiveness of any type of information provision. People learn best when information is presented in a timely, appealing and understandable manner (Cudaback, Dickinson and Wiggins, 1990) and, in particular, they respond best to information that focuses on their specific areas of concern (Glascoe, Oberklaid, Dworkin and Trimm, 1998; Katz, 1994).

Researchers have found that parents, regardless of their educational attainment, socioeconomic status or cultural background, rank reading as the method they most prefer for learning about child development (Gotts, Coan & Kenoyer, 1977 as cited by Nelson, 1986). In Australia, average reading performance is clustered around the 8th grade level (Sarma, Alpers, Prideaux & Kroemer, 1995, as cited by Glascoe et al., 1998). Therefore, written information for distribution to the general population should be pitched at a low reading level. Holcomb and Stith (1985) recommend that to reach a mass audience, the writer of parent education materials should aim at the 7th to 8th grade levels. Glascoe et al. (1998) agreed with this, but suggested that material written at a 5th grade level is preferable. They also recommended that information designed for parents has an eye-catching format and makes liberal use of colour and illustrations. Improving readability increases the accessibility of written materials and improves comprehension, even for parents with well-developed literacy skills.

While many parents prefer written information, effective information strategies require a range of formats to increase accessibility to all sections of the community. Audio and visual mediums (for example, videos) are required to ensure that families with limited literacy, or personal preferences not to read, can also access the information. Translations of information products are required to ensure that language is not a barrier to information access. Parent educators preparing materials for parents from culturally and linguistically diverse backgrounds can facilitate accurate and effective translation by ensuring that the original material is written in plain English, and avoids jargon, culturally specific exemplars and illustrations and assumptions of one language in families

(Cann & Ozolins, 2001). Translated materials in audio formats are also helpful where families prefer not to read, even in their own language.

### **Evidence for the Effectiveness of Information Provision**

Substantial evidence has been found to demonstrate the effectiveness of various types of information provision in supporting parents. This review will briefly describe the evidence base for four innovative information strategies that have the potential to provide a broad spectrum of intervention: media based information (universal prevention); age-paced newsletters (anticipatory guidance); brief specific information (intervention for early difficulties); and self-directed parenting programs (broad-based intervention).

#### ***Media-Based Information***

At this stage, the potential of using mass media in disseminating parenting information has not been fully exploited. The power of mass media to bring messages to the whole population makes media like television an ideal vehicle for promoting positive parenting practices. One example of the use of television, is the FAMILIES television program that was screened in New Zealand (Sanders, 1999). This 13 episode, infotainment program featured topical family issues and was built around a sequential series of positive parenting program segments. By watching the series, parents were exposed to a complete parenting program. Strong television ratings indicated that the program was popular with the target audience. Subsequent evaluation of the impact of the parenting program segments, delivered to parents via video, suggested that the program was also able to produce positive effects on both parent and child behaviour. Other video-based programs have also been shown to be effective as a method of delivering parent training. Kashima, Bake and Landen (1988) compared group and video-based parent training for families of children with an intellectual disability. Video trained families evaluated their training positively and showed significantly greater gains than control parents. The group-trained parents increased their knowledge more than the video-trained parents, but otherwise the results were similar.

#### ***Age-Paced Parent Newsletters***

Age-paced parent newsletters are written information booklets that are given to parents at times that are keyed to their child's birth date. This strategy is a systematic approach to the provision of anticipatory guidance. Information is provided about the appropriate development and care of children before problems emerge in the parent-child relationship. Because parents receive the information based on their child's age, the material is well timed and has a high degree of relevance. Parents report that this form of information provision is useful and that it positively effects their parenting practices and attitudes (Cudaback, Dickinson & Wiggins, 1990; Grimley & Robinson, 1986; Riley, Meinhardt, Nelson, Salisbury & Winnett, 1991). Riley et al. (1991) found that while all parents reported benefits from the newsletters, those parents classified in one of six risk categories reported significantly more positive behaviour changes. Nelson (1986) found that parents that rated a newsletter as useful or very useful were evenly distributed across educational levels and income brackets (although Nelson only had a 27 per cent response rate). Dickinson &

Cudaback (1992) found positive changes in adolescent parents receiving the booklets.

Methodological limitations of studies evaluating age-paced newsletters mean that some caution should be exercised in interpreting these initially promising results. Studies evaluating age-paced newsletters have typically relied on questionnaires posted to parents. Return rates are relatively low, around 50 per cent or less, which raised the possibility that results are positively skewed by the likelihood that parents for whom the program is most beneficial are more likely to return the questionnaires. While there is some evidence that parents from high risk groups (for example, adolescent parents) benefit from the newsletters, a consistent finding of research in this area is that older, married, more highly educated parents benefit more from newsletters. They are more avid readers of the material, are more likely to keep and re-read the material, and are more likely to respond to research questionnaires regarding the material (Cudaback, Dickinson & Wiggins, 1990; Grimley & Robinson, 1986; Kishchuk, Laurendeau, Desjardins & Perreault, 1995). Nevertheless, by providing timely information about child development and behaviour, age-paced newsletters can be an effective tool in preventing early child-rearing difficulties (Riley et al., 1991). Even if the population that could benefit from this approach is limited, implementation of such a strategy may mean that professional time that might have been used by such families could be freed up to spend on families that do require professional assistance.

### ***Brief, Specific Information***

Providing brief, specific information is a useful strategy for parents who have encountered a difficulty in their child's development or behaviour, and request information or advice. This kind of information can be distributed in the form of brief booklets or information sheets.

One study involving a sample of relatively highly educated parents found that information sheets have a high level of acceptability and can be effective in bringing about changes in child behaviour, parental competence and parenting style (Cann, De Bortoli, Rogers & Gavidia-Payne, 2000). McMahon and Forehand (1978) successfully reduced inappropriate mealtime behaviour in children using a brochure to teach parents. Studies have also shown that parents can successfully reduce moderately severe childhood tantrums using self-instructional booklets (Endo, Sloane, Hawkes, McLoughlin & Jenson, 1991; Sloane, Endo, Hawkes & Jenson, 1990). Ergon-Rowe et al. (1991) provided parents with booklets focusing on managing family interactions in three areas: shopping trips, meal times and household responsibilities. Parents reported that the information was useful and resulted in improved child behaviour. There was also evidence that parental learning had generalised. Parents were also able to apply the advice they were given in one context to other situations that had not been addressed directly by the information, resulting in improved child behaviour across a range of situations.

Showers (1989) used information cards on appropriate developmental and behavioural expectations of children, and non-violent approaches to behaviour management in a range of areas, and found significant changes in parental knowledge and parental reports of feelings and behaviour. Seymour, Brock,

During and Poole (1989) compared parents of toddlers who received a standard sleep program with parents who received written information only, and a control group. They found that parents in both treatment groups showed significant improvement compared to those on the waiting list, but that improvement was more gradual for parents receiving written information compared to those receiving the standard program. In their review of research, Glascoe et al. (1998) concluded that this type of information is best when given to parents in conjunction with a brief discussion (from a doctor or health nurse for example) to stimulate the parents' interest and awareness in the material. They also concluded that handouts were particularly useful when the strategy being introduced to parents was relatively complex or involved several steps.

### ***Self-Directed Parenting Programs***

Self-directed parenting programs are broader in their application, aiming to develop a range of parenting skills rather than focus on specific areas of concern. Most self-directed programs developed to date have been based on successful therapist or group based programs. Research on the efficacy of such programs has produced some mixed, but also some promising, results.

One such program is the *Living with Children* parenting manual (Patterson and Gullion, 1971). Christensen, Johnson, Phillips and Glasgow (1980) compared individual treatment, group treatment and a self-directed condition where parents only had access to the *Living with Children* text. They collected parent attitude data, parent collected behaviour data and home observation data, and found that while the self-directed version of the program produced some beneficial results, the group and individual treatment conditions produced significantly better outcomes. Sanders, Markie-Dadds, Tully & Bor (2000) demonstrated that a self-directed parenting program was not as effective as therapist assisted intervention immediately following treatment. At one-year follow-up, however, there was no discernible difference between the self-directed and therapist-assisted groups, suggesting a possible sleeper effect for self-help programs.

Using her *Parents and Children Series*, Webster-Stratton (1992) found that self-administration of this video-based program resulted in significant improvements in child and parent behaviour. It was noted that some parents, such as those who were highly stressed or depressed, needed further treatment following the self-administered program. In another study, Webster-Stratton, Kolacoff & Hollinsworth (1988) compared self-administered videotaped programs with various group-based formats and a waiting list control group. They found that parents in each program reported highly significant changes in their child's behaviour compared to controls. The group-based formats produced slightly better results with respect to parent dropout, maternal stress and satisfaction with the program. Clearly, not all parents respond positively to self-directed programs, but the evidence suggests that enough parents are able to benefit from these programs to warrant further implementation and evaluation.

### **Concluding Comments**

Information-based strategies are proving to be effective in enhancing the confidence and competence of parents. Mass media is a much underutilised and under-researched medium for the delivery of parenting support information.

Parent newsletters, especially age-paced ones, can help to avert potential problems by providing parents with timely, relevant information about child development and behaviour and how to manage it. Brief written information, such as information sheets that deal with a specific problem area, are appropriate for families who are experiencing isolated difficulties, especially when they are provided in response to a parental request for information. Easy and convenient parental access to information such as this can be facilitated by ensuring that the material is available through generic and universal community services (for example, schools, child care centres and preschools). Self-directed parenting programs are also proving effective for parents who are experiencing more complex difficulties or are looking for assistance across a broad range of parenting domains. Research has demonstrated that self-administered written and video programs can result in positive changes in child and parent behaviour. Parents who have lower levels of education, or are dealing with more severe and complex family problems, are less likely to benefit from information alone. The increased use of information and self-directed programs for parents who can benefit, however, could allow professionals to dedicate more time to working with higher need families.

## 6.2 Family-Centred Practice

Another key general strategy known to be effective in supporting families is family-centred practice. This describes **how** service providers should relate to parents rather than **what** they should provide. The principles on which family-centred practice is based have already been listed in Section 5. As noted at the end of that section, the overall evidence indicates that how services are delivered is as important as what is delivered in determining their effectiveness.

There is good evidence for the effectiveness of family-centred practice. Rosenbaum, King, Law, King and Evans (1998) conducted a review of efficacy studies of family-centred practice with paediatric populations. They classified the available studies according to the type of research design used, finding only five studies that involved randomised control trials, the most powerful method of evaluating effectiveness. All of these studies demonstrate the effectiveness of a family-centred approach to service delivery in positively influencing both child and family outcomes.

Other research using less stringent research designs support these findings. Trivette, Dunst, Boyd and Hamby (1995) have shown that different types of family-oriented human services programs (for example, professionally-centred, family-allied, family-centred) can be empirically differentiated, and that adherence to particular kinds of family-oriented models is associated with differences in help-giving practices and various family outcomes. In turn, different help-giving models have differential effects on those receiving the service. Dunst (1997) reviewed research showing that particular help-giving practices contribute to the positive psychological health of parents independently of the contribution of family and child characteristics. Family-centred practices have value-added benefits, that is, they produce positive parent and family benefits beyond those produced by structural intervention factors (such as the form and frequency of services provided) and non-intervention factors.

We also have learned more about the elements of family-centred practice that make it effective. For example, on the basis of a number of studies they have conducted on the characteristics and effects of help-giving behaviours, Dunst and Trivett (1996) conclude that there are three elements of effective help-giving:

- **Technical knowledge and skill:** This refers to the help-giver's specialist knowledge and skills. High quality technical knowledge and skills result in the implementation of appropriate educational, therapeutic and medical interventions. Help that is technically of a high quality but does not incorporate the other two elements can have positive outcomes in one area (for example, in the child's health) but negative outcomes in others (for example, parental resentment and disempowerment as a result of the manner in which the services are delivered).
- **Help-giver behaviours and attributes:** Help-giver behaviours that positively influence psychological wellbeing include good listening, empathy and warmth. Help-giver attributes that have positive outcomes include beliefs in the person's or family's competencies and capabilities. Positive help-giver behaviours and attributes result in (a) greater parental satisfaction with and acceptance of helping, and (b) greater psychological and emotional wellbeing. Help-giving behaviours and attributions are a necessary but not sufficient condition for strengthening family competencies and developing new capabilities. To achieve that, the third element of effective help-giving is necessary.
- **Participatory involvement:** This entails the recipients of help being offered information about intervention options, sharing decision making, and being directly involved in acting on decisions. Effective participatory involvement results in (a) parents feeling more in control and (b) strengthening of parental competencies.

The clear implication is that, for service providers to be effective in supporting families, they need more than technical knowledge and skills; they also need certain attitudes and help-giving skills, and to engage families fully in all decision making and implementation. Training in family-centred practice and in basic help-giving skills is essential.

### 6.3 Social Support

Another important strategy involves strengthening families' social support networks. Numerous studies of children and families both at risk and not have shown that social support directly influences the wellbeing of children and families (Crnic and Stormshak, 1997, Dunst et al., 1997; Sloper, 1999). The work of Anne Oakley and colleagues (Oakley, 1992; Oakley, Hickey and Rajan, 1996) in London has shown that providing social support and reducing the social isolation of pregnant women can actually reduce the likelihood of at risk women having low birth weight babies. Parents with adequate social support are less likely to abuse their children (Thorpe, 1994; Tomison, 1996; Tomison and Wise, 1999).

Summarising the US evidence regarding effective support for families of young children with disabilities, Dunst et al. (1997) report that informal support has a much greater influence on the personal functioning of parents than does formal

support. Parents who have a good informal support network (or to a lesser extent a combination of informal and formal support) are better off psychologically and behaviourally than parents who have no support, and have generally more positive perceptions and attitudes towards their children. Social support from spouse or partner and from friends and family also has positive influences on parenting behaviour. Whether support provided by professionals has the same beneficial effects depends upon two factors: first, the parents' need for support (those with high needs are likely to experience such support positively while those with low needs may experience it negatively) and, second, the nature of the relationship with the professionals (the more the parents view the support provided by professionals as part of their informal rather than formal support network, the more beneficial the support is).

How does social support work? Social support has direct benefits for family functioning and mostly influences child functioning in indirect ways. The primary function of social support is to provide a more solid parenting foundation from which parents may, in turn, facilitate more positive child development (Crnic and Stormshak, 1997).

Dunst et al. (1997) propose that, by virtue of its capacity to influence child, parent and family functioning, social support functions as a form of early intervention. Social support thus consists of a range of supportive experiences and opportunities beyond those directly provided by early intervention programs. As an environmental variable, social support operates whether or not it is deliberately manipulated.

Social changes have increased the likelihood of young parents being socially isolated. According to Ochiltree (2001), these changes include:

- Reduction in support provided by extended families as a result of increased mobility and other factors (for example, grandmothers may be unavailable to provide child care because they are still working).
- Increase in the number of single parent families, with associated financial stresses and time pressures.
- Increase in the number of mothers in the workforce, with consequent reduction in time with the children and with other parents.
- The perception that the local environment (streets and parks) is no longer as safe as they were, partly because many suburbs are now only partially occupied during working hours.
- In rural areas, the loss of basic services as well as employment opportunities have increased social isolation.

The implication is that service providers should regard parent and family social support networks as an important source of support, and strengthening such networks as a valuable form of intervention.

#### **6.4 Community Support**

Community support is also important for optimal family functioning. Humans are social beings and need the support of others for survival. Children are born into a

social group and learn to become members of the community in interaction with their family and other members of the community with whom they have contact. However, there is evidence that links with the community are increasingly difficult to maintain due to changes in society such as the faster pace of life, the complexity of cities and communities, the demands of work and the longer working hours for those in full-time employment. The reliance on cars rather than improving public transport has contributed to the isolation of families and individuals as those without cars have difficulty in getting to many services and to other places where they will meet people. Eva Cox (1995) in her Boyer lectures argued that in recent years there has been an over-emphasis on the importance of economic capital to the detriment of social capital. Social issues have been considered from the perspective of cost-effectiveness and efficiency rather than the benefits to the wellbeing of those involved (Tomison and Wise 1999).

Social capital is essential for the wellbeing of both adults and children and is produced through the many relationships and the connectedness that comes from these relationships (Putnam, 1993, 1995, 2000; Cox, 1995). These relationships develop from both the formal and informal interactions of everyday life and the quality of these relationships is important in forming the social networks through which trust is developed. The degree of social capital in communities varies depending on the extent to which interconnectedness is possible.

Communities high in social capital have accessible information networks that assist people, clear norms about behaviour, employment opportunities, low residential mobility and encourage residents to see themselves as valued (Tomison and Wise 1999). Positive social relationships between community members, and between organisations and individuals within a community, assist parenting and are known to reduce the stress that may lead to maltreatment of children. Connections within the community, whether with neighbours, family, friends or professionals, influence the capacity to seek advice and to cope with difficulties. In communities that have healthy social capital, children are more likely to learn acceptable social behaviour and to accept the expectations of the community for completing school and getting a job.

However, families tend to be more isolated than in the past for the reasons mentioned earlier in this paper and because social capital has declined, particularly in communities characterised by low income and poor housing. Being disconnected from the community can lead not only to loneliness but also to alienation, boredom and low self-esteem, and can impact adversely on family functioning and child development. Many studies have shown that social isolation is associated with greater risk of child abuse and neglect (Tomison and Wise 1999).

Community development is a comprehensive approach to promote and support connectedness, to reduce isolation and to enhance the wellbeing of all members of the community.

Such an approach is founded upon the formation and strengthening of partnerships between families, governments, child welfare, family support, health and education agencies, business, and religious organisations, as a

means of integrating private and social responsibilities for families' (Tomison and Wise, 1999, p. 12).

One such community development program is 'Communities that Care', which was developed to reduce adolescent risk factors and problem behaviours such as crime and drug use. Although it focuses on adolescents, it is based on a community-wide analysis of risk and protective factors that have implications for the whole of the community including young children and their parents. The process involves identifying community leaders who have influence on the community resources and organisations and aims to build local capacity for community prevention of problems by enhancing protective factors in the community, family, schools, individuals and peers. The National Crime Prevention report *Pathways to Prevention* recommends a similar community-based approach to crime prevention. But the crucial aspect of community-wide approaches is the participation of locals and professionals.

There are many services in Victoria for children and parents from the prenatal period to aged eight years. These include prenatal hospital services, the Maternal and Child Health service, new mother's groups, long day care, family day care, out-of-school hours care, preschools and schools, toy libraries, playgroups, neighbourhood houses. Each of these services has the potential to create a network of relationships and a hub of community for staff, parents and children. The implication is that service providers and agencies should actively seek to foster such networks as one way of strengthening the community links that support families.

## **6.5 Making Agencies Family-Friendly**

Universal community agencies, such as preschools, schools and medical centres, are not always viewed as part of the traditional family welfare and support system, yet their regular contact with children and families means they are uniquely positioned to effectively support parents in the task of raising their children. To fully realise this potential, however, such agencies must be attractive, accessible and responsive to the needs of families. Making an agency family-friendly involves the implementation of strategies that promote parental engagement and lead to the development of strong collaborative working relationships between agencies and parents. High levels of family engagement in community agencies provide a solid platform for the provision of parenting information and support services. Becoming family-friendly is a process that often involves a significant paradigm shift for agencies, and considerable organisational change and development. This section sets out the rationale for increasing family engagement and the process for making agencies more family-friendly.

### **Rational for Family Engagement**

There are at least two major reasons to enhance parents' engagement in community agencies: firstly, to extend and augment the level of parenting and family support available in the community, thus reducing the need for specialist services; and secondly, because organisations need parental engagement if they are to successfully achieve the health and educational goals they have for children.

The need for family responsive universal services is born out by the fact that relatively few families will seek specialist professional assistance, even when they are experiencing difficulties with their child's development or behaviour. For example, in the area of children's mental health, it has been estimated that only 2 per cent of children with clinically significant behavioural and emotional problems will receive specialist mental health services (Marshall & Watt, 1999). A recent survey of Australian families (Sanders et al, 1999) found that only 12 per cent of parents had consulted any professional about their child's behaviour in the 12 months prior to the survey, and while approximately 25 per cent of respondents reported that their child had a moderate to severe behavioural problem, only one third of these families had sought professional help. In addition, fewer than 10 per cent of families surveyed had participated in any formal parent education program, and when families did consult a professional, they were most likely to consult their family doctor or their child's teacher.

The low rate of involvement in specialist child and family mental health services or parenting education programs can be contrasted with the near universal involvement of families in generic programs such as the Maternal and Child Health service, general medical practices, preschools and schools. The apparent willingness of parents to consult primary care and educational professionals, such as teachers and family doctors, indicates that such services are perceived as relevant, authoritative and non-stigmatising sources of information about children and parenting, yet teachers and doctors often feel under-resourced and under-prepared to effectively provide parenting support and assistance.

Enhancing the quality of support available to parents through generalist services may be an effective way of reducing the need for scarce specialist resources. However, there are other reasons why parental engagement is desirable. Agencies in the child health, welfare and educational fields have long recognised the critical role that families play in influencing the wellbeing and development of children. This has led to a general acceptance of the need to engage parents in a meaningful partnership in order to more effectively meet program goals. Research has consistently shown, for example, that children of all ages are significantly advantaged when their parents are knowledgeable, encouraging, supportive and involved in school activities (Pelco, Ries, Jacobson & Melka, 2000; Riley, Takai & Dorfman, 1997; Ryan & Adams, 1995). The traditional approach to parental engagement subsequently adopted by schools has essentially been unilateral; efforts are made to engage parents in order to facilitate good educational outcomes for children. However, there is another view that the approach to parent engagement can be more reciprocal in nature. This view stresses the role of schools in supporting parents in the task of raising their children at home. As White (1997) has argued, there is a need for a paradigm shift away from asking parents to support the program goals of agencies, to asking agencies to support parents as the first and most essential carers and teachers of children. This approach is based on the idea that the best interests of children are served when families are engaged in community agencies providing health and educational services, and when those services, in turn, are effectively supporting parents and families as the primary care givers.

## **Barriers to Engagement**

Despite the potential of many community agencies and organisations to provide effective support to parents, there are a range of common barriers to parental engagement and partnership building. Researchers and theorists have described psychological and organisational obstacles that can prevent optimal parental engagement in schools ( Hoover-Dempsey & Sandler, 1997; Lueder, 2000; Riley et al, 1997) and many of these are equally relevant to other community agencies.

They include:

- Parents' experience of organisations as intimidating, alien, threatening and unapproachable.
- Parents' lack of skills and knowledge related to the process of interacting effectively with community agencies.
- Parents' lack of time and resources.
- Constraints on staff time.
- Language, cultural and socioeconomic differences.
- Parental beliefs about what is important, necessary and permissible in relation to their involvement in school life (for example, a belief that education is the sole responsibility of the school may lead to low involvement).
- Parents' own negative history with community agencies (for example, a parent's own experience as a student or their early contact with schools).
- Parents' sense of efficacy regarding their child's health or educational outcomes (the extent to which parents believe they can have a positive influence on their children's health or learning).
- Parents' perceptions that their children do not want their involvement.
- Rigid staff beliefs about the limited role of parents in their organisation.
- Parents' perceptions that the agency does not welcome parent involvement.
- Staff beliefs about the extent of their own and their agency's role in supporting families.
- Lack of training provided to agency staff in working effectively with parents and families.
- Lack of program flexibility and scheduling of activities at times that would allow parental engagement (for example, timing of parent teacher interviews, involvement of non-resident parents).
- Ineffective communication methods used with parents.
- Lack of responsiveness or ability to respond to parents' requests for information, support or advice.
- Poor conflict resolution strategies.
- Staff resignation to low parental involvement based on acceptance of 'hard to reach' client group stereotypes.
- Lack of strong linkages between the organisation (the school) and other community agencies (parenting and family support services).

## **Creating Family Friendly Agencies**

Creating a family friendly environment is the process by which an agency seeks to overcome obstacles to parental engagement and improve its capability to respond to the needs of families effectively. As parent engagement involves substantial cultural and systemic change, planning to increase parental engagement must involve all stakeholders in a community agency (Lueder, 2000). The strategies that are ultimately adopted by agencies depend on how optimal parent involvement is conceptualised and the particular model of parental engagement that is adopted (for a more detailed discussion on this point as it relates to schools, see Lueder, 2000; Reed, Jones, Walker and Hoover-Dempsey, 2000; and Ryan and Adams, 1995). However, a comprehensive plan designed to improve the family friendliness of an organisation has strategies in five areas:

- (1) Psychological
- (2) Organisational
- (3) Physical environment
- (4) Information and programs
- (5) Staff training.

To date, much of the thinking in this area has been done in relation to increasing family involvement in schools. Examples of family engagement strategies that have been developed by researchers in this area are presented below (Epstein, 1992; Copeland & McCreedy, 1997; Heleen, 1992; Riley et al., 1997; Sanders, 1998; White, 1997; Lueder, 2000).

### **Psychological**

Creating a family friendly environment is not a simple task. It often involves creating significant cultural change in the agency and the community. The agency will inevitably have to deal with parental beliefs and attitudes that may mitigate against engagement (for example, beliefs that they have nothing to offer their child's education) and perhaps staff views that the agency mandate does not extend to supporting families. Changing beliefs that may place unintended barriers to parental engagement or lead to self-limited engagement by parents requires an ongoing process of clearly and consistently communicating the benefits of family engagement to parents and staff in an agency.

### **Organisational**

Achieving a family friendly environment also entails attention to organisational structure and processes. Examples of organisational modifications that increase parental engagement and access include:

- The development of policies that clearly value and incorporate active roles for parents in the organisation.
- Providing flexibility in the provision of programs (for example, enrolment, time scheduling) and maximising parental choice (for example, activities, workers, curriculum).
- Provision of parent support services such as after school care or child care while parents participate in agency activities.

- An orientation program for all new families that includes a face to face welcome and an introduction to school activities and forums for involvement.
- Providing staff to personally greet families when they arrive at the agency.
- Linking parents involved in similar activities.
- Opportunities to participate in daily school activity through volunteer programs, as well as governance and decision making forums.
- Assigning parent liaison roles to staff, and providing time release so that staff can engage in parent contact activities.
- An effective communication strategy that incorporates simple information on how to access the service, rights and responsibilities of service users, processes for dealing with complaints and disputes and how the agency is managed.
- Building cultural competence at all levels of the organisation and ensuring that diversity in family backgrounds is recognised and respected.

### **Physical Environment**

The physical features of an organisation's premises can act as a barrier or deterrent to family access, or alternatively create a welcoming and friendly environment. These factors relate to the location of the agency, its hours of operation and access to public transport. Agencies wishing to create family friendly physical environments have used strategies such as:

- Clear signage indicating that families and children are welcome, preferably also in relevant community languages.
- A designated space where parents can visit and spend time, meet staff or access parenting and family information resources (such as books, brochures, videos, Internet).
- A prominently placed guide to agency staff, with photos to promote recognition of staff and understanding of the various roles in the agency.
- Waiting areas that are child proof and safe (for example, furniture that does not have sharp edges, breakable items out of reach) with comfortable adult-size seating and appropriate toys or activities available for younger children accompanying parents.
- Ease of access to key telephone numbers including any answering machines or telephone contacts for out of hours calls.

Agencies should also consider aspects of the physical environment that expose parents to agency business while they are on the premises. This includes being cognisant of conversations that take place between staff and other parents, or between staff about a client, in the hearing of other parents.

### **Staff Training**

Many professionals who work in agencies that have regular contact with families are not formally trained in working with parents. Agencies can significantly enhance their capacity to assist parents by ensuring that staff have the opportunity for professional development in the area of working with families. Such training can usefully incorporate communication skills, problem solving, and

conflict resolution. Frontline staff—receptionists and other office staff for example—should not be overlooked, as it is often these staff who have the first contact with families, and this contact can have a significant positive or negative effect on subsequent parental engagement. Training should aim to ensure that frontline staff give families the message that they are welcome and that the organisation will endeavour to meet their needs in a calm and friendly way.

### **Parenting Information Resources And Programs**

Many of the strategies discussed above provide the foundation required for the development of strong collaborative family-school partnerships. This kind of relationship then improves the likelihood that parents will accept opportunities to participate in specific parenting programs or use parenting and family support information resources offered by the agency.

Providing a range of information products is an important and practical way that community agencies can support parents. Information for parents can range from advice on the best ways to communicate and interact with the agency, through to general information relating to child development and parenting. Written information must be appealing, readable and available in community languages. Video-based information should be considered for families who prefer this information medium or lack literacy skills.

Finally, a family friendly environment involves provision of parent education and support programs. These may range from general parenting education programs that deal with issues related to child development, promoting learning and dealing with challenging behaviour, to more targeted issue specific programs (for example, helping children learn to read, drugs, bullying).

### **Empirical Basis of Interventions Designed To Make Agencies More Family Friendly**

At this stage, most documented strategies that relate to making agencies family friendly are based on a philosophical commitment to parent engagement, case studies and anecdotal experience and feedback. With a few exceptions, the effectiveness of these strategies in increasing parental engagement, and then in turn improving outcomes for children, is yet to be demonstrated empirically. Some of the limited research to be conducted on models or strategies for enhancing parental engagement in schools has produced promising results. After reviewing this literature, Epstein (1997) concluded that programs delivered by schools that help parents to praise and encourage their children, and guide parents in helping with homework, increase children's academic development. Clearly, while strategies for improving family engagement that have been described in the literature to date have strong face validity, there is a need for ongoing research to discover what parent engagement strategies work, with what populations and under what conditions.

### **Summary**

Making agencies family friendly involves developing and implementing strategies that increase parent engagement and involvement. A whole of agency approach is required to ensure that policy, programs and practice accurately reflect a

commitment to family involvement. A comprehensive approach to making an agency family friendly involves a diverse range of strategies including: I

- Identifying and overcoming psychological barriers to engagement (beliefs and attitudes).
- Developing effective communication practices
- Making the physical environment welcoming and encouraging of parent participation
- Developing the skills of school staff in working with parents and family members.

Once parental engagement is achieved, agencies are well on the way to normalising the process of parental help-seeking and ensuring that parents can comfortably approach staff with issues relating to their child at school or at home. Strong parental engagement is also likely to increase uptake of information and programs that are designed to assist parents and strengthen families.

## 7. Effective Programs

This section provides details of a range of parenting and general intervention programs that have been proven to be effective with children and families.

### 7.1 Parenting Programs

<b><i>Program</i></b>	<b><i>Target Age</i></b>
Parents as Teachers (PAT)	Antenatal, Infancy/Toddler
HUGS	Infancy
Step by Step Child Care	Infancy/Toddler
The Parents and Children Series	Infancy/Toddler, Preschool, Primary School
Project 12-Ways	Infancy/Toddler, Preschool, Primary School
Triple P Positive Parenting Program	Infancy/Toddler, Preschool, Primary School
Defiant Children	Infancy/Toddler, Preschool, Primary School
Helping the Non-Compliant Child	Preschool, Primary School
FAST Track: Families and Schools Together	Primary School
The FRIENDS Anxiety Prevention Program	Primary School

<b>Baby Happiness, Understanding, Giving and Sharing (HUGS) Program</b>	
<b>Author</b>	Jeannette Milgrom (Austin Hospital, Victoria)
<b>Type of Program</b>	HUGS is a group program designed to promote positive interaction between mothers and infants. It was developed specifically for women who are experiencing difficulties interacting with their infant, either due to post-natal depression or other reasons.
<b>Objectives</b>	The program aims to help mothers understand and respond sensitively to their infant's cues, especially as they play with their infant. Other areas addressed include beliefs about parenting, infant temperament, family of origin, partner relationships and social support.
<b>Background</b>	Postnatal depression affects up to 20% of all mothers, and around 50% of these are not recovered by the end of the first year. There is evidence that postnatal depression is associated with problems in mother-infant interaction, and longer term developmental and behavioural difficulties in children. The HUGS program was developed, as part of an ongoing program of treatment and research in the area of post-natal depression, to prevent negative consequences of this disorder on the developing mother-child relationship.

<b>Description</b>	<p>Sessions of between one, and one and a half hours in duration are conducted weekly or more frequently as required. The program has six phases, with the number of sessions in each phase (usually one to three) determined by the group.</p> <ul style="list-style-type: none"> <li>• Phase 1: Setting the tone. Aims to develop a trusting group environment where mothers feel they can share their pregnancy, labour and early parenting experiences. The needs of the mother are emphasised, particularly the need for practical support and occasional breaks from the demands of caring for their baby.</li> <li>• Phase 2: Play and physical contact. Participants are introduced to baby massage, and discuss physical contact and age appropriate play with infants.</li> <li>• Phase 3: Observing and interpreting infant cues. Promotes appreciation of the skilled way infants communicate through verbal and non-verbal behaviours.</li> <li>• Phase 4: Parental response to infant cues. Discusses feelings of uncertainty that can arise in attempting to interpret infant signals. Past experiences and relationships with mothers' own parents are often addressed.</li> <li>• Phase 5: Attribution of personality and individual differences. Mothers are encouraged to identify and describe positive attributes of their infant's personality.</li> <li>• Phase 6: Partnership/marriage This optional session examines ways to strengthen couples' relationships. A separate session is sometimes conducted for fathers.</li> </ul> <p>The program can be facilitated by nurses, psychologists, psychiatrists, or allied health professionals. Facilitators require knowledge of infants' psychological and motor development.</p>
<b>Evidence Base</b>	<p>Program components were selected on the basis of previous research in the areas of infant development and mother-infant relationships. One study has been conducted to evaluate the effectiveness of the HUGS program for women with long-standing depression. The researchers found that compared to a control group, women who had participated in the program experienced a significant reduction in the level of their depression, although they remained moderately depressed (Meager &amp; Milgrom, 1996). Evaluation of the HUGS program is continuing.</p>
<b>Strengths and Limitations</b>	<p>Few programs that target parenting skills in the infancy period have been formally documented and evaluated. The limited number of studies published to date, whilst suggesting that the HUGS program is promising, prevent firm conclusions about its effectiveness at this stage. Fortunately, evaluation of HUGS is continuing.</p>
<b>Availability</b>	<p>The program is published in a book (Milgrom, Martin and Negri, 1999).</p>
<b>References</b>	<p>Meager, I. and Milgrom, J. (1996). Group treatment for postpartum depression: a pilot study. <i>Australian and New Zealand Journal of Psychiatry</i>, 30, 852-860.</p> <p>Milgrom, J. (1994). Mother-infant interactions in postpartum depression: an early intervention program. <i>Australian Journal of Advanced</i></p>

	<p><i>Nursing, 11 (4), 29-38.</i></p> <p>Milgrom, J., Martin, P.R. and Negri, L. (1999). <i>Treating Postnatal Depression. A Psychological Approach for Health Care Practitioners.</i> Chichester, UK: Wiley</p>
<b>Website</b>	None

<b>PARENTS AS TEACHERS (PAT)</b>	
<b>Auspice</b>	Centre for Parent Education (Newton, Massachusetts). Original authors include M.K. Meyerhoff and B.L. White.
<b>Type of Program</b>	The PAT program is a universal parenting program aimed at parents of young children.
<b>Objectives</b>	PAT aims to help parents understand what to expect during each stage of their child's development, and to provide practical ways of promoting their child's development, manage misbehaviour effectively and promote strong parent-child relationships.
<b>Background</b>	The New Parents as Teachers (NPAT) program commenced in 1981, sponsored by the Missouri Department of Elementary and Secondary Education. It was designed as a pilot program to assess the value of providing parents with high quality information about child development during the period from pregnancy to three years of age. In 1984, Missouri legislature required school districts to provide parent education and developmental screening from birth to kindergarten and NPAT was implemented on a statewide basis. It is now delivered in 49 US States, five US Territories, and six other countries. A second program is now available that caters for children aged 3–5 years.
<b>Description</b>	<p>Core program components include:</p> <ul style="list-style-type: none"> <li>• Personal visits: a parent educator helps the family to develop appropriate expectations for each stage of their child's development. They also offer parents practical ways to encourage their child's learning.</li> <li>• Parent meetings: parents meet to enhance their knowledge and share experiences, concerns and successes.</li> <li>• Screenings: periodic screenings of each child's health, development, vision and hearing are conducted.</li> <li>• Links to community resource network: families with needs beyond the scope of the PAT program are helped to access other community services.</li> </ul> <p>Curriculum materials are provided to every parent educator attending training. A program administration guide is required for each region implementing the program. Training consists of a five-day course and a one day follow-up session, and is designed to equip participants with the skills required to implement the PAT program.</p>
<b>Evidence Base</b>	The PAT program has been shown to enhance the cognitive and social development of children, and improve parental knowledge of child development. Long term positive effects in reading and maths have also

	development. Long term positive effects in reading and maths have also been reported. High quality parental involvement with the parent educator was found to be a necessary ingredient in the success of the program (Pfannenstiel & Seltzer, 1989).
<b>Strengths And Limitations</b>	<p>A website describes past and current research related to PAT. Few reports have been published in the scientific literature, which raises the question of whether the research has been subjected to the peer review process that such publication requires. Peer review is an important way of ensuring that evaluations have strong methodology so there can be confidence in the outcomes. Nevertheless, from the material that is available, this program appears to have been thoroughly evaluated, and evaluation of program outcomes is continuing.</p> <p>PAT is designed as a universal intervention involving several services and is therefore quite costly to implement and run. It should also be noted that the US does not have universal early childhood services such as Victoria's Maternal and Child Health Service, so there is a question about the appropriateness of total implementation of the program in an Australian context. However, aspects of the program curriculum may be particularly valuable to agencies that deliver early childhood services, and could potentially be integrated into existing programs.</p> <p>The NPAT institute in the United States provides professional training to educators who wish to deliver the program. It is worth noting, however, that the original program developer has voiced reservations about the quality of professional training now compared to that provided in the initial pilot program, and questioned the effectiveness of parent training being provided by the trained educators (White, 1990).</p>
<b>Availability</b>	Training and manuals are only available through the NPAT institute during training. Some of the material on which the program is given in a book (White, 1990).
<b>References</b>	<p>Pfannenstiel, J.C. and Seltzer, D.A. (1989). New Parents as Teachers: Evaluation of an early parent education program. <i>Early Childhood Research Quarterly</i>, 4, 1-18.</p> <p>White, B. (1990). <i>The New First Three Years of Life</i>. New York: Simon &amp; Schuster.</p>
<b>Website</b>	<a href="http://www.acf.dhhs.gov/programs/hsb/">www.acf.dhhs.gov/programs/hsb/</a>

<b>STEP BY STEP CHILD CARE</b>	
<b>Auspice</b>	Maurice Feldman (Queen's University and Ongwanada Centre, Kingston, Ontario, Canada) and Laurie Case (Surrey Place Centre, Kingston, Ontario, Canada)
<b>Type of Program</b>	Step by Step Child Care is a prevention program designed to assist parents who have an intellectual disability.
<b>Objectives</b>	To improve parenting skills of parents with intellectual disability so as to reduce the risk of child neglect, developmental delays, and behaviour problems.
<b>Background</b>	Parents with an intellectual disability, who come to the attention of service providers, are generally experiencing difficulties in caring for their children in a range of areas. Some of these difficulties have significant and long term ramifications for their children's health, safety and development (Feldman, 1998). There is increasing recognition, however, that many of these parents are able to learn parenting skills and provide acceptable child care if they are given appropriate training and supports (Tymchuck & Feldman, 1991). Specialised programs for families where a parent has an intellectual disability are rare. Step by Step Child Care was developed in response to this service gap.
<b>Description</b>	<p>The program is designed for parents of children from birth to three years. Parents are provided with individual parenting skills training during weekly home visits, of one to two hours in duration, for as long as it takes the parent to learn the skills. The program moves through a series of essential child care skills including newborn care, nappies, bathing, feeding, cots and bedtime, safety and first aid, and parent-child interaction.</p> <p>Each program is individualised on the basis of a thorough assessment, including interviews, psychological tests and observation. The assessment looks at parenting capacity and broader contextual issues (for example, personal experience of parenting, housing and family support). Specific child care skills are evaluated directly using checklists based on detailed task analyses of key child care tasks. Task analyses break complex tasks into a series of smaller steps. By recording the parent's performance on each step, and how much help was required to complete the step, the practitioner obtains a detailed analysis of parenting skill level and can monitor changes in skill level as the program proceeds.</p> <p>Teaching strategies include:</p> <ul style="list-style-type: none"> <li>• Giving simple instructions and explanations</li> <li>• Using pictorial prompts</li> <li>• Modelling and role playing</li> <li>• Providing feedback and encouragement</li> <li>• Succeeding on one skill before moving to the next.</li> </ul> <p>Resource materials for parents contain simple illustrations and minimal written language. Simple English and short sentences ensure maximum readability. The practitioner manual includes instructions for producing audio cassettes to accompany the parent resources. Resource materials for parents are more plentiful and detailed in the child care, health and safety components than in the parent-child interaction sections.</p> <p>Professionals from a range of backgrounds can deliver Step by Step Child</p>

	Care. However, they require knowledge of both child development and the effects of mild intellectual disability on parenting. Knowledge of active skill training methods is essential.
<b>Evidence base</b>	The effectiveness of this program has been examined in several studies. Compared to control groups, parents with an intellectual disability who participated in the program showed significant improvements in child care skills (Feldman, Case and Spark, 1992) and parent-child interaction (Feldman, Sparks and Case, 1993). Parent training also had direct benefits for children. For example, children showed increases in rate of weight gain following their parents receiving training in skills related to feeding and nutrition, and children of parents who received the parent-child interaction component of the program showed significant improvements in their language development.
<b>Strengths and Limitations</b>	Step by Step Child Care is an important program in an area that has been widely neglected, and is highly recommended to professionals who work with parents who have learning difficulties. Whilst the range of skills covered by the program to date is somewhat limited, practitioners could use the basic methodology of task analysis to incorporate additional parenting skills required by individuals they are working with.
<b>Availability</b>	<b>Step by Step Child Care: A Manual for Parents and Child-Care Providers</b> (1993). Copies are available directly from the author at: feldmanm@pavlov.psyc.queensu.ca
<b>References</b>	<p>Feldman, M. A. (1998). Parents with intellectual disabilities: Implications and intervention. In J. R. Lutzker (Ed.). <i>Handbook of Child Abuse and Neglect Research</i>. (pp. 171-191). Baltimore: Paul H. Brookes.</p> <p>Feldman, M. A., Case, L. and Sparks, B. (1992). Effectiveness of a child-care training program for parents at-risk for child neglect. <i>Canadian Journal of Behavioural Science</i>, 24, 14-28.</p> <p>Feldman, M. A., Sparks, B. and Case, L. (1993). Effectiveness of home-based early intervention on the language development of children of mothers with mental retardation. <i>Research in Developmental Disabilities</i>, 14, 387-408.</p> <p>Tymchuck, A. J. and Feldman, M. A. (1991). Parents with mental retardation and their children: Review of research relevant to professional practice. <i>Canadian Psychology/Psychologie Canadienne</i>, 32, 486-496.</p>

<b>THE PARENTS AND CHILDREN SERIES</b>	
<b>Author</b>	Carolyn Webster-Stratton, University of Washington
<b>Type of Program</b>	The Parents and Children Series was designed for parents of children aged between two and eight years with behavioural problems. It can also be used as a preventative program, before child behaviour problems arise or become more serious.
<b>Objectives</b>	The program aims to improve long term outcomes for children with behavioural problems by assisting their parents to improve their communication, limit setting, anger management and problem solving skills.
<b>Background</b>	Originating in the United States, the Parents and Children Series has been extensively researched with children with and without behavioural problems.
<b>Description</b>	<p>The Parents and Children Series is a videotape-based program. It can be offered in self-administered format or as a group program with 10 to 14 participants. The BASIC program contains nine videotapes in a series, each building on the content covered in the one before. The videos contain over 200 brief vignettes that depict parents handling various situations with their children. In a group format, the vignettes are used as discussion starters. The group leader highlights key points and directs the group's focus to the key skills being depicted. In the self-administered format, parents receive a video each week and individually work through an associated manual.</p> <p>BASIC group intervention consists of two and a half-hour sessions conducted over 12 to 14 consecutive weeks. It covers issues such as play, praise, rewards, limit setting and managing misbehaviour. Intervention strategies are based on long established learning principles. Emphasis is placed on helping parents to be more positive in their interactions with their children and providing alternative responses to common behaviour problems. The ADVANCE version is a supplementary program developed to address specific risk factors. It comprises three modules: communication skills, anger management, coping and problem solving.</p> <p>Program materials include the videotape series, a leaders' manual, parent weekly 'refrigerator' notes, parent home activity assignments and a book for parents. The leader's manual is comprehensive. It enables a leader to conduct parenting groups without extensive training in the program, especially if they have prior experience in conducting groups for parents. Formal training is not required to purchase or use the manual. Training is available in the United States and ranges from one day to one week. To become a certified group leader, a practitioner must complete training requirements, lead two parent groups, undergo peer review, and submit parent evaluations of the programs they conducted.</p>
<b>Evidence Base</b>	This program has been extensively evaluated over a period of more than 17 years using control group comparisons and reliable and valid outcome measures. Following participation in the program, parents engage in less criticism and physical punishment and use more praise and effective discipline practices (Webster-Stratton, 1984,1994). Parent reports and direct observation indicate a reduction in child problem behaviour and an

	increase in pro-social behaviour following program completion, and these gains are maintained at follow-up (Webster-Stratton, 1994, Webster-Stratton & Hammond, 1997; Webster-Stratton, Hollinsworth & Kolpacoff, 1989). The American Association Task Force identified the Parent and Children Series as one of two programs that met their stringent requirements for empirically supported mental health interventions for conduct-disordered children (Breston and Eyberg, 1998).
<b>Strengths and Limitations</b>	The program's strong evidence and research support make it one of the best corroborated mental health interventions for conduct-disordered children available. The availability of videos in British and Spanish dialects is also an advantage. As the program has not been formally evaluated in Australia, it is not known how the program would translate to the Australian context. Another disadvantage is the lack of professional training programs in Australia.
<b>Availability</b>	The program can be ordered by mail or over the Internet directly from the US. The cost for the Basic Series is US\$1300. The address is: Incredible Years 1411 8th Avenue West Seattle WA. Telephone: 888 506-3562
<b>References</b>	<p>Breston, E.V. &amp; Eyberg, S.M. (1998) Effective psychosocial treatments of conduct-disordered children and adolescents, 29 years, 82 studies, and 5,272 kids. <i>Journal of Clinical Psychology</i>, 27, 180-189.</p> <p>Webster-Stratton, C. (1984) Randomized trial of two parent-training programs for families with conduct-disordered children. <i>Journal of Consulting and Clinical Psychology</i>, 52(4), 666-678.</p> <p>Webster-Stratton, C (1994) Advancing videotape parent training: A comparison study. <i>Journal of Consulting and Clinical Psychology</i>, 66, 583-593.</p> <p>Webster-Stratton, C. &amp; Hammond M. (1997) Treating children with early-onset conduct problems: A comparison of child and parent training interventions. <i>Journal of Consulting and Clinical Psychology</i>, 65(1), 93-109.</p> <p>Webster-Stratton, C., Hollinsworth, T., &amp; Kolpacoff, M. (1989) The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. <i>Journal of Consulting and Clinical Psychology</i>, 57(4), 550-553.</p>
<b>Website</b>	<a href="http://www.incredibleyears.com">www.incredibleyears.com</a>

<b>PROJECT 12-WAYS</b>	
<b>Authors</b>	John Lutzker (Southern Illinois University at Carbondale)
<b>Type of Program</b>	Project 12-Ways is a program for high risk families. The two criteria established for eligibility to participate in Project 12-Ways are active protective services status (high risk of abuse or neglect) or low socioeconomic status (falls at or below the State's criterion line for poverty status).
<b>Objectives</b>	Treatment and prevention of child abuse and neglect.
<b>Background</b>	Project 12-Ways was born out of a need to develop a broad approach to the treatment of child abuse and neglect. The term 'ecobehavioural' was subsequently adopted to describe a model of family intervention that extended beyond child behaviour management, to include a wide range of domains in family life.
<b>Description</b>	Project 12-Ways is administered out of Southern Illinois University and has run continuously in Southern Illinois since 1979. It provides <i>in situ</i> treatment (in homes, schools, foster homes, etc) in many different areas: parent-child interaction, stress reduction, assertiveness, self-control, money management, leisure time, health, nutrition, couple relationships, problem solving, multiple setting behaviour management training. The program is individually tailored to families, based on their needs.
<b>Evidence Base</b>	Single case studies have provided some promising evidence for the effectiveness of this program. Clinical records have demonstrated that less subsequent child abuse occurred in families who participated in the program, compared to families in other areas where the program was not available (Lutzker & Rice, 1984; Lutzker et al, 1998). The program has also been used with other populations and tested to see whether it can be effective with fewer components. Project Ecosystems was developed for families of children with developmental disabilities and Project Safecare was designed to test an intervention providing a streamlined number of modules, delivered by less qualified trainers. Project Safecare incorporates only health training, home safety and parent-child interaction training. Case studies and reviews of clinic report data suggest that these modified programs are also helpful, however, further studies utilising more scientifically rigorous methodology are required before definite conclusions about efficacy can be drawn (Lutzker & Campbell, 1994). Follow-up studies are yet to be completed.
<b>Strengths and Limitations</b>	The breadth of the program is its major asset, especially for practitioners who work with families who have multiple and complex needs. Agencies could consider using individual components of the program as each component has been evaluated separately and could be used independently without destroying the integrity of the program. Program manuals have not yet been published.
<b>Availability</b>	Program manuals have not yet been published commercially, however, some detailed program descriptions (Lutzker, Huynen & Bigelow, 1998) have been published in journals and book chapters.
<b>References</b>	Lutzker, J.R. (1992). Developmental disabilities and child abuse and neglect: The ecobehavioural imperative. <i>Behaviour Change</i> , 9 (3),

	<p>149-156</p> <p>Lutzker, J.R. (Ed.) (1998). <i>Handbook of Child Abuse Research and Treatment</i>. New York: Plenum Press.</p> <p>Lutzker, J.R. and Campbell, R. (1994). <i>Ecobehavioural Family Interventions in Developmental Disabilities</i>. California: Brooks/Cole Publishing Company.</p> <p>Lutzker, J.R. and Rice, J.M. (1984). Project 12-Ways: measuring outcome of a large in-home service for treatment and prevention of child abuse and neglect. <i>Child Abuse and Neglect</i>, 8, 519-524.</p> <p>Lutzker, J.R. and Rice, J.M. (1987). Using recidivism data to evaluate Project 12-Ways: An ecobehavioural approach to the treatment of child abuse and neglect. <i>Journal of Family Violence</i>, 2(4), 283-290.</p> <p>Lutzker, J.R., Huynen, K.B., and Bigelow, K.M. (1998). Parent Training. In (Eds). VB. Van Hasselt and M. Hersen. <i>Handbook of Psychological Treatment Protocols for Children and Adolescents</i>. Mahurrah, NJ: Lawrence Erlbaum Assoc.</p>
<b>Website</b>	None

<b>TRIPLE P POSITIVE PARENTING PROGRAM</b>	
<b>Auspice</b>	Matthew R Sanders, Carol Markie-Dadds and Karen Turner (Parenting and Family Support Centre, The University of Queensland, Brisbane, Queensland).
<b>Type of Program</b>	Triple P is a multilevel program that encompasses universal preventative intervention, designed for all parents, through to more intensive interventions for families of children with behavioural problems. Components of the program are specifically designed to assist parents where the situation is complicated by parental depression or relationship difficulties.
<b>Objectives</b>	Triple P aims to prevent and ameliorate behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.
<b>Background</b>	<p>The development of a tiered multilevel strategy in Triple P is based on the recognition that parents have differing needs regarding the type, intensity and method of assistance they require. The multilevel strategy is designed to maximise efficiency, contain costs and ensure the program is widely accessible within the community.</p> <p>Triple P is a form of behavioural family intervention based on social learning principles (Patterson, 1982). It is essentially an educational program, involving active training of parents in the use of child management and positive parenting skills. The program content draws on social learning, cognitive, behavioural and developmental theory, as well as research into risk factors associated with the development of social and behavioural problems in children.</p> <p>Triple P emphasises parenting practices that create nurturing, safe, engaging, non-violent and low conflict environments for children, as well</p>

	<p>as parenting skills that promote children's social, emotional, language, intelligence and behavioural competencies. Eighteen parenting skills are introduced in four categories:</p> <ol style="list-style-type: none"><li>(1) Developing a positive relationship (quality time, talking, affection)</li><li>(2) Encouraging desirable behaviour (attention, praise, engaging activities).</li><li>(3) Teaching new behaviour and skills (modelling, incidental teaching, 'Ask, Say, Do', behaviour charts).</li><li>(4) Promoting children's self-control (rules, directed discussion, planned ignoring, clear instructions, logical consequences, quiet time, time-out).</li></ol> <p>The therapeutic process utilised by the program aims to empower families to help themselves by building on existing parenting strengths, identifying weaknesses, selecting goals for change and implementing planned changes with their children. Parents are encouraged to develop self-reliance by assisting them to learn how to set goals for change, self-monitor, self-evaluate and self-correct.</p>
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<p><b>Description</b></p>	<p>The program is appropriate for all families with children aged 0–12 years. It is divided into five levels:</p> <ul style="list-style-type: none"> <li>• Level 1 (Universal Triple P) is essentially a self-help intervention that involves providing information about positive parenting strategies to any parent interested in promoting their child's development and wellbeing and managing everyday child behaviour problems. Resources at this level include the Positive Parenting Booklet, 40 parent tip sheets and a series of four videos.</li> <li>• Level 2 (Selected Triple P) involves combining brief, time-limited professional consultation with strategic use of information for parents experiencing specific behaviour problems. Intervention at this level generally consists of up to two sessions of approximately 20 minutes duration each. This level of intervention utilises Level 1 resources.</li> <li>• Level 3 (Primary Care Triple P) incorporates active skills training, such as skill demonstrations by the practitioner and practise of skills by parents, into the consultation process. The intervention consists of four sessions of approximately 20 minutes duration, and is appropriate for families who are concerned about a specific problem that is of relatively recent onset and of mild to moderate severity. Programs are generally conducted either in community agencies or on a home visit basis. Resources utilised at this level are the same as those used in Level 2 interventions, with the addition of a Primary Care Triple P Facilitators Kit (including a practitioner manual and flip chart).</li> <li>• Level 4 (Standard, Group and Self-Directed) involves broad-based parenting skills training. This level of intervention is appropriate for families seeking information across a range of parenting issues and for families who are experiencing longer term and more severe difficulties with their children's behaviour. The duration of intervention ranges from eight weeks for the group format to 10 weeks for the standard (one to one) format. Standard Triple P programs are generally conducted either in community centres or in the parent's home. Facilitator kits are available for Standard and Group Triple P, with parent workbooks available for each program variant at this level.</li> <li>• Level 5 (Enhanced Triple P) is an intensive family intervention that follows on from the parenting skills training provided in Level 4, and is appropriate for parents who are continuing to experience difficulties. It incorporates assistance for families experiencing relationship difficulties or personal adjustment problems such as depression, anxiety, anger or stress. The length of intervention at this level varies from three to approximately nine weeks, according to each family's needs. Resources utilised at this level are the Enhanced Triple P practitioner's manual and a parent workbook.</li> </ul> <p>All levels of the program can be delivered in home or clinic settings. To deliver Triple P programs as accredited providers, practitioners must first complete a training and accreditation process. Post training support in the form of regular newsletters and access to a dedicated website is available to practitioners who successfully fulfil accreditation requirements.</p>
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<p><b>Evidence Base</b></p>	<p>The component parts of Triple P are based on extensive research in clinical work with families who have children experiencing behavioural difficulties. However, the various levels of Triple P have been subject to extensive evaluation.</p> <p>Research on Triple P has consistently found significant improvements for families and children on a range of parent and child measures (see Sanders, 1999). Lower levels of child behaviour problems, increased levels of parenting competence, and more frequent use of positive parenting practices immediately following completion of the program have been reported, with improvements being maintained at follow-up (Connell, Sanders &amp; Markie-Dadds, 1997; Sanders, Markie-Dadds, Tully &amp; Bor, 2000; the Western Australian Health Department, 1996).</p> <p>A large well designed clinical trial conducted in Australia that involved randomly assigning distressed families of preschoolers with behavioural problems to various levels of the program, and comparing them to a wait list control group, has demonstrated the effectiveness of Self-Directed, Standard and Enhanced formats of the program (Sanders, Markie-Dadds, Tully &amp; Bor, 2000). The effectiveness of Group Triple P has been examined in field trials in at least three States of Australia, and in each case, comparable results to the earlier clinical trials have been reported (for example, Cann, Rogers, Burke &amp; Littlefield, 2001). Final conclusions about the efficacy of the Group Triple P program, however, must await the findings of a properly constituted clinical trial involving random allocation of subjects and broader measurement of outcomes including behavioural observation. Field trials of Primary Care Triple P have also been conducted, including one small study here in Melbourne that involved randomly allocating parents to Selected Triple P, Primary Care Triple P or wait list control. Parents in both the Selected and Primary Care Triple P programs reported positive change, with more change being reported in the Primary Care Group (Matthews et al., 2001). While these findings are promising, as in the case with Group Triple P, further studies are required.</p>
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<p><b>Strengths and Limitations</b></p>	<p>Triple P has been developed, used and researched within the Australian context and is appropriate for use in Australia. Well-designed studies have consistently demonstrated significant child and parent benefits from the program. Despite the number of studies that have evaluated the effectiveness of Triple P, some levels of the program have as yet not been exposed to a high level of evaluation (including the lower levels of the program and also the group format of Level 4). This needs to be done to ensure that all levels of the program produce effective outcomes for children and families. Evaluation of Triple P is continuing and it is expected that the findings of the systematic program of evaluation will continue to inform the development of the program.</p>
<p><b>Availability</b></p>	<p>The Triple P program, and the many resources it produces, are widely available throughout Australia. Parent Tip Sheets, the Positive Parenting Booklet, the Positive Parenting Video Series and a Developmental Wall Chart are available to Victorian service providers from the Victorian Parenting Centre (versions designed for national and international use are available from Triple P International). Selected Parent Tip Sheets and the Positive Parenting booklet are also now available in eight community languages.</p> <p>Facilitator's Kits for each level of intervention and parent workbooks are available from Families International along with additional resources, including the 'Every Parent' book and additional videos.</p> <p>Contact details for both organisations are:</p> <ul style="list-style-type: none"> <li>• Victorian Parenting Centre, 24 Drummond Street, Carlton VIC 3053</li> <li>• Triple P International, PO Box 1300 Milton QLD</li> </ul>

<b>References</b>	<p>Cann, W., Rogers, H., Burke, K and Littlefield, L (2001). 'The effectiveness of a population based behavioural family intervention program', Paper presented at the World Congress of Cognitive Behavioural Therapy, Vancouver.</p> <p>Connell, S., Sanders, M.R. &amp; Markie-Dadds, C. (1997). Self-directed behavioural family intervention for parents of oppositional children in rural and remote areas. <i>Behaviour Modification</i>, 21(4), 379-408.</p> <p>Matthews, J., Cann, W., Sultana, C. and Rogers, H. (2001). 'Brief behavioural family intervention incorporating written advice: two studies with differing degrees of therapist input.' Paper presented at the World Congress of Cognitive Behavioural Therapy, Vancouver.</p> <p>Sanders, M. (1999). The Triple P-Positive Parenting Program: Towards an empirically validated multi-level parenting and family support strategy for the prevention and treatment of child behaviour and emotional problems. <i>Clinical Child and Family Psychology Review</i>, 2(2), 71-90.</p> <p>Sanders, M.R., Markie-Dadds, C., Tully, L., &amp; Bor, W. (2000). The Triple P-Positive Parenting program: A comparison of enhanced, standard, and self directed behavioral family intervention. <i>Journal of Consulting and Clinical Psychology</i>, 68(4), 624-640.</p> <p>Sanders, M.R. &amp; Markie-Dadds, C. (1996). Triple P: A multilevel family intervention program for children with disruptive behaviour disorders. In P. Cotton, H. Jackson, (Eds.), <i>Early Intervention and Prevention in Mental Health</i> (pp. 59-85). Melbourne, Australia: Australian Psychological Society Ltd.</p>
<b>Website</b>	<a href="http://www.triplep.net">www.triplep.net</a>

<b>DEFIANT CHILDREN</b>	
<b>Author</b>	Russell Barkley, Director of Psychology, University of Massachusetts
<b>Type of Program</b>	This program was designed to treat children with severe behavioural problems, such as those associated with ADHD, Oppositional Defiant Disorder and Conduct Disorder. Although not designed as a 'blanket treatment', the author says that the program may also be useful for children with milder behaviour problems.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• To improve parental management skills and competence in dealing with child behaviour, particularly non-compliance.</li> <li>• To improve parental knowledge of the causes of misbehaviour.</li> <li>• To improve child compliance to commands and rules given by parents.</li> </ul>
<b>Background</b>	The program is based on earlier parent training work (specifically the work of Forehand & McMahon, 'Helping the non-compliant child', see related review). Barkley has expanded and modified these existing programs to deal with ADHD and other behavioural disorders.

	<p>Barkley lists six concepts of effective child management on which the program is based:</p> <ol style="list-style-type: none"> <li>1. Immediacy of consequences.</li> <li>2. Specificity of consequences.</li> <li>3. Consistency of consequences.</li> <li>4. Establishment of incentive programs before punishment.</li> <li>5. Anticipation of and planning for misbehaviour.</li> <li>6. Reciprocity of family interactions and uselessness of fault finding.</li> </ol>
<b>Description</b>	<p>The program, in group or individual format, is designed around ten 2½ hour sessions. As parents are not permitted to proceed to the next step in the program until they have mastered earlier steps, some families will take longer than others to work through the sessions. For families participating in a group training program, one missed assignment is permitted and families must meet with the therapist to discuss this before the next meeting.</p> <p>The core parent training program focuses on helping parents to increase their child's compliance with parental requests. Ten self-contained units are:</p> <ol style="list-style-type: none"> <li>1. Why children misbehave.</li> <li>2. Pay attention.</li> <li>3. Increasing compliance to commands and requests.</li> <li>4. Decreasing disruptiveness – increasing independent play.</li> <li>5. When praise is not enough – poker chips and points.</li> <li>6. Time out.</li> <li>7. Extending time out to other misbehaviours.</li> <li>8. Managing non-compliance in public places.</li> <li>9. Handling future behaviour problems.</li> <li>10. Booster sessions.</li> </ol> <p>Each session begins with a review of homework and family events, then continues with introduction of new material. Parents are encouraged to practise strategies within the sessions. Problems envisaged with implementation are discussed and homework is assigned.</p> <p>The practitioner's manual is extensive. It contains the rationale, goals and step by step instructions for conducting each session, as well as suggested parent home assignments, parent handouts outlining the key concepts of each session, and a range of parent and child assessment questionnaires. There is no specific training required for delivery of the program, so a qualified counsellor can self-train from the manual. However, it is recommended that the program be delivered by a practitioner with knowledge of behavioural theory and practice.</p>
<b>Evidence Base</b>	<p>According to Barkley (1997), available data suggests that up to 64 per cent of children with ADHD or other severe oppositional behaviour, can expect to demonstrate clinically significant change in the level of behavioural difficulties they experience. Improvement is greater in younger children (under six years) and in children with less clinically</p>

	severe problems. Defiant and aggressive behaviour is likely to decrease most, with ADHD symptoms improving only mildly or not at all. At least one other study has found that parents of children with ADHD report reductions in stress, increases in self-esteem and improvements in the overall severity of ADHD symptoms following the program (Anastopoulos, Shelton, DuPaul & Guevremont, 1993).
<b>Strengths and Limitations</b>	<p>Only a few studies have examined the effectiveness of this program as a whole package. However, it is based on other programs that have been extensively researched and found to be effective in the treatment of children with behavioural problems. Whilst practitioners can be confident this is an evidence-based program, further evaluation of the outcomes of the whole program are required.</p> <p>Everything needed to conduct the program is provided in the program manual, which is widely available. As the program does not have a built-in system of professional training, effective implementation requires the practitioner to have a greater existing knowledge of behavioural theory and intervention.</p>
<b>Availability</b>	The manual can be ordered from a number of book companies on the Internet or through bookstores.
<b>References</b>	<p>Anastopoulos, A.D., Shelton, T.L. DuPaul, G.J. and Guevremont, D.C. (1993). Parent training for attention-deficit hyperactivity disorder: Its impact on parent functioning. <i>Journal of Abnormal Child Psychology</i>, 21, 581-597.</p> <p>Barkley, R.A. (1997). <i>Defiant Children. A Clinician's Manual for Parent Training</i> (2<sup>nd</sup> Ed.). New York: The Guilford Press.</p> <p>Barkley, R.A. (1987). <i>Defiant Children. Parent-Teacher Assignments</i>. New York. The Guilford Press</p>
<b>Website</b>	None

<b>HELPING THE NON-COMPLIANT CHILD</b>	
<b>Authors</b>	Rex L. Forehand (Institute for Behavioural Research, University of Georgia, USA) and Robert J. McMahon (Department of Psychology, University of Washington, USA).
<b>Type of Program</b>	Prevention of serious conduct disorders
<b>Objectives</b>	This program is one of the earliest developed for the treatment and prevention of serious behavioural problems in children. The stated objective of this program is to prevent serious conduct disorders in children. This is done by teaching parents how to change their children's non-compliant and disruptive behaviour.
<b>Background</b>	The program is based on social learning theory and was developed as a response to requests from other professionals for a comprehensive parent training program.
<b>Description</b>	The program is targeted at parents of children aged three to eight years, who are engaging in non-compliant behaviour. Where possible, it is

	<p>who are engaging in non-compliant behaviours. Where possible, it is recommended that one-way mirrors and communication devices (for example, 'bug in the ear') are used to allow the practitioner to provide immediate feedback to parents as they interact with their children. Sessions typically occur weekly for a period of up to 12 weeks, and parents proceed in a step wise fashion through a series of skills, moving from one skill to the next as they demonstrate confidence and competency in the earlier step.</p> <p>Parents are introduced to a range of skills, intended to help them modify unhelpful interactions with their children, in two distinct phases: the differential attention phase and the compliance training phase. In the differential attention phase, parents learn how to observe and then attend to and encourage desirable behaviours in their children. In the compliance training phase, parents learn how to give effective instructions and how to use time out as a consequence for non-compliance. A variety of instructional methods are employed including teaching, modelling and role playing, so that parents have an opportunity to practise the strategies with the support of the practitioner before trying them at home.</p> <p>A published guide to the program is available (Forehand &amp; McMahon, 1981). This comprehensive manual gives information about the development of the program, session content, and parent worksheets and handouts that can be copied and given to each family as required. The book also contains evaluation tools, including a consumer satisfaction questionnaire, a behavioural coding system and extensive instructions on how to conduct observations of parent-child interaction.</p> <p>Training for practitioners is recommended by the authors. Currently, training is available in the US only.</p>
<p><b>Evidence Base</b></p>	<p>Program evaluation is extensive and has examined the short and long term effectiveness of the program with children exhibiting high levels of non-compliance, delinquency and other problem behaviours. For example, one lengthy follow-up study looked at outcomes for 26 families who had completed the program at least 14 years earlier, compared to matched community subjects (Long, Forehand, Wierson &amp; Morgan, 1994). Results indicated that at follow-up, children in the intervention group could not be distinguished from the comparison group on measures of delinquency, emotional adjustment and academic achievement. Parents' perceptions of the program have also been systematically investigated. Consumer satisfaction with the program is high (McMahon, Tiedemann, Forehand &amp; Griest, 1984) and strategies recommended by the program have a high level of community acceptance (Calvert and McMahon, 1987).</p>
<p><b>Strengths and Limitations</b></p>	<p>This program has a strong evidence base and has, in turn, influenced the development of many more recent programs (such as Triple P) that aim to achieve similar outcomes. The published version of this program is now a little dated; however a revised edition of the program is expected shortly. Formal training in the program is very costly and only available in the United States</p>
<p><b>Availability</b></p>	<p>The program manual is still currently available and can be ordered through specialist bookstores at a cost of around \$80.</p>
<p><b>References</b></p>	<p>Calvert, S.C. &amp; McMahon, R.J. (1987). The treatment acceptability of a behavioural parent training program and its components. <i>Behavior</i></p>

	<p><i>Therapy, 2, 165-179.</i></p> <p>Forehand, R.L. &amp; McMahon, R.J. (1981). <i>Helping the Noncompliant Child: A Clinician's Guide to Parent Training</i>. New York: Guilford Press.</p> <p>Long, P., Forehand, R., Wierson, M. and Morgan, A. (1994). Does parent training with young noncompliant children have long-term effects? <i>Behavior Research and Therapy, 32(1), 101-107.</i></p> <p>McMahon, R.J., Tiedemann, G.L., Forehand, R. and Griest, D.L. (1984). Parental satisfaction with parent training to modify child noncompliance. <i>Behaviour Therapy, 15, 295-303.</i></p>
<b>Website</b>	None

<b>FAST TRACK</b>	
<b>Auspice</b>	<p>Conduct Problems Prevention Research Group:</p> <p>D. Coie, K.A. Dodge (Duke University)  L.M. Collins, M.T. Greenberg (Pennsylvania State University)  J.E. Lochman (University of Alabama)  R.J. McMahon (University of Washington)  E.E. Pinderhughes (Vanderbilt University)</p>
<b>Type of Program</b>	The Fast Track program was designed to prevent behavioural disorders in school age children.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• To integrate provision of universal and selective (high risk) services into a comprehensive model that involves the child, school and community.</li> <li>• To develop, implement and evaluate a comprehensive multi-site intervention designed to prevent serious and chronic antisocial behaviour in high risk children when they first enter school.</li> <li>• To learn what children need to succeed in school, in order to learn what to do to help them.</li> <li>• To reduce the frequency, severity and latency of onset of adolescent problem behaviours in the high risk intervention sample.</li> </ul>
<b>Background</b>	<p>The Fast Track program is based on the assumption that antisocial behaviour in children and adolescents results from a range of individual and social factors. Children who live in communities characterised by low income and high crime rates are at higher risk of developing behavioural problems. Marital conflict or instability in families make effective parenting difficult to achieve, particularly with children who are impulsive or have a challenging temperament. High risk children often enter school unprepared socially, emotionally and cognitively and their parents are often unprepared to relate to the school effectively.</p> <p>Fast Track is a comprehensive program with a range of components that target parents, children and classrooms. The program is currently being implemented in selected public schools across the United States (Durham, North Carolina, Central Pennsylvania; Seattle and Highline, Washington; and Nashville, Tennessee) and intervention continues from grades one to six.</p>

<b>Description</b>	<p>Fast Track incorporates a range of strategies including:</p> <ol style="list-style-type: none"> <li>1. Teacher-led classroom curricula to develop emotional concepts, social comprehension and self-control (universal) of children.</li> <li>2. Parent training groups that encourage a good family-school relationship and teach parents behaviour management skills.</li> <li>3. Home visits to build parental problem solving skills and promote feelings of empowerment and self-efficacy.</li> <li>4. Child social skill training groups.</li> <li>5. Child tutoring in reading.</li> <li>6. Child friendship enhancement in the classroom.</li> </ol> <p>The universal aspect of the intervention (social skills training for children) continues throughout the elementary school years. A follow-on indicated intervention continues up to grade 10 for children who are identified as being at high risk because of earlier behaviour problems in preschool and at home.</p> <p>Intervention staff who conduct training sessions are generally masters level trained. The teachers who conduct the generalised curricula attend specialised Fast Track training programs. There are no training programs or manuals currently available as it is a trial program.</p>
<b>Evidence Base</b>	<p>A wide number of evaluation strategies are being employed to evaluate different aspects of the program. Published studies are generally showing good results. Universal intervention successfully decreased aggression and increased self-control and on-task behaviour in target children (CPPRG, 1999a). After the first year of intervention, children improved on emotional and social coping skills and basic word-attack skills when compared with controls. Parents in the intervention condition demonstrated more warmth and positive involvement, more appropriate and consistent discipline, and more positive school involvement than those in the control condition. They also reported high levels of satisfaction with the program (CPPRG, 1999b). Evaluation is continuing.</p>
<b>Strengths and Limitations</b>	<p>Fast Track is an important example of a comprehensive prevention program delivered within a school community. At this stage, FAST is a demonstration/research project that is not yet ready for further dissemination as a package. However, ongoing evaluation provides an opportunity to examine the effectiveness of this kind of comprehensive approach to the prevention of social and emotional problems in children.</p>
<b>Availability</b>	<p>Published reports about the project and research program are available in scientific journals. A website provides a list of current and future publications. Program manuals or professional training programs have not been released. Close collaboration with the project team would be required to accurately replicate the program in another setting. However, the program designers have utilised a range of existing programs in their strategy (for example, The Parent and Children's Services) which are currently available.</p>
<b>References</b>	<p>Conduct Problems Prevention Research Group (1999a). Initial impact of the Fast Track prevention trial for conduct problems: II. Classroom effects. <i>Journal of Consulting and Clinical Psychology</i>, 67(5), 648-657.</p>

	<p>Conduct Problems Prevention Research Group (1999b) Initial impact of the Fast Track prevention trial for conduct problems: I. The high risk sample. <i>Journal of Consulting and Clinical Psychology</i>, 67 (5), 631-647.</p> <p>Conduct Problems Prevention Research Group (2000) merging universal and indicated prevention programs: The Fast Track model. <i>Addictive Behaviours</i>, 25 (6) 913-927.</p> <p>Conduct Problems Prevention Research Group (1992) A developmental and clinical model for the prevention of conduct disorder: The FAST Track Program. <i>Development and Psychopathology</i>, 4, 509-527.</p>
<b>Website</b>	<a href="http://fasttrackproject.org/default.htm">http://fasttrackproject.org/default.htm</a>

<b>FRIENDS</b>	
<b>Authors</b>	Paula Barrett, Hayley Lowry-Webster and Cynthia Turner (Griffith University, Brisbane)
<b>Type of Program</b>	The FRIENDS program can be used in individual clinical treatment or as a school-based universal prevention program.
<b>Objectives</b>	The main objective of the program is to prevent the development of serious mental disorders, emotional distress and impairment in social functioning by teaching children and young people how to cope with and manage anxiety and depression, both now and in later life. The aims of the program are to help children: (1) think more positively; (2) relate more confidently with others; (3) become more aware of their feelings; and (4) be better equipped to deal with their emotions.
<b>Background</b>	<p>Anxiety is the most common psychological problem reported by children and tends to persist into adulthood if left untreated. The FRIENDS program was developed at Griffith University (Queensland) as an early intervention program for anxiety and depression in children and adolescents. The program combines cognitive-behavioural skill training for children, with parallel training sessions for their parents. The FRIENDS program combines skills and techniques based on the physiological, cognitive and learning components of anxiety. With regard to physiology, children are taught how to recognise the bodily changes they experience when they are feeling anxious, following which they are taught relaxation and deep-breathing techniques to help them relax. In the cognitive domain, children are taught how to recognise and challenge negative self-talk, and how to replace negative self-talk with more helpful thoughts. Children are also introduced to behavioural strategies for overcoming fears such as breaking down feared situations into small steps, gradually exposing themselves to any feared situation, and rewarding themselves for attempting each step. The learning aspect refers to the problem solving strategies that are introduced as a way of dealing with situations that give rise to anxiety. Parents are introduced to each component of the program and taught how to support their child in the use of the strategies.</p> <p>FRIENDS is currently used in Australia, England, Ireland, Canada and The Netherlands.</p>

<p><b>Description</b></p>	<p>FRIENDS consists of weekly one-hour sessions for children over a period of ten weeks, two booster sessions and four parent training evenings, and is suitable for children aged seven to 16 years. A practitioner manual provides detailed session plans and there are accompanying child and parent workbooks.</p> <p>The children’s sessions cover a range of anxiety management skills. Parents are introduced to the strategies and taught how they can aid and support their children’s progress. The approach includes didactic instruction, games, stories, group discussion, role plays and home activities.</p> <p>The content of the program is organised around teaching participants the steps of the FRIENDS plan. The word “FRIENDS” is used as a mnemonic device to help children remember the fundamental features of the program:</p> <p>Step 1           <b>F</b> = Feeling worried?  Step 2           <b>R</b> = Relax and feel good  Step 3           <b>I</b> = Inner thoughts  Step 4           <b>E</b> = Explore plans  Step 5           <b>N</b> = Nice work, reward yourself!  Step 6           <b>D</b> = Don’t forget to practise  Step 7           <b>S</b> = Stay cool</p> <p>Booster sessions are provided for children at one month and at three months post-intervention. The purpose of these sessions is to encourage participants to continue using the FRIENDS plan when encountering difficult situations and to review their experiences and problem solve any difficulties.</p> <p>The four parent training sessions cover a range of topics including: the purpose and theoretical background of the FRIENDS program; normalising the emotional state of anxiety; the relationship between thoughts and feelings; recognition of body clues that indicate anxiety; challenging negative self-talk and other problem solving strategies.</p> <p>The FRIENDS program can be implemented by various mental health and educational professionals (for example, psychologists) who are familiar with cognitive behaviour therapy-based family interventions. Those without this specialist clinical background (for example, teachers) are able to attend intensive one day training workshops run by Griffith University prior to running programs. The cost is \$150.00 per participant for a 20-participant group training session.</p>
<p><b>Evidence Base</b></p>	<p>The results of previous studies examining the effectiveness of cognitive-behavioural approaches in ameliorating anxiety have generally supported this type of intervention (Kendall, 1994, Kendall &amp; Southam-Gerow, 1996). Studies have revealed that children in a FRIENDS intervention group report fewer anxiety symptoms following program completion, than a comparison cognitive behavioural therapy group at post-test (Lowry-Webster &amp; Barrett, 2000). Recent research has also demonstrated that the FRIENDS program is an effective treatment for clinically anxious children (Shortt, Barrett and Fox, in press). These preliminary results appear to support the benefits of a school-based universal cognitive-behavioural intervention program (Lowry-Webster &amp; Barrett, 2000).</p>

<b>Strengths and limitations</b>	At present, FRIENDS remains the only clinically validated early intervention and prevention program for anxiety and depression in Australia. Evaluation of all aspects of the program is continuing.
<b>Availability</b>	FRIENDS for Children is readily available through the publishers, Australian Academic Press. An introductory sample pack of the two major publications (Group Leader's Manual and Workbook) is available for \$69.30 (including GST and postage within Australia).
<b>References</b>	<p>Kendall, P.C. (1994). Treating anxiety disorders in children: Results of a Randomized clinical trial. <i>Journal of Consulting and Clinical Psychology</i>, 62, 100-110.</p> <p>Lowry-Webster, H.M. and Barrett, P.M. (2000). A Universal Prevention Trial of Anxiety and Depressive Disorders in Childhood: Preliminary Data from an Australian study. Submitted for publication.</p> <p>Shortt, A.L., Barrett, P.M. and Fox, T.L. (2001). An evaluation of the FRIENDS program: A cognitive-behavioural group treatment for anxious children and their parents. <i>Journal of Clinical Child Psychology</i>, 30 (1), 525-535.</p>
<b>Website</b>	<p>An order form with all materials and prices listed may be downloaded from the website address:</p> <p><a href="http://www.australianacademicpress.com.au">www.australianacademicpress.com.au</a></p>

## 7.2 Intervention Programs

With the exception of PRISM, all the programs in this section have been proven to be effective with children. Despite the fact that it is an experimental program at this stage, PRISM has been included as it is a promising initiative that is well designed, Victorian-based and uses local infrastructure.

<b>Program</b>	<b>Target Age</b>
Early Head Start	Antenatal, Infancy/Toddler
Hawaii's Health Start	Infancy/Toddler
PRISM	Infancy/Toddler
Even Start	Infancy/Toddler, Preschool, Primary School
Perry Preschool Program	Preschool
Head Start Transition	Preschool, Primary School

<b>EARLY HEAD START</b>	
<b>Auspice</b>	The Administration on Children, Youth and Families, Washington, D.C.
<b>Type of Program</b>	A treatment program to enhance children's development from prior to birth and throughout the first three years.
<b>Objectives</b>	<p>The program aims to improve outcomes in four domains:</p> <ul style="list-style-type: none"> <li>• Children's development (including health, resiliency, social competence, cognitive and language development)</li> <li>• Family development (including parenting and relationships with children, the home environment and family functioning, family health, parent involvement and economic self-sufficiency).</li> <li>• Staff development (including professional development and relationships with parents).</li> <li>• Community development (including enhanced child care quality, community collaboration, and integration of services to support families with young children).</li> </ul>
<b>Background</b>	<p>In 1994, the Carnegie Corporation report <i>Starting Points</i> identified the fragmentation of community services for families with infants and toddlers as a 'quiet crisis'. In response, the Administration on Children, Youth and Families designed the Early Head Start program to operate and be funded through the broader Head Start program (which applies to four year olds). The program was conceived as a comprehensive two generation program for low income families with infants and toddlers within the broader Head Start program, which usually provides a year's educational intervention to children aged around four. The program includes intensive services that</p>

	<p>begin before the birth of the child and focuses on both enhancing the child's development and supporting the family in the first three years of the child's life. Early Head Start is based on the evidence that the first three years of children's lives provide the basis for later development, and support at this time can reduce risk and promote protective factors for the child and enhance family life. The program commenced in 1995 with 68 grants for programs and is family-centred and community-based.</p>
<p><b>Description</b></p>	<ul style="list-style-type: none"> <li>• The principles on which this program is based are: high quality; prevention and promotion; positive relationships and continuity; parent involvement; inclusion; culture; flexibility, responsiveness, comprehensiveness and intensity; transition and collaboration.</li> <li>• Performance standards have been developed for the program. Some programs are funded as part of existing Head Start programs while others are new programs supported through a specific training and technical assistance strategy.</li> <li>• Target group: low income families where the mother is pregnant or has an infant or toddler. Families are from diverse cultural backgrounds.</li> <li>• Location: By 2001 there were 650 programs serving more than 55,000 families in a diversity of locations, both rural and urban, across the US.</li> <li>• Mode of delivery: varied, as there are multiple sites involved in this program, but both home visits and child care services are involved and there is intervention at individual, group and community level.</li> <li>• Intervention strategies: developing strong relationships with other community-based services and parenting education. At some sites the program focuses on child development through child care services while at others the focus is more on a home visitation approach, and other services are involved in partnerships.</li> <li>• Length of intervention: around three years. The overall program started in 1995 and expanded over the following years.</li> <li>• Resources (for example, manuals etc.): available through the Early Head Start program to funded programs.</li> <li>• Training required for delivery: available to funded programs through the Head Start Bureau. However, staff development is an integral part of program plans and quality improvement at each site.</li> </ul>
<p><b>Evidence Base</b></p>	<ul style="list-style-type: none"> <li>• This is a promising program but no evaluation material is as yet available, although an evaluation using a comprehensive experimental design is underway. This evaluation will cover all aspects of the program, including the implementation, and the research team is already at work.</li> <li>• Future research/ongoing research: The evaluation team is from the Center for Young Children and Families at Columbia University, Teachers College. The national evaluation team will be led by Dr. J. M. Love, Dr. E. E. Kisker and Dr. J. Brookes-Gunn. The Administration on Children, Youth and Families has also funded 15 local research teams to work with 16 of the Early Head Start programs to conduct research on central local issues and to participate in national evaluation activities. A Consortium of ACYF staff, members of the national evaluation team and local researchers will address issues relating to policy, assessment and other research issues.</li> </ul>

<b>Limitations</b>	As yet, no evidence to support the program is available, although it is based on evidence from other research studies, such as the Abecaderian experimental research study, which found that intervention to support children from similar families was most effective when started early in the life of the child.
<b>Availability</b>	Available from The Administration on Children, Youth and Families; contact staff - Judith Jerald, Helen Raikes or Rachel Chazan Cohen.
<b>References</b>	Taylor, H. (1995/96), 'Early Head Start: A New Commitment to Children and Families', <i>Head Start Bulletin</i> , Vol.1, No.57.  The Quiet Crisis. (2001) Head Start Bureau website.  'Early Head Start Research and Evaluation', <i>Head Start Bulletin</i> , 1995/96, Vol.1, No.57.
<b>Website</b>	<a href="http://www.acf.dhhs.gov/programs/hsb/">www.acf.dhhs.gov/programs/hsb/</a>

<b>PRISM: PROGRAM OF RESOURCES, INFORMATION AND SUPPORT FOR MOTHERS</b>	
<b>Authors</b>	J. Lumley, R. Small, S. Brown, C. Mitchell and L. Watson (Centre for the Study of Mothers' and Children's Health), in collaboration with J. Gunn (Department of General Practice and Public Health, University of Melbourne), and P. Hawe (Department of Community Health Sciences, University of Calgary, Canada).
<b>Type of Program</b>	PRISM is a community intervention trial targeted at women in the 16 municipalities taking part, eight intervention areas and eight comparisons.
<b>Objectives</b>	PRISM aims to improve the physical and emotional health of women following child birth via an integrated program of primary care (general practitioners and maternal and child health nurses, community agencies, community mental health services and local government) and community-based strategies.  The program aims to improve: <ul style="list-style-type: none"> <li>• Recognition and treatment of depression and common postnatal physical health problems in primary care.</li> <li>• Listening skills and offers of 'time to talk' by general practitioners and maternal and child health nurses.</li> <li>• Local availability of social support and time-out for women with young children.</li> <li>• Information to mothers about local services and about their own health after the birth of a baby.</li> </ul>
<b>Background</b>	Based on research that shows that mothers need support, information and access to local services after the birth of a baby and that these supports are associated with positive health and wellbeing for both mothers and children.

<p><b>Description</b></p>	<ul style="list-style-type: none"> <li>• Target group: all mothers giving birth in the 16 participating municipalities at six months postpartum.</li> <li>• Location: 16 Victorian municipalities, randomised to eight intervention and eight matched for comparison on socio-demographic factors, numbers of births, geographic area and levels of community activity.</li> <li>• Mode of delivery: varied depending on the service involved—both individual and group. Information is also distributed to mothers, including local guides to services and voucher schemes established with the support of businesses and local services. PRISM newsletters distributed to both intervention and comparison communities.</li> <li>• Intervention strategies: support, information, listening, treatment of conditions where needed and time-out for women with young children.</li> <li>• Length of intervention: so far for approaching three years.</li> <li>• Resources: information kits for mothers with a father’s leaflet included.</li> <li>• Training required for delivery: training workshops with GPs, Maternal and Child Health nurses. Local steering committees have been established in each treatment area to allow for local involvement and to work with project staff.</li> </ul>
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<p><b>Evidence Base</b></p>	<ul style="list-style-type: none"> <li>• Uses an experimental design with randomised assignment of municipalities to the treatment and control group. The control group is matched on a number of socio-demographic factors.</li> <li>• Evaluation and measurement strategies employed: the evaluation will assess the major maternal health outcomes (depression and physical health) and flow on effects from the program. Both process and impact evaluation will be undertaken to document and assess different program elements and to enhance the ability of the program to be reproduced if successful.</li> <li>• Findings of published available studies: not available as yet.</li> <li>• Conclusions from evidence: not available as yet as evaluation is not complete.</li> <li>• Limitations of evidence: no evidence published as yet and because it is an experimental project none will be published before completion. The project appears promising as it is built on existing services and is being thoroughly documented and evaluated for effectiveness.</li> <li>• Future research/ongoing research: the evaluation is ongoing. In addition there is the ECO-PRISM project which will assess the net costs of PRISM and the broader outcomes of network development, the value placed on the new/extended service and its outcomes by mothers and service providers. The sustainability of the intervention long term will also be assessed. The question asked in this project is: ‘Does the value of these outcomes exceed the net costs of the intervention?’.</li> </ul>
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<b>Limitations</b>	<ul style="list-style-type: none"> <li>• Lack of information on outcomes, however, this will be available ultimately as the project involves evaluation of both the processes involved and the outcomes.</li> <li>• The positives are that the program is built around Victorian service infrastructure.</li> </ul>
<b>Availability</b>	Not available at present; still in the experimental stage.
<b>References</b>	Centre for the Study of Mothers' and Children's Health, Annual Report: 1997-1998; 1999-2000; 2000-2001.
<b>Website</b>	None available.

<b>HAWAII'S HEALTHY START PROGRAM</b>	
<b>Auspice</b>	Dr. Calvin Sia established the original Centre in Hawaii, from which this program developed, with funding from the National Centre on Child Abuse and Neglect.
<b>Type of Program</b>	This preventative program is targeted to families of newborns identified as at-risk of abusing or neglecting children.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• To identify vulnerable families before daily stressors, isolation and lack of parenting knowledge lead to abusive and neglectful parenting behaviours.</li> <li>• The prevention of child abuse and neglect in families identified as at-risk.</li> <li>• Promotion of child health and development in the newborns of families at risk of poor child outcomes.</li> <li>• Promotion of positive parenting.</li> <li>• The enhancement of parent-child interaction and parenting skills.</li> </ul>
<b>Background</b>	<ul style="list-style-type: none"> <li>• Rationale and context for program development: the program was developed in order to prevent abuse in vulnerable families before child protection services became involved by providing services directly and by promoting use of preventive and early intervention services.</li> <li>• Theoretical background: the program is based on Henry Kempe's lay therapy program for families already known to child protective services and the work of Selma Fraiburg.</li> </ul>
<b>Description</b>	<ul style="list-style-type: none"> <li>• Families taking part in this program were identified through examination of their medical records for risk factors, such as an unemployed partner, unstable housing, no telephone, marital and/or family problems, inadequate income, history of abortions, substance abuse, psychiatric care, depression and so on. When</li> </ul>

	<p>there was some doubt about the family, an early identification worker interviewed the mother using Kempe’s Family Stress Checklist. Families identified as at-risk were invited to take part in a home visiting program designed to help with the challenges of child rearing.</p> <ul style="list-style-type: none"> <li>• Location: developed from the original programs to 14 sites in Hawaii.</li> <li>• Mode of delivery: weekly home visiting by trained para-professionals which over time dwindle to quarterly. Intervention strategies: home visiting; developing a trusting relationship, assisting parents to address any existing crises, assisting families by building on their strengths and modelling problem solving skills. They also helped link families with needed services such as housing, nutritional assistance, child care and vocational and/or educational training.</li> <li>• At the same time, para-professionals promoted child health and development through parent education, modelling effective parent-child interaction, and ensuring that the child had a source of paediatric care. Community-based Family Resource Centres were developed as part of the program.</li> <li>• Length of intervention: originally 12 months when the program was first developed but was changed to three years.</li> <li>• Resources: none listed.</li> <li>• Training required for delivery: all home visitors have a bachelor’s degree and one week of pre-service training plus 30 hours of in-service training. They were also chosen on the basis of their suitability – warmth, cultural sensitivity, self-assurance and parenting skills.</li> </ul>
<p><b>Evidence Base</b></p>	<ul style="list-style-type: none"> <li>• Evaluation and measurement strategies employed: six sites were evaluated with programs operated by three agencies. The evaluation used a randomised trial study design with at-risk families assigned to home visit - the Hawaii Healthy Start Program (HSP) group (n=373) or a control group (n=270). Data were collected through maternal interviews, observation of the home environment, observation of mother-child interactions, child development testing and Child Protection Services reports. Where possible, the measures used had established validity and reliability in a variety of populations.</li> <li>• Evaluation findings after two years of the program operation: attrition was a problem and only 49 per cent of families continued active in the program; the three agencies taking part in the study varied greatly in their retention rates.</li> <li>• Conclusions from evidence: at two years, the Hawaii Healthy Start program and control group did not differ in maternal life skills, social support, substance use or depressive symptoms. Both groups were similar in overall home learning environment and parent-child interactions but there were differences in other parenting measures. Healthy Start mothers used less violent discipline strategies than control group mothers, they experienced less stress related to parenting and felt more competent in adult relationships compared with the control group. Healthy Start</li> </ul>

	<p>mothers reported better linkage to paediatric care and decreased injury due to partner violence than control group mothers.</p> <ul style="list-style-type: none"> <li>• Limitations of evidence: results varied across the agencies involved. Families served by some agencies did not experience benefits in parent-child interaction, child development or maternal confidence in adult relationships nor were there decreases in partner violence. There were found to be significant differences in program implementation across the three administering agencies, which affected involvement levels and possibly outcomes.</li> <li>• Future research/ongoing research: future evaluations need to monitor implementation of programs as well as outcomes.</li> </ul>
<b>Limitations</b>	This program was developed in Hawaii with its own particular service infrastructure and conditions.
<b>Availability</b>	Unknown
<b>References</b>	Duggan, A., McFarlane, E., Windham, A., Rohde, C., Salkever, D., Fuddy, L., Rosenberg, L. Buchbinder, S. & Sia, C. (1999), 'Evaluation of Hawaii's Healthy Start Program', <i>The Future of Children</i> , Vol.9, No.1.
<b>Websites</b>	<a href="http://www.acf.dhhs.gov">www.acf.dhhs.gov</a> <a href="http://www.casenet.org">www.casenet.org</a> <a href="http://www.alliance.napwash.org">www.alliance.napwash.org</a> <a href="http://www.nal.usda.htm">www.nal.usda.htm</a> <a href="http://www.ncemh.org">www.ncemh.org</a>

<b>EVEN START</b>	
<b>Auspice</b>	<ul style="list-style-type: none"> <li>• US Department of Education</li> <li>• The Even Start Association</li> </ul>
<b>Type of Program</b>	<p>This program has both a prevention and treatment focus:</p> <ul style="list-style-type: none"> <li>• Prevention of literacy difficulties in children through a program targeted to low income families and an enhancement of learning.</li> <li>• Treatment of parents learning through adult education and parenting education to enhance their competence and confidence and enable them to assist in their children's learning.</li> </ul>
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• To help break the cycle of poverty and increase the educational opportunities for families through integrating early childhood education, adult education and parenting education into a unified literacy program.</li> <li>• To help parents improve their basic skills.</li> <li>• To help parents become effective partners in their children's education.</li> </ul>

	<ul style="list-style-type: none"> <li>To assist children reach their full potential as learners.</li> </ul>
<b>Background</b>	<ul style="list-style-type: none"> <li>Rationale and context for program development: research in the US has indicated that children's success in school is closely related to their mother's level of education with the children of mothers with higher levels of education having greater success and staying at school longer than the children of mothers with lower levels of education.</li> <li>Theoretical background: a growing body of research has indicated that it is what parents actually do with their children that is more important than aspects of socioeconomic status. Recently researchers have become interested in the notion that disadvantaged parents and children are a 'learning unit' and that family and intergenerational literacy programs are a promising approach to supporting parents in their role as first teachers. It has been found that, in such programs, 'Low-literate parents, particularly mothers, are more likely to exert a positive influence on their children's academic performance when they are able to enhance their own literacy skills'.</li> </ul>
<b>Description</b>	<ul style="list-style-type: none"> <li>Target group: low income families with children aged 0–7 years and with at least one parent in need of educational services. The program can begin at any time in the first seven years of a child's life.</li> <li>Location: United States.</li> <li>Mode of delivery: the program is provided in three settings—home, centre, and social outings (for example, home/clinic based, individual, group, self-directed, information).</li> <li>Intervention strategies: <ul style="list-style-type: none"> <li>~ <i>Adult education</i>: basic adult education (including English as a second language), vocational training, career guidance, college readiness and job shadowing, computer skills.</li> <li>~ <i>Parenting education</i>: understanding development and behaviour management,</li> <li>~ <i>Early Childhood Education</i>: social skills, basic concepts and physical coordination.</li> </ul> <p>An elementary education program is provided for school-aged children.</p> <p>The individual programs often draw on existing curricula (for example, Head Start).</p> </li> <li>Length of intervention: 100 hours of adult education per year per parent; 32 hours of parent education per year per parent. Thirteen per cent of parents reached their goals during the first 12-month period (1994–95) and 64 per cent continued into the second year.</li> <li>Resources: not known.</li> <li>Training required for delivery: not known.</li> </ul>
<b>Evidence</b>	<ul style="list-style-type: none"> <li>Evaluation and measurement strategies employed: evaluated for</li> </ul>

<b>Base</b>	<p>effectiveness using pre and post tests but no control groups.</p> <ul style="list-style-type: none"> <li>• Findings of published available studies: <ul style="list-style-type: none"> <li>~ Children made greater gains in school readiness skills than could have been expected from maturation alone and there were also gains in measures of language development.</li> <li>~ The parents made gains that were comparable with other adult education programs—50 per cent of parents increased two grade levels in reading and maths.</li> <li>~ Parenting education was associated with improved cognitive and emotional support for children across all age groups.</li> <li>~ The amount of service provided by Even Start programs was associated with positive outcomes.</li> <li>~ Children from the most disadvantaged families made fewer gains than those from families somewhat less disadvantaged.</li> <li>~ Programs that devoted more time to shared parent-child activities were associated with improved cognitive stimulation and emotional support in the home environment compared to programs that devoted less time to shared activities.</li> <li>~ The findings suggested that shared activities were an effective part of the program.</li> </ul> </li> <li>• Conclusions from evidence: overall, the evaluation concluded that there were indications that the Even Start program helped improve parents’ academic skills and children’s language development.</li> <li>• Limitations of evidence: the evaluation used no control group and is an interim report only.</li> <li>• Future research/ongoing research: planned.</li> </ul>
<b>Limitations</b>	Designed for the American context which has a very different service infrastructure from Australia.
<b>Availability</b>	US Department of Education: Even Start Family Literacy Program.

<b>References</b>	<p>Benjamin, L.A. (n.d.), <i>Parents’ Literacy and Their Children’s Success in School: Recent Research, Promising Practices, and Research Implications</i>, Office of Research, Office Educational Research and Improvement, US Department of Education, Washington.</p> <p>Toa, F. (1997), <i>National Evaluation of the Even Start Family Literacy Program: 1995 Interim Evaluation</i>, U.S. Department of Education, Washington D.C.</p> <p>National Even Start Association, <i>Even Start Family Literacy Program Description</i>, U.S. Department of Education, Washington D.C.</p>
<b>Websites</b>	<p><a href="http://www.evenstart.org">www.evenstart.org</a> (National Even Start Association)</p> <p><a href="http://www.ed.gov">www.ed.gov</a> (US Department of Education)</p>

	<a href="http://www.familit.org">www.familit.org</a> (National Centre for Family Literacy)
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<b>PERRY PRESCHOOL PROGRAM</b>	
<b>Author</b>	David Weikart, Director of the Highscope Foundation, Ypsilanti, U.S., High/Scope Educational Research Foundation.
<b>Type of Program</b>	Treatment—enhanced preschool program.
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• To provide quality preschool experience to children from poor and minority families.</li> <li>• To increase IQ of these children and promote their readiness for school.</li> </ul>
<b>Background</b>	<p>In the early 1960s, many studies showed that children from low income and minority families had lower scores on intelligence tests than children from middle class and advantaged families. It had also been found that intelligence was not genetically fixed and was largely a product of the environment and that intelligence could be raised by intervention in the environment of children. Around this time a number of early childhood intervention studies started based on the belief that by enhancing the learning environment children from poor families could overcome their lack of educational success at school and the cycle of poverty could be broken. One of these research-based early intervention studies was the Perry Preschool project. Around about the same time, and for the same reasons, President Johnson commenced the 'War on Poverty' which included Project Head Start which was modelled on these early intervention studies and aimed to break the cycle of poverty through improving the educational opportunities of children from poor families.</p>
<b>Description</b>	<ul style="list-style-type: none"> <li>• Target group: children aged three and four years from poor and minority families.</li> <li>• Location: Ypsilanti area in the US.</li> <li>• Mode of delivery: home-based intervention for parents and centre-based for children in small groups.</li> <li>• Intervention strategies: <ul style="list-style-type: none"> <li>~ Parents: home visits by teachers to encourage parent involvement and to implement the preschool curriculum at home.</li> <li>~ Children: the program involved 10 categories of key experiences: creative representation, language and literacy, social relations and personal initiative, movement, music, classification (recognising similarities and differences), number, space and time. The emphasis was on children engaging in activities that involved solving problems, making choices and taking responsibility within a program with a consistent daily routine.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Length of intervention: 1–2 years, sessions of two hours, five days a week.</li> <li>• Resources: none beyond normal preschool resources.</li> <li>• Training required for delivery: Staff involved were trained preschool teachers.</li> </ul>
<b>Evidence Base</b>	<ul style="list-style-type: none"> <li>• Evaluation and measurement strategies employed: the evaluation was an experimental design to test the efficacy of the program. It involved the random assignment of 133 mostly black children from similar poor family backgrounds to a treatment or control group. The evaluation research was longitudinal and data have been collected on these children since inception of the program into adulthood. The original program ran between 1963 and 1967. The latest report has followed both treatment and comparison group children to age 27.</li> <li>• Findings of published available studies: at age 27 program group members were more likely than the comparison group to report higher monthly earnings, own their own homes, and their cars. Program group members were also less likely to be on welfare assistance than comparison group members. During schooling, program children were less likely to be placed in remedial programs, failed fewer grades and were more likely to graduate from high school than children in the comparison group. Not only did they have more school success but program children were also less likely to be involved in delinquency, teenage pregnancy and had improved chances of employment.</li> <li>• Cost-benefit analysis indicated that the program saved taxpayers money. For every dollar invested there was a saving of \$7.16 in costs that might have been incurred if the program had not intervened. The savings involved are comprised of reduced need for special education in school, higher taxes paid by program members because of higher earnings in the workforce, savings in welfare assistance, savings from the criminal justice system and savings to potential victims of crime. The economic return from the program outperformed the stockmarket from 1963 to 1993.</li> <li>• Conclusions from evidence: programs such as the Perry Preschool program are a worthwhile investment not just for children and families but for the community as a whole.</li> <li>• Limitations of evidence: the sample was not large and the social and economic context has changed in recent years.</li> <li>• Future research/ongoing research: continuing to follow the children involved.</li> </ul>
<b>Limitations</b>	The program was located in the United States, which has a less supportive early childhood infrastructure than Australia.
<b>Availability</b>	Contact the High/Scope Educational Research Foundation for further information.
<b>References</b>	Schweinhart, L. Barnes, H. & Weikart, D. (1993), <i>Significant Benefits: The High/Scope Perry Preschool Study Through Age 27</i> , Monograph No.10, High/Scope Educational Research Foundation, High/Scope

	<p>Press, Ypsilanti Mi.</p> <p>Schweinhart, L. &amp; Weikart, D., (1983), 'The effects of the Perry Preschool Program on youths through age 15 – a summary', in <i>As the Twig is Bent: Lasting Effects of Preschool Programs</i>, The Consortium of Longitudinal Studies, Lawrence Erlbaum, Hillsdale New Jersey.</p> <p>Schweinhart, L. &amp; Weikart, D. (1986), 'What do we know so far? A review of the Head Start Synthesis Project', <i>Young Children</i>, Vol.41, No.2.</p>
<b>website</b>	<a href="http://www.highscop.org/research/">www.highscop.org/research/</a>

<b>HEAD START TRANSITION</b>	
<b>Auspice</b>	National Head Start Transition Demonstration Study, Head Start Bureau, United States
<b>Type of Program</b>	Treatment
<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Designed to enhance the transition to public school of former Head Start program children in order to improve educational achievement and prevent the fading of gains made in the preschool program.</li> <li>• To test the value of extending comprehensive Head Start type supports 'upward' through the first four years of primary school.</li> <li>• Each local program also aimed to include children with disabilities in regular classrooms, to address cultural and linguistic diversity issues, and to develop individualised transition plans for each child.</li> </ul> <p>(Head Start children are children from families identified as poor and/or minority families who have taken part in a preschool program which aims to raise their intelligence and preparation for school.)</p>
<b>Background</b>	<p>It has been well documented that children from low income disadvantaged families often fail to achieve success at school. In the 1960s, the United States government set up the Head Start program in the 'War against poverty' to improve the educational opportunities of these children through an enhanced preschool program usually over the year before children commenced school. At the time it had been found that children's intelligence could be raised through educational interventions where previously it had been thought that intelligence was genetically determined and fixed. Head Start programs were thus designed to raise intelligence.</p> <p>The evidence from the large number of Head Start programs carried out since the commencement of Head Start indicates that Head Start children compared with children from similar family backgrounds in control groups start school ready to learn, however, the cognitive gains that they make in the preschool years tended to fade at school and they were still at some risk of poor school achievement. Experimental research had shown that children from poor families who have received preschool support achieve better at school if they</p>

	continue to receive support in the early years of primary school than children who receive support in the preschool years only.
<b>Description</b>	<ul style="list-style-type: none"> <li>• Target group: children who have been in Head Start programs before starting school.</li> <li>• Location: there are 30 transition programs in 30 states of the US and one in the Navajo Nation. These projects involve more than 450 public schools in total.</li> <li>• Mode of delivery: school-based generally. Focused on all children not just the Head Start children in the schools involved but each child has an individualised transition plan.</li> <li>• Intervention strategies: each of the 31 Transition Demonstration programs set up a governing board comprising at least 51 per cent of Head Start parents. Each program involved a group of schools and each implemented a program suited to their own specific situation but in keeping with the overall aims of the project. Each included: parent involvement activities; educational enhancement activities; family social support services; and health and nutrition.</li> <li>• Length of intervention: the first four years of primary school from the 1991–92 school year to 1997–98.</li> <li>• Resources: no information available.</li> <li>• Training required for delivery: no information available.</li> </ul>
<b>Evidence base</b>	<ul style="list-style-type: none"> <li>• Evaluation and measurement strategies employed: Sample: 31 demonstration programs involving 450 public schools and 7,515 former Head Start children and their families, plus other children in the same schools and classrooms and their families.</li> <li>• Child tests: <ul style="list-style-type: none"> <li>Reading score: Woodcock-Johnson Tests of Achievement.</li> <li>Math score: no information other than it was a nationally used test. Teacher ratings of children’s academic abilities.</li> <li>Teacher ratings of children’s social skills.</li> <li>Parent ratings of children’s school adjustment.</li> <li>Children’s views of school experiences.</li> </ul> </li> <li>• Findings: <ul style="list-style-type: none"> <li>Child level: Head Start children started school ready to learn and showed good progress in reading and maths in the Demonstration Program schools. They not only retained gains from earlier Head Start experience but accelerated in their progress. Teachers, parents and children all reported positive school adjustment to the end of third grade.</li> <li>Parents: highly valued the success of their children in the school setting.</li> <li>The majority of former Head Start children were also positively rated for their social skills.</li> </ul> </li> </ul>

	<p>School level: the data at Demonstration school level differed in only small ways from the comparison schools and although there were small positive differences in academic and social skills they were not statistically different. Reasons given for this were that only a fifth of Demonstration programs were implemented at consistently high levels and the comparison schools often set up additional supports and programs which were similar to the Transition Demonstration schools.</p> <ul style="list-style-type: none"> <li>• Limitations of evidence: there has been only one evaluation of the program so far and no time as yet for a repeat of the program.</li> <li>• Future research/ongoing research: Depending on whether there is any follow-up of the children involved in this demonstration program or further programs developed. At present there is no information about the possibility of either.</li> </ul>
<b>Limitations</b>	This is a demonstration program only although it involved a large number of sites. It remains to be seen if the program will be implemented more widely and it is in the US.
<b>Availability</b>	Report released on the website of the US Department of Health and Human Services which is the overseeing body for the Head Start Bureau.
<b>References</b>	Head Start Children's Entry into Public School: A Report on the National Head Start/Public School Early Childhood Transition Demonstration Study'. (Ramey, S., Ramey, C., Phillips, M., Lanzi, R. Brezausek, C. Katholi, C., Snyder, S. & Lawrence, F. 2000). Evaluated by Civitan International Research Centre at the University of Alabama.
<b>Website</b>	<a href="http://www.acf.dhhs.gov/programs/hsb/">www.acf.dhhs.gov/programs/hsb/</a>

## **8. Conclusions: What We Know and What We Need To Know**

### **8.1 What We Know**

What we have learned from research and practice is that carefully designed and implemented interventions and programs can make a significant positive difference to the lives of young children and their families, especially those who are at risk. This is also the conclusion reached by the Committee on Integrating the Science of Early Childhood Development (Shonkoff and Phillips, 2000):

In the final analysis, there is considerable evidence to support the notion that model programs that deliver carefully designed interventions with well-defined goals can affect both parenting behavior and the developmental trajectories of children whose life course is threatened by socioeconomic disadvantage, family disruption, or diagnosed disability. Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts. In contrast, services that are supported by more modest budgets and based on generic support, often without a clear delineation of intervention strategies matched directly to measurable objectives appear to be less effective for families facing significant risk. (p. 379)

The programs described in this report can therefore make a significant contribution to ensuring that young children and families get off to a positive start in life. However, there is still a lot that we need to know.

### **8.2 What We Need To Know**

Although we can be confident that we can make a difference in the lives of vulnerable children and families, there is still much that we do not know about how to do this. To ensure that our interventions, programs and service models are as effective and helpful as possible, we need to know the following:

- ***Whether successful US models are equally successful in the Australian context***

Most of the interventions and programs described in this report were developed in the US. The US has different social problems and service systems to Australia, and we cannot assume that interventions that are successful in the US will be equally successful in the Australian context. To find out if any modifications are needed for local conditions, more research is needed.

- ***How to deliver support and services to families in a coordinated fashion***

The individual programs and interventions described in this report generally focus on one aspect of child or family functioning. While the evidence indicates that such interventions can be effective, there are many other aspects of family functioning that may need intervention and support, particularly in the more vulnerable and at-risk families. Other evidence suggests that failure to attend to these factors may ultimately result in any

benefits gained from targeted interventions being overwhelmed by the financial and social stresses being experienced by these families. To prevent this from happening, we need to develop systems for delivering a range of supportive interventions to families in a coordinated fashion.

- ***How to tailor services to meet the needs of individual families***

Guralnick (1998) maintains that:

early intervention programs can and should be uniquely tailored to the prevailing levels of family characteristics and stressors associated with a child's disability or risk status. For many children, early intervention may not be needed in its most intensive (and expensive) forms where child-related stressors are either insufficient in magnitude or buffered by family characteristics that prevent interference with sound developmentally appropriate family interaction patterns. (p. 336)

Thus, Guralnick proposes that:

A far more sophisticated system can be put in place through matching the specifics of early intervention program components (eg. intensity, type of curriculum) with child (eg. type of severity of disability) and family characteristics (eg. social supports, financial resources) and family interaction patterns (eg. parent-child transactions) (p.336).

However, as yet, we do not know how to do this systematically across the service system.

- ***How to provide all families with the kind of supportive social environment that will enable them to raise healthy and competent children***

While we now understand more about the important role played by social support and cohesive communities in helping families function effectively, we are only just beginning to learn how to help families build the social networks they need and help communities become more cohesive and supportive. This needs to be a focus of ongoing efforts.

- ***How to effectively meet the needs of all families in a multicultural community***

Victoria is the most multicultural State in Australia, yet families from culturally and linguistically diverse backgrounds are consistently underrepresented in services provided for families. More research is needed on the appropriateness of existing models of parenting and family support, and more work is required to enhance the cross-cultural competence of professionals who work with families from diverse cultural backgrounds.

- ***How to enable services to be truly inclusive***

Our society has become much more diverse over the last few decades, not just multiculturally, but also in terms of family structures, demographics, work patterns and lifestyles. This means that there is a greater diversity of young children and families needing support from early childhood services, which were originally designed to cater for a more homogeneous population. To truly meet the individual needs of all these children and families, services

and service providers need to become more inclusive, that is, better able to cater for children from different cultures and families, as well as those with disabilities or language or learning problems.

## 9. References

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