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# Triple P Evaluation Research Team

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All of the data in relation to the Triple P – Positive Parenting Programme were collected and anonymised at LWPP. Quantitative implementation data were collected and validated at LWPP. Qualitative data collection was facilitated by LWPP. Data in the population survey were collected by two market research agencies, Millward Brown and Amárach.

During the course of the evaluation, a number of individuals and organisations supported LWPP, including the Department of Public Health in the HSE, the Centre for Effective Services (CES), Professor Danny Perkins and the members of the Expert Advisory Committee (EAC) for this evaluation.

HSE Midland Regional Ethics Committee gave ethical guidance and approval in relation to the Parenting Study component of the evaluation.

The methodology for the Population Study was based on the ‘Every Family’ Australian study and this was developed by LWPP and NUI Galway, with the advice of the EAC. Triple P personnel in Australia also provided information to assist with analysis of the Population Study data.

The methodology for the Parenting Study was also based on the ‘Every Family’ Australian study and was developed by LWPP and the Department of Public Health, HSE, Tullamore, together with NUI Galway. Triple P personnel in Australia also provided information to assist with analysis. The submission for ethical approval for the Parenting Study was prepared by LWPP and the Department of Public Health, HSE, Tullamore, and ethical guidance and approval was received from the HSE Midland Regional Ethics Committee.

The methodology for the Implementation Study was also jointly developed and the parent and practitioner focus group protocols formed part of the application for ethical approval mentioned above. All monitoring data and receipt of evaluation questionnaires were recorded, managed and anonymised by LWPP before forwarding to NUI Galway for analysis.

The methodology for the Partnership Study was developed by NUI Galway in consultation with LWPP and with the advice of the EAC.

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## Executive Summary

The Triple P – Positive Parenting Programme (Triple P) is a multi-level, public health approach to parenting. It was implemented in Longford and Westmeath by the Longford Westmeath Parenting Partnership (LWPP). The Triple P Programme was targeted at parents of children aged 3-7 through four modes of delivery: a universal media strategy, seminars, workshops and groups.

The Parenting Study used a quasi-experimental (pre-test – post-test within-groups) design to evaluate child and parent outcomes associated with participation in Triple P. There were statistically significant gains for children’s emotional and behavioural problems, and parenting attitudes and skills, parental anxiety, stress and depression. There was also a statistically significant reduction in the number of children categorised as ‘borderline/abnormal’ for emotional and behavioural problems.

The Population Study used a quasi-experimental (non-randomised between-groups) design, with treatment and comparison areas, to analyse the population-level impact of Triple P. There was a population-level impact on children’s emotional and behavioural problems, parental distress, parental discipline and parents’ relationships with their children, and also the number of children categorised as ‘borderline/abnormal’ for emotional and behavioural problems.

Qualitative and quantitative data collected as part of the Partnership Study show the nine partner organisations valued the partnership approach as necessary so as to both reduce child and family problems and also to reach many segments of the community in non-stigmatising ways. Although the partnership faced significant challenges, in particular the capacity of partner organisations to meet their programme delivery commitments, there were high levels of trust and a strong commitment to partnership. The partners also have begun to utilise what was learned from the Longford Westmeath implementation in order to promote the roll-out of population-based programmes to other areas.

Qualitative and quantitative data collected as part of the Implementation Study show the partners successfully implemented an evidence-based public health parenting support. While important lessons have been learned about the need to monitor fidelity and also to integrate all practitioners in programme delivery, parents were highly satisfied with the quality of programme delivery, parents spoke with other parents about Triple P and passed on parenting tips, and practitioners believed the programme was successful.

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# Introduction

This is a summary report of the final evaluation of the Triple P Programme in Longford Westmeath. The evaluation, from February 2010 to June 2013, had the following four components:

- **The Parenting Study** used a quasi-experimental (pre-test – post-test within-groups) design and evaluated child and parent outcomes associated with participation in Triple P. Follow-up data were collected from a sub-sample of participants.
- **The Population Study** used a quasi-experimental (non-randomised between-groups) design, with treatment and comparison counties, and analysed the impact of Triple P at population level.
- **The Partnership Study** used qualitative and quantitative data to explore the success of the partners in establishing the partnership and supporting delivery of the programme, as well as the learning gained from adopting a partnership approach.
- **The Implementation Study** employed qualitative and quantitative data to analyse programme utilisation, organisation and fidelity.

This report is structured as follows: *Chapter 1* presents the principles of the Triple P Programme and *Chapter 2* describes the evidence base for the programme. *Chapter 3* provides an overview of the Longford Westmeath Parenting Partnership (LWPP), including its Memorandum of Understanding. *Chapter 4* provides a summary of changes over time by programme participants. *Chapter 5* summarises findings on the impact of Triple P at the population level. Findings on the partnership are summarised in *Chapter 6* and findings on programme implementation are summarised in *Chapter 7*. Finally, the findings from all four strands of the evaluation are summarised in *Chapter 8* and their implications for policy and practice are presented.



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# 1. About Triple P – Positive Parenting Programme

The Triple P – Positive Parenting Programme (Triple P) is a multi-level, public health approach to parenting. The programme was developed by Professor Matthew Sanders and colleagues at the University of Queensland, Australia. It was implemented in the Longford Westmeath region by the Longford Westmeath Parenting Partnership (LWPP).

## The positive parenting approach

The Triple P Programme aims to promote the strategies and opinions of positive parenting. The aims of Triple P include the following (Turner *et al*, 2002):

- to create a safe, supervised, and protective environment necessary for healthy development;
- to create a positive learning environment, where parents respond constructively to child-initiated interactions;
- to use assertive discipline: being consistent, responding quickly and decisively;
- to have realistic, developmentally appropriate expectations of children;
- to promote children's problem-solving capacities;
- to develop the capacity for self-regulation as a parent;
- to take care of oneself as a parent.

The Triple P Programme was targeted at parents of children aged 3-7 through the following four modes of delivery:

- **Level 1 – Media strategy:** Health promotion and social marketing strategies were employed to target the entire population to promote positive parenting and also increase receptivity to parenting programmes.
- **Level 2 – Triple P Seminars:** A series of 3 individual 90-minute seminars were provided and were open to all parents. They are designed to aid the management of discrete child behaviour problems not complicated by other major behaviour management difficulties or family dysfunction. The individual seminars were:
  - Power of positive parenting
  - Raising confident, competent children
  - Raising resilient children
- **Level 3 – Workshop Triple P:** A series of 4 individual 2-hour workshops targeted parents of children with mild to moderate behavioural difficulties. The individual workshops were:
  - Dealing with disobedience
  - Managing fighting and aggression
  - Hassle-free shopping with children
  - Developing good bedtime routines
- **Level 4 – Group Triple P:** An 8-week programme, including 5 group sessions, each of 2 hours, and 3 one-to-one telephone sessions. The Group intervention is for parents of children with more severe behaviour difficulties. The individual group sessions were:
  - Session 1: Positive parenting
  - Session 2: Promoting children's development
  - Session 3: Managing misbehaviour
  - Session 4: Planning ahead
  - Session 5-7: Implementing parenting routines (telephone sessions)
  - Session 8: Programme close

## A population-based approach to parenting

When a ‘population’ or ‘public health’ approach is adopted, the aim is not just to **improve outcomes** for the parents who attend the sessions and their children, but also to change the **ecological context** for parenting through a series of universal and targeted supports. As evidence shows, social and environmental factors can be used to facilitate or influence behaviour and to change attitudes (Cohen *et al*, 2000). The population-based approach of Triple P includes the following characteristics (Sanders and Prinz, 2008):

- it uses multiple settings, disciplines and service modalities;
- the focus is on the reduction of prevalence rates for child and family problems;
- it is designed to reach many segments of the community in non-stigmatising ways.

In addition, the **principle of minimal sufficiency** requires that the minimally sufficient support should be provided to parents since parents with different levels of need can engage with different components of the programme. For example, Group Triple P is targeted at those with more elevated needs (Sanders, 1999). A **multidisciplinary approach** is adopted since the programme can be delivered by different professions (*ibid*). The programme can also accommodate **varied delivery modalities**: face-to-face, group, telephone or self-directed delivery are all possible (*ibid*).

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## 2. Evidence base for Triple P

There is explicit support for evidence-based parenting programmes in the Irish statutory sector (Gillen *et al*, 2013a; Devaney *et al*, 2013). The literature also includes numerous studies on the evidence base for Triple P, as well as other parenting programmes, an overview of which is provided below. While the Triple P Programme has been evaluated in other contexts, this is the first evaluation of the Triple P Programme in Ireland.

### Programme impact and Triple P

There is an emerging evidence base concerning the success of various parenting programmes implemented in Ireland and targeting parents of young children (Devaney *et al*, 2013). An RCT evaluation is underway of *Lifestart*, for parents of children aged up to 5 years. *The Incredible Years Programme* for parents of children aged 3-7 focuses on social competence, communication and educational attainment, and an RCT evaluation reported statistically significant programme impacts for parenting competencies and well-being, as well as for child behaviour (McGilloway *et al*, 2009). The experimental evaluation of the *Preparing for Life* home visiting and parenting programme also found significant effects at 24 months for child development, child health and parenting skills (Doyle, 2013).

The evidence base for Triple P includes a recent meta-analysis that reported ‘medium’ effect sizes for child and parenting outcomes across 116 Triple P studies (Sanders *et al*, 2014). In Brisbane, Workshop Triple P led to ‘large’ improvements for child behaviour, dysfunctional parenting, parental self-efficacy and parenting experience (Morawska *et al*, 2010). In the implementation of Group Triple P, ‘medium’ to ‘large’ short-term gains were observed for both parent and child outcomes in two Australian studies (Sanders *et al*, 2005; Zubrick *et al*, 2005). A population-level impact on child and parent outcomes was observed in the evaluation of Triple P in Western Australia (Sanders *et al*, 2008) and in the USA (Prinz *et al*, 2009).

### Programme implementation, partnership and Triple P

This study also evaluates the implementation of the Triple P Programme in Longford Westmeath. Evaluating programme implementation involves both analysing ‘the extent to which the intended target population receives the intended services’ and also ‘comparing the plan for what the programme should be doing with what is actually done’ (Rossi *et al*, 2004, p. 171). Successfully implementing Triple P requires the recruitment of parents and also the identification, engagement, training and support of a population of programme providers (Shapiro *et al*, 2010). The literature highlights a number of key challenges for Triple P implementation. Engaging the available workforce from different disciplines and agencies is required by a population-based approach and this is a ‘complex task’ (Sanders *et al*, 2005). It is a challenge to ensure practitioners are both confident as Triple P facilitators and also supported by their own organisation to implement the programme (Shapiro *et al*, 2010). Finally, it is necessary to put in place procedures to promote programme fidelity (i.e. to ensure the programme is implemented as it was set out to be) since the programme may do a ‘disservice’ if there is significant programme ‘drift’ (Sanders and Prinz, 2008, pp. 131-32).

In addition, a partnership approach was adopted in the implementation of Triple P. The following are some of the main challenges to partnership working:

- clearly identifying partners’ roles and responsibilities (Duggan and Corrigan, 2009);
- gaining a commitment from different services to work together (Valentine *et al*, 2006);
- dealing with the different ways that professionals can understand and intervene in the world due to professional, linguistic and ethical differences (Johnson *et al*, 2003);

- addressing perceived differences in power among partners that can hinder relationships (Milbourne, 2005).

The present study examines whether these challenges were present in the Longford Westmeath Parenting Partnership (LWPP).

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## 3. Longford Westmeath Parenting Partnership and Triple P

The Longford Westmeath Parenting Partnership (LWPP) was established during late 2006 and early 2007, and comprises 9 organisations (*see Table 1*). Its purpose is to deliver evidence-based parenting knowledge and skills to the population of Longford and Westmeath, and to prioritise the delivery of Triple P in the first instance.

**Table 1: Longford Westmeath Parenting Partnership (LWPP) partner organisations**

Partner organisations in LWPP
Athlone Community Services Council
Athlone Education Centre
Carrick-on-Shannon Education Centre
Health Service Executive
Longford Community Resources Limited
Longford Vocational Educational Committee
Longford County Childcare Committee
Westmeath Community Development
Westmeath County Childcare Committee

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### Core Team

The implementation of Triple P by LWPP was managed by a Core Team, which involved six specific roles:

1. The **Project Director** was responsible for all governance, research and clinical elements of planning and delivery.
2. The **Partnership Manager** (and **Chair**) had responsibility for interagency collaboration and delivery of the project plan.
3. The **Programme Coordinator** provided support in relation to planning, delivery and development of related protocols.
4. The **Researcher** provided support in relation to planning and research, management of data and development of related protocols.
5. **Panel 1 Practitioners** delivered the programme and provided support to Panel 2 practitioners.
6. The **Office Administrator** and **Clerical Officer** provided administration support to the project as well as to the Project Director and Partnership Manager.

### Panel 1 and Panel 2 practitioners

Panel 1 practitioners were referred to as the Principal Programme Delivery Team and were to be comprised of 8 practitioners (representing 5.6 whole-time equivalents). Panel 2 practitioners were to be comprised of more than 60 practitioners from a range of different partner organisations, each committed to the allocation of a minimum of 100 hours to Triple P on an annual basis, following the successful completion of all Triple P training requirements and the attainment of Triple P accreditation.

### Memorandum of Understanding

It was agreed that the LWPP would be best served by a formal agreement between partners. The partners agreed a Memorandum of Understanding (MoU) after a process of consultation and facilitation. According to the MoU, the purposes of LWPP were to implement a community-based intervention focused on reducing childhood emotional and behavioural problems among children; to strengthen collaborative relationships and

pathways between service providers; to promote and deliver professional training in relation to mental health promotion and the detection/early intervention in childhood emotional and behavioural problems; and finally to promote and support the delivery of evidence-based parenting knowledge and skills to the population of Longford and Westmeath.

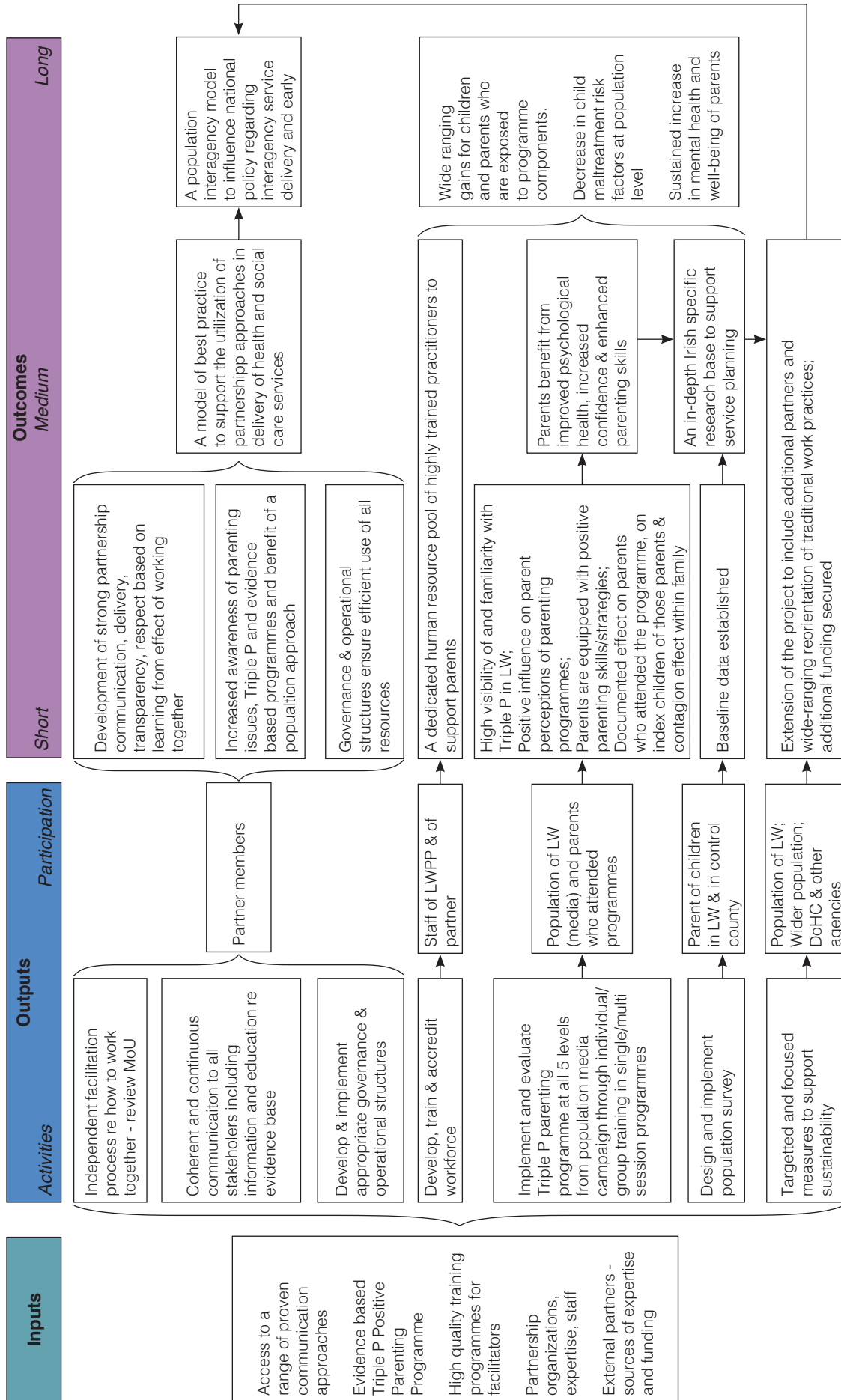
The MOU contains the 6 principles of LWPP:

1. the needs of children, young people and parents are paramount;
2. all partners are to be collectively accountable for the achievement of joint targets;
3. all partners are equal and their respective contributions have parity of esteem;
4. the Health Service Executive (HSE) undertakes to participate as an equal partner and manage its status with sensitivity;
5. decisions will be made at the lowest level consistent with efficiency and achievement of outcomes (the principle of subsidiarity);
6. LWPP cannot interfere with or override decisions of its constituent organisations nor require them to act in any way that is contrary to their mission or statutory responsibility.

## Logic model

The LWPP logic model for the implementation of Triple P in Longford Westmeath is presented in Figure 1. It includes a number of inputs, outputs, and short-, medium, and long-term outcomes. The evaluation of the implementation of Triple P addresses the success of the partners in putting in place the proposed inputs and outputs in successful partnership working, practitioner training and support, and programme delivery, as well in attaining the intended outcomes for children and parents.

Figure 1: Logic Model for Triple P – Positive Parenting Programme (Longford Westmeath Parenting Partnership)



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## 4. Summary findings on changes made by programme participants

This chapter presents and discusses the improvements reported by parents participating in Triple P. In the evaluation of Group Triple P (8-week programme) and Workshop Triple P (standalone 2-hour sessions), data were collected from parents both at the start and at the completion of their participation in Triple P and follow-up data were collected from sub-samples after 6 months (Workshop Triple P) and 12 months (Group Triple P). The findings show consistent positive changes, which were maintained over time, on key parenting and child behaviour variables and no significant negative changes.

### Method

The Parenting Study was a quasi-experimental pre-test – post-test within-groups design. As the study did not include a control group or random allocation of participants, conclusions cannot be inferred with confidence about causality regarding programme effectiveness (Society for Prevention Research, 2004). Nonetheless, as the interval between pre-test and post-test was short and as the sample size was large, it is reasonable to infer that changes reported by parents were associated with their participation in the programme (Shadish *et al*, 2002). The research questions were as follows:

1. What were the characteristics of those participating in the programme?
2. What improvements were reported by participating parents for child and parent outcomes?
3. Were the improvements maintained over time?
4. Were improvements made by all groups?

### Data analysis

The changes made by parents were explored through repeated measures analysis of variance (ANOVA). Changes are presented as standardised differences, i.e. effect sizes (Cohen's *d*). On two measures of child problems (Eyberg Child Behaviour Inventory and the Strengths and Difficulties Questionnaire), bandings of normal, borderline and abnormal are provided as a 'rough and ready' method for detecting 'caseness' or clinical cut-offs or extreme scores (i.e. the extent and level of clinical need in the sample). Parents attending Seminars provided data on satisfaction with the programme, which were analysed as part of the Implementation Study.

### Profile of participants

In Group Triple P and in the 3 separate Workshops, the average age of parents was between 36 and 38, and the majority were married (69%-83%), female (86%-94%), born in Ireland (76%-90%) and had received further post-second-level education or training (48%-72%). A sizeable minority were in receipt of a medical card (27%-39%) and had insufficient money to purchase much of what they really wanted after essential expenses were paid (21%-28%).

Group Triple P is intended for parents of children with more severe behaviour difficulties. Although no screening was used in recruitment for Group Triple P, the programme reached its target population of children with emotional and behavioural problems. Parents attending Group Triple P reported higher levels of need, scoring in the borderline/abnormal range in terms of child conduct problems ( $M = 3.07$ ,  $SD = 1.9$ ) and the impact of child emotional and behavioural problems ( $M = 1.04$ ,  $SD = 1.7$ ).



## Parent and child outcomes: Group Triple P

The evaluation of Group Triple P from pre-intervention to post-intervention included only those for whom data were available at both time points ( $n=393$ ). In relation to the total number who consented to participate and who had a child in the target age range, this represented a response rate of 74%.

Participation in Group Triple P was associated with statistically significant, large, end of programme (i.e. 8 weeks) improvements in **child outcomes** (see Table 2a). Parents reported statistically significant improvements for:

- the frequency of disruptive behaviours ( $d = 1.76$ );
- the number of disruptive behaviours that were a problem for parents; ( $d = 1.89$ );
- children's conduct problems ( $d = 1.35$ ), emotional symptoms ( $d = 0.61$ ), hyperactivity ( $d = 1.17$ ), peer problems ( $d = 0.47$ ) and pro-social behaviour ( $d = 0.99$ );
- the impacts of emotional and behavioural difficulties ( $d = 0.82$ ).

The majority of children in the clinical range moved into the normal range following participation in Group Triple P on all the above dimensions (see Table 2a for percentage change for each measure).

Participation in Group Triple P was also associated with statistically significant, large, end of programme (i.e. 8 weeks) improvements in **parent outcomes** (see Table 2b) for:

- parenting discipline ( $d = 1.99$ ), laxness ( $d = 1.51$ ), over-reactivity ( $d = 1.74$ ) and verbosity ( $d = 1.44$ );
- parents' self-efficacy ( $d = 1.33$ );
- parental depression ( $d = 0.75$ ), anxiety ( $d = 0.60$ ) and stress ( $d = 0.89$ );
- inter-parental conflict: the number of conflict areas ( $d = 0.74$ ) and their intensity ( $d = 0.79$ );
- parental relationships ( $d = 0.43$ ).

For the sub-sample of parents who were followed up at 12 months ( $n=59$ ; response rate=34%), statistically significant improvements were reported on all items measured, i.e. child behaviour and parenting discipline. In addition, gains were greater at the 12-month follow-up than at 8 weeks for the number of disruptive child behaviours that were a problem for parents ( $d = 2.37$ ).

## Parent and child outcomes: Workshop Triple P

The evaluation of the 3 Triple P Workshops from pre-intervention to post-intervention included only those for whom data were available at both time points for each workshop, i.e. Workshop 1: Dealing with disobedience ( $n=191$ ); Workshop 2: Managing fighting and aggression ( $n=64$ ); and Workshop 3: Developing good bedtime routines ( $n=24$ ). In relation to the total number who consented to participate and who had a child in the target age range, this represented response rates of 47%, 52% and 57% respectively.

Participation in the workshops was associated with statistically significant, medium to large, short-term (i.e. 6 weeks) improvements in **child outcomes** (see Table 3). Statistically significant gains were not observed on all measures for all 3 workshops. Therefore, we have listed below the gains made and in each instance the effect sizes observed among participants in the separate workshops (W1-W3):

- the frequency of disruptive behaviours (W1:  $d = 1.10$ ; W2:  $d = 0.68$ ; W3:  $d = 0.65$ );
- the number of disruptive behaviours (W1:  $d = 1.09$ ; W2:  $d = 0.92$ ; W3:  $d = 1.15$ );
- the percentage of children who moved out of the clinical range for frequency (W1: 61%,  $n=27$ ) and number (W1: 67%,  $n=29$ ; W2: 63%,  $n=12$ ) of disruptive behaviours.

Participation in the workshops was also associated with statistically significant, medium to large, short-term (i.e. 6 weeks) improvements in **parent outcomes** (see Table 3). Gains were reported for:

- the perceived difficulty of the child's behaviour (W1:  $d = 0.70$ ; W2:  $d = 0.92$ );
- the extent to which parenting was regarded as rewarding (W1:  $d = 0.44$ ; W2:  $d = 0.83$ ), stressful (W1:  $d = 0.43$ ; W2:  $d = 0.60$ ) and depressing (W1:  $d = 0.42$ ; W2:  $d = 0.53$ );
- how confident participants were as parents (W1:  $d = 0.34$ ; W2:  $d = 0.75$ );
- how supported they felt in their role as a parent (W2:  $d = 0.51$ );
- the extent of partner agreement upon discipline (W2:  $d = 0.59$ ; W3:  $d = 0.91$ );
- the extent of partner support around discipline (W2:  $d = 0.74$ ).

Long-term gains were analysed among a sub-sample of participants ( $n=21$ ; response rate = 26%) who were followed up at 6 months in the 'Dealing with disobedience' Workshop. Parents reported statistically significant longer term improvements for child and parent outcomes:

- the frequency of disruptive behaviours ( $d = 1.15$ );
- the number of disruptive behaviours that were a problem ( $d = 1.15$ );
- how supported they felt in their role as a parent ( $d = 1.18$ ).

## Differences in changes made by subgroups

Differences in gains by subgroups were observed on only a minority of outcomes and suggest that Triple P was appropriate for parents generally. The 'Dealing with disobedience' Workshop was more effective on some outcomes for mothers rather than fathers (the number of disruptive behaviours that are a problem for the parents and 'parenting is demanding'), parents of girls rather than boys ('parenting is demanding' and 'parenting is stressful') and younger parents rather than older parents (the frequency of disruptive behaviours). Group Triple P was more effective on the measure of pro-social child behaviour for younger parents and those from the lowest socio-economic group. In addition, differences in outcomes for those who had or had not attended Triple P previously were analysed. Once again, the findings suggest that parents made gains whether or not they had previous exposure to the Triple P Programme.

**Table 2a: Short-term changes for Group Triple P: Child outcomes and movement from 'extreme's into 'normal' range**

Group Triple P (n=391)	SDQ Total	SDQ Emotional	SDQ Conduct	SDQ Hyperactivity	SDQ Peer Problems	SDQ Impact	ECBI Intensity	ECBI Problem
	1.51*** 66% (99)***	0.611*** 59% (68)***	1.347*** 51% (115)***	1.164*** 60% (84)***	0.466*** 60% (73)***	0.817*** 56% (90)***	1.755*** 80% (97)***	1.888*** 73% (110)***

**Notes:** \* p<.05, \*\* p<.01, \*\*\* p<.001. Figures represent Cohen's d effect sizes. Percentages are of those in the borderline/abnormal range at pre-intervention who moved out of that range and into the normal range at post-intervention (followed by frequency in parenthesis). ECBI = Eyberg Child Behaviour Inventory; SDQ = Strengths and Difficulties Questionnaire.

§ Borderline to abnormal range scores for ECBI intensity >131; ECBI Problem > 15; SDQ Total Difficulties Scale = 14-40; Emotional Symptoms Scale = 4-10; Conduct Problem Scale = 3-10; Peer Problem Scale = 3-10; Hyperactivity Scale = 6-10; Pro-social Scale = 0-5, also termed 'caseness' or 'extreme' scores.

**Table 2b: Short term changes for Group Triple P: Parent outcomes**

Group Triple P (n=391)	Parenting Scale Total	Parenting Laxness	Parenting Over-reactivity	Parenting Verbosity	PSBC	DASS Depression	DASS Stress	DASS Anxiety	Relationship Quality Index	Parent Problem	Parent Problem Intensity
	1.992***	1.507***	1.741***	1.436***	1.328***	0.745***	0.885***	0.598***	0.429***	0.74***	0.785***

**Notes:** \* p<.05, \*\* p<.01, \*\*\* p<.001. Figures represent Cohen's d effect sizes. PSBC = Problem Setting and Behaviour Checklist; DASS = Depression-Anxiety-Stress Scale.

**Table 3: Short-term changes for Workshop Triple P: Child and Parent outcomes and movement from 'extreme's into 'normal' range**

Workshop	ECBI Intensity	ECBI Problem	Difficult behaviour	Parenting rewarding	Parenting demanding	Parenting stressful	Parenting fulfilling	Parenting depressing	Confident as parent	Supported as parent	Agree discipline	Supportive partner	Happy relationship
W1: Dealing with disobedience (n=191)	1.096*** 61%(27)***	1.093*** 67%(29)***	0.703***	0.444**	0.063	0.429**	0.187	0.417***	0.34*	0.255	0.201	0.191	0.142
W2: Fighting and aggression (n=64)	0.667* 46% (6)	0.924** 63% (12)*	0.924**	0.83**	0	0.602*	0.068	0.527*	0.749**	0.514*	0.59*	0.735**	0.32
W3: Bedtime routines (n=24)	0.652 20% (1)	1.146* 60% (3)	0.09	0	0.692	0.86	0.096	0.193	0.283	0.837	0.912*	0.742	0.57

**Notes:** \* p<.05, \*\* p<.01, \*\*\* p<.001. Figures represent Cohen's d effect sizes. Percentages are of those in the borderline/abnormal range at pre-intervention who moved out of that range and into the normal range at post-intervention (followed by frequency in parenthesis). ECBI = Eyberg Child Behaviour Inventory. § Borderline to abnormal range scores for ECBI intensity > 131; ECBI Problem > 15, also termed 'caseness' or 'extreme' scores.

The findings from the current study provide further evidence for the success of the Triple P Programme for participating parents. In particular, they provide evidence for its success as a universal programme that also benefits those with higher levels of need. These findings are important given that in one reported study no programme effects were observed (Little *et al.*, 2012) while two recent papers have made criticisms of the evidence base for Triple P (Wilson *et al.*, 2012; Coyne & Kwakkenbos, 2013). The ‘large’ effect sizes in the current study for Group Triple P can be interpreted alongside a recent meta-analysis of Triple P studies, which reported ‘medium’ effect sizes for participants in Group Triple P (Sanders *et al.*, 2014). As was the case in the Brisbane evaluation of Group Triple P (Sanders *et al.*, 2005), the evidence shows the success of a universal programme for all families, including those with high baseline needs. In the current study, participants in Group Triple P reported higher levels of need prior to the intervention than parents in the Workshops. Nonetheless, significant gains were made on all outcome measures. In addition, there was a statistically significant reduction in children categorised as ‘borderline/abnormal’ for child emotional and behavioural problems. In the current study, ‘medium’ to ‘large’ effect sizes were observed for participants in Workshop Triple P. In addition, although workshops are designed for moderate levels of need and are less intensive than Group Triple P, nonetheless, there was a statistically significant reduction in children categorised as ‘borderline/abnormal’ for child emotional and behavioural problems.

The findings also provide evidence for the long-term improvements experienced by parents who participate in Triple P. In the current study, improvements were observed among Group Triple P participants after a 12-month period for all items measured, i.e. the frequency and number of disruptive behaviours and for parenting discipline. Similar results were reported from the Western Australia study (Zubrick *et al.*, 2005). In the current study, long-term gains (i.e. 6-months follow-up) were observed for participants in workshops, as was the case in two Brisbane studies (Joachim *et al.*, 2010; Morawska *et al.*, 2010).

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## 5. Summary findings on impact of Triple P at population level

The aim of this element of the evaluation was (a) to document need for Triple P in the intervention and comparison areas; (b) to investigate whether the population had been exposed to Triple P over the course of the intervention period; and (c) to assess whether there had been any impact of Triple P in the population. The findings show clear perceived need among parents for assistance with their parenting, relatively high levels of intervention exposure in the intervention countries and a positive impact of the programme at the population level on key parenting and child behaviour variables.

### Method

Data were collected from parents in Autumn 2010 (Time 1) and Spring 2013 (Time 2) by interviewers calling to households. The sample frame comprised parents with children aged 3-7 in the two intervention counties plus two comparison counties, matched by social, economic and demographic profile. At Time 1, 1,501 parents in the intervention area and 1,495 in the comparison area were interviewed; at Time 2, the numbers were 1,521 and 1,544 respectively. Parents were sampled independently at both time points; while there may have been some overlap, the samples were independent of one another.

Data were collected on demographic variables; child problems (SDQ); parenting strategies (Kessler Psychological Distress Scale, K10); parenting confidence scale; parenting experience scale; family climate scale; relationship with child scale; positive parenting scale; parental responsibility scale; appropriate discipline scale; inappropriate discipline scale; inappropriate parenting for anxious or fearful behaviour scale; opinion on parenting scale; further items on perceived support, stress, parental consistency and satisfaction with their relationship with their child; and help-seeking behaviour (professional help sought, perceptions of and experiences with parenting programmes). At Time 2, specific and more detailed questions on exposure to Triple P were also included.

The Population Study was structured around 3 research questions:

1. What was the prevalence and baseline comparison of child emotional and behavioural problems and negative parental strategies, experiences, and opinions?
2. What was the extent of exposure to Triple P in the intervention counties?
3. Was there an intervention effect on child emotional and behaviour problems and negative parental strategies, experiences and opinions?

### Data analysis

Data were collected in geographical clusters, but the level of correlation within clusters was low (generally less than 5%) and thus data were treated as independent for the purposes of analyses. A range of statistical techniques were employed, including Chi-square tests, t-tests, logistic regression and analysis of covariance. The prevalences presented below have been weighted for each subsample by child's gender and age, parent's socio-economic status and location within the intervention and comparison areas.

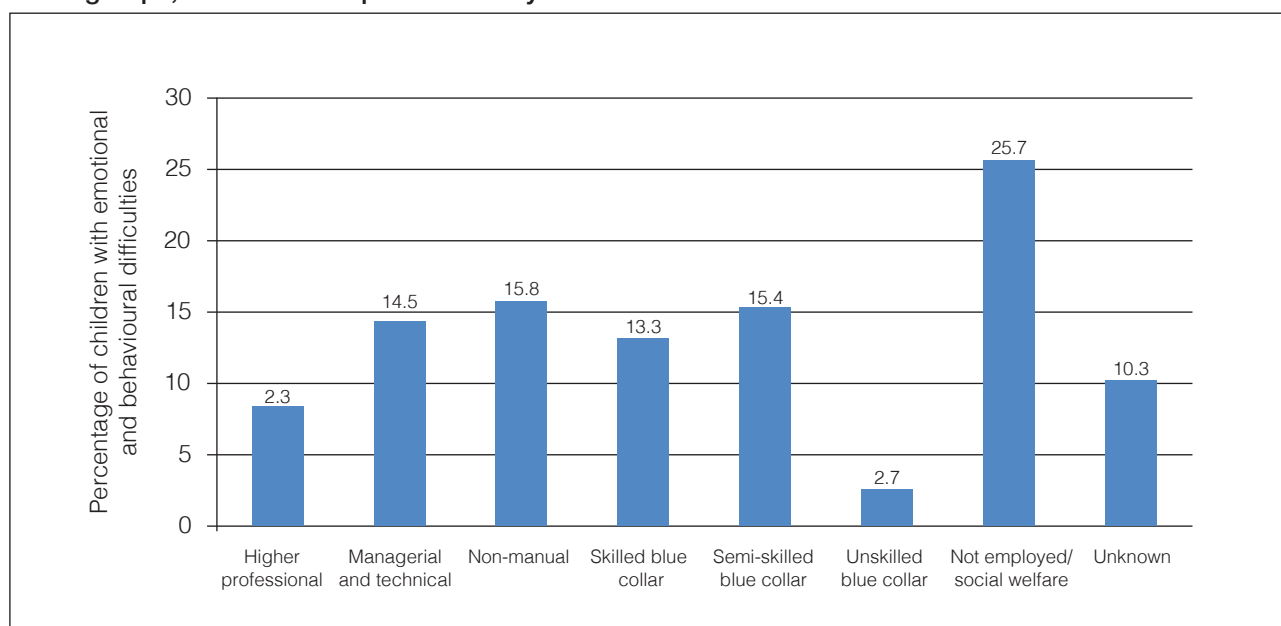
### Extent of need for Triple P

For the success of a population approach, knowledge is needed of baseline rates of 'child problems, and parent risk and protective factors targeted by the intervention' (Sanders *et al*, 2005, p. 15). The population survey showed that households with children in the sample areas (both intervention and comparison areas)

were broadly similar to households with children nationally in terms of marital status, type of family and social class (Haase *et al*, 2003). The percentage of owner-occupiers (nearly 50%) was below the national level of 75% (CSO, Census, 2006) and entitlement to a medical card (approximately 50%) was higher than the national level of 36% (CSO, 2012).

At Time 1, before the intervention commenced, 17.8% (n=267) of parents in the intervention areas were concerned with their child’s emotional and behavioural well-being, while 3.5% (n=52) reported definite or severe problems. There were only small differences between the intervention and comparison areas in the mean SDQ scores. At Time 1, 10.3% (n=154) of index children in the intervention sample were in the ‘abnormal’ range (Total Difficulties Scale) compared to 8.4% (n=125) in the comparison sample; and 6.9% (n=104) in the intervention sample were ‘borderline’ compared to 6.1% (n=91) in the comparison sample. The combined percentage for borderline/abnormal was comparable to other studies in Ireland (17% in McKeown and Haase, 2007) and elsewhere (UK norms for 5-10 year olds: 18%; US norms for 4-7 year olds: 12%) for similar age groups. Boys were more likely to be reported to have borderline or abnormal symptoms for total difficulties, conduct problems and hyperactivity, while younger children were more likely to have borderline or abnormal symptoms on the conduct problems sub-scale. Significant associations were found between social class and peer problems, hyperactivity and emotional symptoms, with participants from lower social classes reporting higher levels of problems (*see Figure 2*), but significant child problems were reported across all social class groups.

**Figure 2: Weighted<sup>§</sup> percentage of children with emotional and behavioural difficulties across Social Class groups, at Time 1 – Population Study**



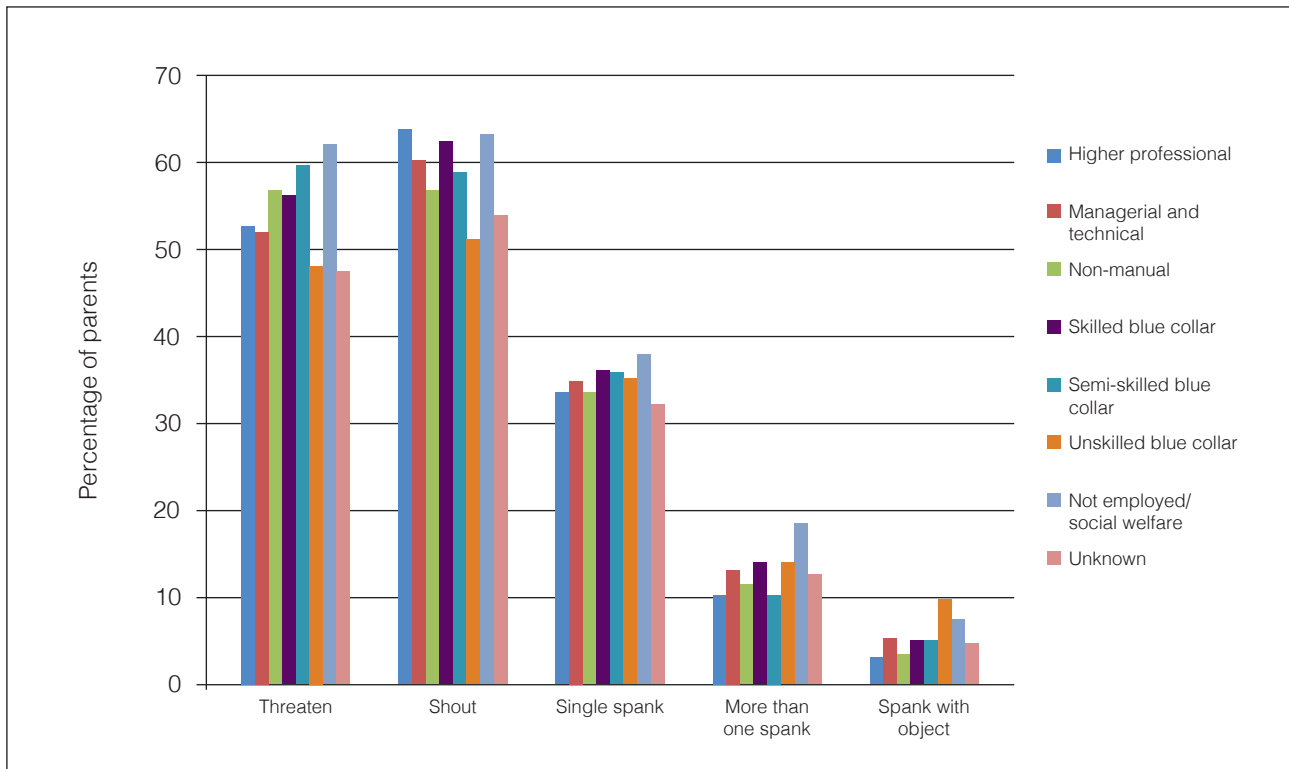
<sup>§</sup> Weighted by age and gender of target child, social class of parents and aggregate area

In terms of parental outcomes, 41.3% (n=620) of those from the intervention areas and 39.4% (n=589) of those from the comparison areas reported feeling stressed and approximately 19.7% (n=590) of *all* Time 1 respondents reported symptoms of moderate to severe psychological distress. While there were significant differences between the intervention and comparison Time 1 samples on a range of parenting measures, the differences were small and not likely to be of practical interest. Further, inappropriate parenting behaviours around discipline were reported in all social groups, with no significant differences between social classes (*see Figure 3*).

The percentages of parents using appropriate reinforcement strategies to encourage desirable behaviour (more than 80% of parents) and appropriate discipline practices (60%-90% of parents) were comparable to those reported by Sanders *et al* (2007). The current study shows the use of inappropriate or coercive practices for child misbehaviour were found across all social class groups (*see Figure 3*), but were lower than figures

reported by Sanders *et al* (2005 and 2007). Approximately 40% of parents in the current study reported feeling stressed, with 20% reporting moderate to severe stress.

**Figure 3: Weighted<sup>§</sup> percentage of parents using coercive or inappropriate strategies for misbehaviour by Social Class groups, at Time 1 – Population Study**



§ Weighted by age and gender of target child, social class of parents and aggregate area

## Exposure to Triple P

A central aim of Triple P is to normalise or de-stigmatise help-seeking behaviour (Sanders and Prinz, 2008). At Time 2, following the intervention, the majority of respondents from the intervention areas reported that they had heard of Triple P (60%, n=905), up from 18.8% (n=282) at Time 1. While 36.1% (n=521) knew somebody who had taken part in Triple P, 68% (n=347) of these had received parenting tips or information from that person. These rates of exposure and the reported communication between participants and non-participants are likely to have aided progress towards normalising help-seeking for parenting issues in the intervention area. In terms of personal participation, 20.6% (n=313) of the Time 2 intervention sample had participated in Triple P over the previous 2 years, which is comparable to the figures on programme delivery reported below of Workshops delivered to 12% of the population and Group delivered to 8% of the population. There was a low level of contagion in the comparison areas, where 12.7% (n=195) had heard of Triple P, 6.7% (n=95) knew someone who had taken part, 77.2% (n=71) of whom had received parenting tips or information from the participant, and 2.5% (n=39) had themselves taken part in Triple P over the previous 2 years. These low rates of contagion in the comparison areas are not likely to have unduly influenced study findings.

Regarding specific Triple P activities, in the intervention areas 22.6% (n=344) had read a Tippiaper (Triple P newspaper), 9.5% (n=144) had attended a Triple P Seminar, 4.5% (n=69) had attended a Workshop and 7.5% (n=114) had attended Group Triple P. The population survey sample under-represents the actual proportion of the population who had attended a Triple P Workshop over the course of the intervention and thus may underestimate the intervention impact.

Female respondents were significantly more likely to have been exposed indirectly or directly to Triple P and more socio-economically advantaged parents were more likely to have read a Tippaper or attended a Seminar or Group Triple P.

## Intervention effects

The data show there was a significant impact of Triple P at the population level for both children and parents (see Table 4). A population effect is when there is a significant positive change in the intervention areas that does not occur in the comparison areas, and can be interpreted as providing evidence for the impact of the intervention in the areas where it was implemented. There were significant, small, population effects on **child outcomes** for:

- emotional and behavioural problems (Total Difficulties score on the SDQ) ( $d = 0.11$ );
- emotional symptoms ( $d = 0.12$ ).

There was no significant difference between comparison and intervention areas for conduct problems and peer problems, although scores improved more on these sub-scales in the intervention areas than the comparison areas. No significant patterns were observed on the hyperactivity sub-scale. Differences over time in the proportions of those with elevated scores on these scales were also assessed and are included below (see Table 5).

**Table 4: Summary of population-level impact of Triple P Programme – Child and parent outcomes**

Group	Intervention		Comparison		Overall		
	Means (SE) <sup>§</sup>		Means (SE) <sup>§</sup>		Effect estimate <sup>¶</sup>	Effect size (Cohen's $d^A$ )	p
	Pre	Post	Pre	Post			
<b>Child outcomes</b>							
SDQ Total Difficulties	8.27 (0.20)	7.31 (0.19)	7.63 (0.20)	7.26 (0.20)	-0.602	-0.11	0.038*
SDQ Emotional Symptoms	1.79 (0.07)	1.42 (0.06)	1.77 (0.07)	1.62 (0.07)	-0.220	-0.12	0.028*
SDQ Conduct Problems	1.71 (0.06)	1.44 (0.06)	1.55 (0.06)	1.4 (0.06)	-0.116	-0.07	0.176
SDQ Peer Problems	1.5 (0.06)	1.26 (0.05)	1.26 (0.06)	1.14 (0.06)	-0.113	-0.07	0.174
SDQ Hyperactivity	3.28 (0.09)	3.19 (0.08)	3.04 (0.08)	3.11 (0.08)	-0.153	-0.07	0.209
SDQ Pro-social	8.15 (0.07)	8.47 (0.07)	8.02 (0.07)	8.34 (0.07)	0.008	0.00	0.942
<b>Parenting outcomes</b>							
Confident parenting	36.28 (0.23)	36.19 (0.21)	35.72 (0.23)	36.23 (0.22)	-0.593	-0.10	0.076
Good experience of parenting	18.71 (0.10)	19.49 (0.10)	18.67 (0.10)	19.24 (0.10)	0.205	0.07	0.169
Parental psychological distress	12.39 (0.20)	11.64 (0.19)	13.92 (0.20)	14.08 (0.20)	-0.907	-0.17	0.002**
Positive family climate	22.82 (0.15)	23.63 (0.14)	22.96 (0.14)	23.61 (0.14)	0.158	0.04	0.460
Good relationship with child	18.23 (0.09)	19.01 (0.09)	18.21 (0.09)	18.27 (0.09)	0.721	0.30	0.000***
Engage in positive parenting	13.12 (0.08)	13.16 (0.08)	13.01 (0.08)	12.76 (0.08)	0.292	0.13	0.016*
Engage in parental responsibilities	21.86 (0.12)	21.14 (0.11)	21.02 (0.12)	20.34 (0.12)	-0.037	-0.01	0.834
Parenting consistency	4.17 (0.03)	4.16 (0.03)	4.24 (0.03)	4.19 (0.03)	0.043	0.06	0.320
Likely to use appropriate discipline	21.18 (0.14)	21.83 (0.13)	21.06 (0.13)	20.91 (0.13)	0.796	0.23	0.000***



Unlikely to use inappropriate discipline	19.35 (0.13)	21 (0.11)	19.15 (0.12)	20.7 (0.12)	0.105	0.03	0.55
Unlikely to use inappropriate parenting for anxious behaviour	18.8 (0.10)	19.5 (0.09)	18.67 (0.09)	18.86 (0.09)	0.513	0.21	0.000***
Inappropriate opinions on parenting	15.44 (0.17)	15.06 (0.15)	14.56 (0.16)	14.48 (0.16)	-0.289	-0.07	0.229
Inappropriate opinions on smacking	10.99 (0.17)	9.06 (0.16)	9.91 (0.17)	8.41 (0.17)	-0.426	-0.09	0.087
Satisfied with available parenting services	2.76 (0.05)	3.28 (0.04)	2.37 (0.04)	2.36 (0.04)	0.533	0.46	0.000***
Satisfied with available parenting information	2.76 (0.05)	3.28 (0.04)	2.4 (0.04)	2.28 (0.04)	0.643	0.56	0.000***
Likelihood of participating in future parenting programmes	4.23 (0.11)	4.25 (0.10)	4.87 (0.11)	4.36 (0.11)	0.542	0.18	0.001**

§ Covariate adjusted means derived from ANCOVA models (see Tables B.5a-v in Appendix B.5).

SE= standard error of covariate adjusted means.

Φ The difference between the change over time in the covariate adjusted means of the intervention group and the change over time in the covariate adjusted means of the comparison group.

Δ Effect estimate divided by the pooled standard deviation.

\* statistical significance at  $p < 0.05$ ; \*\* statistical significance at  $p < 0.01$ ; \*\*\* statistical significance at  $p < 0.001$

Shaded rows represent statistically significant findings.

As Table 4 shows, there were significant, small to medium, population effects on **parent outcomes** for:

- parental psychological distress ( $d = 0.17$ );
- reporting a good relationship with one's child ( $d = 0.30$ );
- engaging in positive parenting ( $d = 0.13$ );
- being likely to use appropriate discipline ( $d = 0.23$ );
- being unlikely to use inappropriate discipline for anxious behaviour ( $d = 0.21$ ).

There was no significant difference between comparison and intervention areas for confident parenting or positive family climate, although scores improved more in the intervention areas. No significant patterns were observed for good experience of parenting, inappropriate opinions on parenting or parenting consistency.

There were also significant, small to medium, population effects for:

- satisfaction with parenting information available ( $d = 0.56$ );
- satisfaction with parenting services ( $d = 0.46$ );
- likelihood of participating in future parenting programmes ( $d = 0.18$ ).

## Extreme scores by location pre- and post-intervention

The objective of a population-level intervention is to reduce need and negative behaviours across the whole population – so that even those with relatively little need have that need reduced. Of particular interest is whether a population-level intervention can work with those who have high levels of need or negative behaviours (also called extreme scores) as well as with the broader population.

There were significant changes in the numbers of children with borderline or abnormal scores on the child SDQ scales in the intervention areas (*see Table 5*). Specifically, there were significant reductions in the percentage of respondents who scored very highly on the SDQ scales in the intervention areas (pre-post difference of the intervention areas minus the pre-post difference of the comparison) for:

- emotional and behavioural problems (Total Difficulties Score on the SDQ);
- emotional symptoms;
- conduct problems;
- peer problems;
- hyperactivity.

These population-level patterns of impact reflect those described for changes to mean scores, with the exception of the hyperactivity scale. Outcomes on the Total Difficulties and Emotional Symptoms scales show approximately 30% reductions in the odds of clinical-to-borderline cases in the intervention area following programme implementation.

Statistically significant improvements on parenting outcomes were also identified:

- parental psychological distress (intervention down from 9.1% to 6.2%; comparison stable over time at 9.0%);
- feeling stressed (intervention down from 41.8% to 27.7%; comparison down from 39.5% to 36.1%);
- reporting a good relationship with child (intervention up from 99.5% to 99.7%; comparison down from 99.7% to 99.0%);
- engaging in parental responsibilities (intervention up from 98.8% to 99.1%; comparison down from 99.3% to 97.1%);
- consistent parenting (intervention up from 83.8% to 85.9%; comparison down from 87.7 to 81.4%);
- being unlikely to use inappropriate discipline (intervention up from 98% to 98.7%; comparison down from 98.5% to 96.8%);
- having an appropriate opinion on parenting (intervention up from 81.6% to 82.9%; comparison down from 84.8% to 79.8%);
- having an appropriate opinion on smacking (intervention up from 94.2% to 99%; comparison up from 96.9% to 97.4%);
- feeling supported (intervention up from 80.8% to 88.7%; comparison up from 86.7% to 87.3%).

Reports of parental psychological distress and of stress both showed approximately 30% reduction post-intervention in the number of cases in intervention areas. Significant improvements post-intervention in extreme scores were found for the range of parenting outcomes listed above. Of particular note are those parenting outcomes that have demonstrated particularly substantial changes over time in favour of the intervention group – those that are not only statistically significant but are also likely to be of practical importance for child and parenting outcomes. These comprise consistent parenting, appropriate opinions on parenting and smacking, feeling stressed and feeling supported in the parenting role.

**Table 5: Proportion of children with elevated (clinically abnormal or borderline cases<sup>§</sup>) scores on child outcomes in intervention and comparison areas pre- and post-intervention**

	Percentage of abnormal or borderline cases		No. of cases (per 100 <sup>1</sup> ) difference Post – Pre	% difference Pre – Post
	Pre	Post		
<b>Total difficulties</b>				
Intervention	16	10	-7.2	-37.5
Comparison	13.4	14.5		+8.6
Odds ratio	1.2*	0.7***		
Tarone's Chi (p)	17.4*** (p = 0.000)			
<b>Emotional symptoms</b>				
Intervention	17	12	-5.8	-29.6
Comparison	15.9	16.7		+5.2
Odds ratio	1.1	0.7***		
Tarone's Chi (p)	10.8** (p = 0.001)			
<b>Conduct problems</b>				
Intervention	27.3	18.7	-7.2	-31.4
Comparison	21.3	19.9		-6.6
Odds ratio	1.4***	0.9		
Tarone's Chi (p)	10.2** (p = 0.001)			
<b>Peer problems</b>				
Intervention	21.2	15.3	-4.7	-27.9
Comparison	18.6	17.5		-6.2
Odds ratio	1.2	0.9		
Tarone's Chi (p)	5.8* (p = 0.016)			
<b>Hyper-activity</b>				
Intervention	15.6	13	-8.2	-16.5
Comparison	12.3	17.9		+45.4
Odds ratio	1.3**	0.7***		
Tarone's Chi (p)	19.7*** (p = 0.000)			
<b>Pro-social</b>				
Intervention	16.5	10.4	-3.2	-37.1
Comparison	10.2	7.3		-28.1
Odds ratio	1.8***	1.5*		
Tarone's Chi (p)	1.1 (p = 0.305)			

<sup>1</sup> This refers to the numbers out of 100 (or percent) from the general population survey.

§ Borderline to abnormal range scores for Total Difficulties Scale = 14-40; Emotional Symptom Scale = 4-10; Conduct Problem Scale = 3-10; Peer Problem Scale = 3-10; Hyperactivity Scale = 6-10; Pro-social Scale = 0-5, also termed 'caseness'.

Proportions weighted by age and gender of child, socio-economic group and aggregated area.

Odds ratio shows odds of reporting parenting strategy, behaviour or opinion in the intervention counties compared to comparison counties.

Tarone's Chi indicates the extent and significance of the differences over time for the two groups (intervention and comparison).

\* statistical significance at p<0.05; \*\* statistical significance at p<0.01; \*\*\* statistical significance at p<0.001

For the success of a population approach to be demonstrated, outcomes must be tracked at a population level rather than at an individual family level (Sanders *et al*, 2005, p. 15). Population-level data in the current study were derived from geographically stratified quota samples, based on socio-economic measures, from two intervention counties and two comparison counties. The data show a number of significant and positive effects for the intervention areas compared to the comparison areas. These effects were found on child behavioural and emotional problems, parental psychological distress, reporting a good relationship with the index child, appropriate parenting strategies, satisfaction with parenting information available, satisfaction with parenting services and likelihood of participation in future parenting programmes.

Regarding child outcomes, effects were observed on the Total Difficulties score on the SDQ and for the subscales for emotional symptoms and pro-social behaviours. These findings reflect similar population-level improvements as those reported by Sanders *et al* (2008) in a population-level study among 4-7 year-olds in Australia. As in the current study, Sanders *et al* found no significant impact on mean scores for the child behavioural sub-scales of hyperactivity, conduct problems and peer relationship difficulties. Sanders *et al* (2008) noted that the lack of effects on these sub-scales may have resulted since the majority of parents sampled in their study were exposed to 'light touch' interventions of the Triple P Programme. The pattern is similar in the current study, with lower percentages of the intervention sample having attended the more intensive 8-week parenting course (Group Triple P) than the less intensive levels of the programme.

In contrast to Sanders *et al* (2008), the current study demonstrates significant population-level improvements in engagement in positive parenting. In addition, a significantly higher level of improvement in parents reporting a good relationship with their child was found within intervention areas. Parental functioning, partially measured in the current study as the level of parental psychological distress and parental stress, reflects similar improvements to those demonstrated by Sanders *et al* (2008) for parental depression levels, with an approximate 30% reduction in the number of 'cases', or extreme scores, post-intervention for both of these outcomes. Taken together, these findings support a positive population-level impact of the Triple P multi-level intervention.

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## 6. Summary findings on partnership

The evaluation investigated the strengths and the challenges of a partnership approach, as well as what was learned from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes to other areas. The findings show that substantial success was enjoyed in developing a partnership approach to implement Triple P and the considerable learning from this experience has informed the replication of the project in neighbouring areas.

### Method

As part of the Partnership Study, 43 semi-structured, open-ended interviews were conducted with 17 representatives from the 9 partner agencies. Data were collected at the following four time points:

- May 2011: n=12 (8 HSE, 4 Statutory, Community, and Voluntary sector, 5 non-respondents);
- November 2011: n=12 (6 HSE, 6 Statutory, Community, and Voluntary, 5 non-respondents);
- September 2012: n=11 (5 HSE, 6 Statutory, Community, and Voluntary, 6 non-respondents);
- May 2013: n=8 (6 HSE, 2 Statutory, Community, and Voluntary, 9 non-respondents).

In interpreting the data, the Research Team sought to discover the emerging themes in relation to a partnership approach and its contextual setting, and also to interpret the meaning of the representatives' experiences of the Longford Westmeath Parenting Partnership (LWPP). Documents from LWPP were also analysed to provide an overview of the establishment of the partnership and also the Memorandum of Understanding.

The Partnership Study was structured around 3 research questions:

1. What were the strengths of a partnership approach?
2. What challenges did the partners face and how were they addressed?
3. What has been learned from the Longford Westmeath implementation in order to promote the further roll-out of population-based programmes?

### Strengths of the partnership approach

In the literature, it is argued that partnership working is needed for a population approach that is aimed at both the reduction of child and family problems and also reaching many segments of the community in non-stigmatising ways (Sanders and Prinz, 2008, p. 131). The partner representatives in LWPP believed that the current profile of partner organisations was necessary to attain these aims. In particular, the involvement of Statutory, Community, and Voluntary sector partners improved access to parents, while having the HSE involved helped secure the trust of parents. The partner representatives also acknowledged that the Triple P Programme, as a universal and evidence-based approach, required a level of engagement and collaboration that was ambitious and a new departure for all concerned.

Good relationships were a key strength of the LWPP partnership. The process of developing the Memorandum of Understanding and the practice of having it in place were key strengths since they encouraged openness in communication. There were also high levels of trust between partners. This was of particular importance because the partners held unequal amounts of resources. Another strength was the support received from the HSE. HSE representatives emphasized that the success of the partnership was due in part to support from senior management of various HSE disciplines and its consistency with national policy. Although the representatives reported having received mixed feedback from staff involved in delivery, a final strength of the partnership was the positive attitudes among the representatives themselves to working with evidence-based programmes.

## Challenges the partnership faced and how they were addressed

The literature suggests that to deliver the Triple P Programme successfully requires not only the recruitment of parents but also the identification of a population of providers and the engagement and training of providers (Shapiro *et al*, 2010, p. 225). Ensuring that all partners contribute what is expected of them is a common challenge of partnerships (Valentine *et al*, 2006). In the current study, a key challenge faced by the partnership concerned the capacity of partner organisations to meet their programme delivery commitments. Partnership structures and processes, in particular the role of the Project Management Team, facilitated partners to adapt their commitments in light of learning from experience and changes in available resources. However, at least partly as a result of the opportunities to adapt commitments, the scale and level of programme delivery was highly variable among partners. Other partners were unable to release staff to deliver Triple P because of increased funding cuts.

In addition, representatives from one professional group drew attention to a perceived tension between the Triple P model and their own approach to parenting interventions. As the literature shows, a significant challenge for partnership working is that professionals can have a different mode of understanding and intervening in the world (Johnson *et al*, 2003; Frost, 2005; Horwath and Morrison, 2007).

Finally, partner representatives had concerns relating to the creation of Tusla, the Child and Family Agency. Its establishment led to uncertainty among representatives from the HSE and LWPP Project Management Team over which statutory body will have responsibility for the partnership and Triple P in the future.

## What was learned from the Longford Westmeath implementation in order to promote the further roll-out of population-based programmes

An overarching objective of LWPP is to utilise what was learned from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes to other areas. A key issue for replication of the partnership concerns the reasons why organisations would join a partnership in the first place. Representatives were asked about their initial motivations for joining the partnership.

HSE representatives provided the following reasons, among others:

- to recruit and gain access to parents;
- to remove the *'inefficiency'* of implementing different overlapping parenting programmes;
- to increase collaboration between HSE Departments.

Reasons provided by representatives from the Statutory, Community, and Voluntary sector included:

- published evidence that Triple P was effective;
- the leadership shown by the Project Management Team;
- the need for consistency in parenting support.

However, while some organisations joined LWPP to contribute to related goals of social inclusion, they subsequently experienced pressure from funders not to see LWPP as their *'core business'*.

An important area of learning concerned the value of the Memorandum of Understanding (MOU). The MOU had value as *'a living document'* since it embodied a way of working together that represented the values and aims of the partnership. The MOU was used to help identify areas of potential conflict and was *'process-driven'* and therefore seen as *'objective'*.

Representatives were asked about the future development of the partnership. Some believed no new partner organisations were needed so long as sustained and increased involvement by existing partners was ensured. Others believed that the Department of Education and Skills and the discipline of Social Work should be more closely involved so as to recruit parents with higher levels of need.

A further area of learning concerned the number of professionals trained as Triple P practitioners who did not deliver the programme. As a result, a 'Person Specification Document' was developed for the recruitment of practitioners for the roll-out of Triple P in Laois and Offaly by the Core Team. It was also believed that although all partners should deliver Triple P, not all should have the same responsibilities in programme delivery.

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## 7. Summary findings on programme implementation

The evaluation investigated the extent and nature of programme take-up, how well the programme was organised and the extent to which the programme was implemented in line with the model as specified. The findings show the partners enjoyed considerable success implementing Triple P since programme implementation was well organised, parents were highly satisfied with programme delivery and content, and considerable progress was made towards reaching targets for programme delivery.

### Method

Qualitative data were collected from a number of sources: 5 focus groups with Workshop Triple P and Group Triple P participants (n=33), 5 telephone interviews with Seminar participants (n=5), 3 focus groups (n=21) with practitioners, interviews with the LWPP Core Team (December 2011 and May 2013) and interviews with representatives from The Atlantic Philanthropies (who provided funding for the project) and the HSE (December 2011 and August 2013).

Quantitative data were collected through a survey completed by practitioners. The Time 1 survey (November 2011) included 8 practitioners from Panel 1 and 13 from Panel 2, while the Time 2 survey (November 2012) included 7 practitioners from Panel 1 and 6 from Panel 2 (all of the latter were Public Health Nurses). Data from the population surveys concerning exposure to Triple P were also employed. Finally, documentary data on programme implementation were sourced from the minutes of meetings, communications between partners, the Memorandum of Understanding and programme records.

The Implementation Study was structured around 2 research questions:

1. What was the nature and extent of programme take-up (i.e. programme utilisation)?
2. How well was the programme organised and to what extent was it implemented in line with the model as specified (i.e. programme organisation and programme fidelity)?

### Nature and extent of programme take-up

For the success of a population approach, evidence-based interventions must be available, they must be accessible and culturally appropriate, and a system of training and dissemination must be in place (Sanders *et al*, 2005, p. 15). Therefore, implementation issues are central since programme impact will remain limited unless ‘evidence-based programmes are deployed by a large range of providers and used by a significant portion of the population’ (Shapiro *et al*, 2010, p. 223).

### Recruiting parents

The aim of the media strategy was to target the entire population with the aim of increasing the visibility and reach of the programme, de-stigmatising and normalising the process of seeking help for parenting, and ‘preventing the development of adverse outcomes’ (Turner *et al*, 2005, p. 20). The findings show the most common way that parents heard about the programme was through schools, friends and relatives, followed by pre-school and primary care. A minority heard of the programme directly through the LWPP media strategy. The evidence shows that there was a high level of programme awareness in the population. Data from the Population Study collected at Time 2 show that more than 60% of respondents had heard of Triple P and more than one-third said that they knew somebody who had attended at least some part of the Triple P Programme.



Some participants in focus groups (both parents and practitioners) had a negative view of the 'Stay Positive!' recruitment posters. Name recognition for the Tippiaper was low among parents, although they did recognise copies of the Tippiaper and reported positively on its content. Parents reported choosing to participate in Triple P for a variety of reasons, including a general desire for education, recent changes in family life and perceived child behaviour or emotional problems. Panel 1 practitioners believed that much had been learned about recruitment, including how delivery could be better aligned with parenting responsibilities (e.g. certain times of the day, days of the week and months of the year were better suited to family life).

## Progress made towards achieving targets in delivering programme to parents

Different programme delivery targets were set for the various Triple P levels. This was a direct result of the *principle of minimal sufficiency*, which requires that the minimally sufficient support should be provided to parents since parents with different levels of need can engage with different components of the programme (Sanders, 1999).

Considerable progress was made towards reaching delivery targets:

- Workshops were delivered to 12% of parents with a child aged 3-7 in the two counties.
- Group Triple P was delivered to 8% of parents with a child aged 3-7 in the two counties.

Targets were not met for Workshops or Seminars (*see Table 6*). The delivery of Level 3 was greater in 2012 (n=657) than in the preceding 16 months (n=443). Also, three iterations of Level 3 were implemented: delivery of the Workshop version began in mid-2011 and superseded two Primary Care versions (one delivered in GP practices and one delivered by PHNs). Delivery of Seminars also increased in 2012, when Seminars were offered to parents in primary schools.

For Group Triple P, the target of 717 participating parents was met and surpassed (n=803). The delivery of Group Triple P was greater in the first 16 months up to the end of 2011 (n=611) than in 2012 (n=192). The Core Team gave the following reasons to explain why:

- It was important to provide practitioners with experience first in delivering the most demanding programme level before they progressed to deliver other levels;
- On the basis of the principle of programme sufficiency, the number of high need families suited for Group Triple P and still available would have declined after Year 1; and
- More resources were targeted at delivery of Seminars and Workshops in Year 2.

**Table 6: Programme delivery**

	Delivery	Targets
<b>Level 2: Triple P Seminar Series</b>		
Seminar 1: Power of positive parenting	1,303	
Seminar 2: Raising confident, competent children	1,283	
Seminar 3: Raising resilient children	113	
<b>Total</b>	<b>2,699</b>	<b>4,777</b>
<b>Level 3: Workshop and Primary Care Triple P</b>		
Workshop 1: Dealing with disobedience	726	
Workshop 2: Managing fighting and aggression	181	
Workshop 3: Hassle-free shopping with children	10	
Workshop 4: Developing good bedtime routines	109	
No workshop identified	21	
Primary Care Triple P	53	
<b>Total</b>	<b>1,100</b>	<b>2,628</b>
<b>Level 4: Group Triple P</b>	<b>803</b>	<b>717</b>

Levels 3 and 4 figures are for unique participants; Level 2 figures contain duplicates (parents counted more than once).

The progress made in the delivery of all four levels of Triple P, and the timeframe for associated key decisions and actions, are outlined in Figure 4.

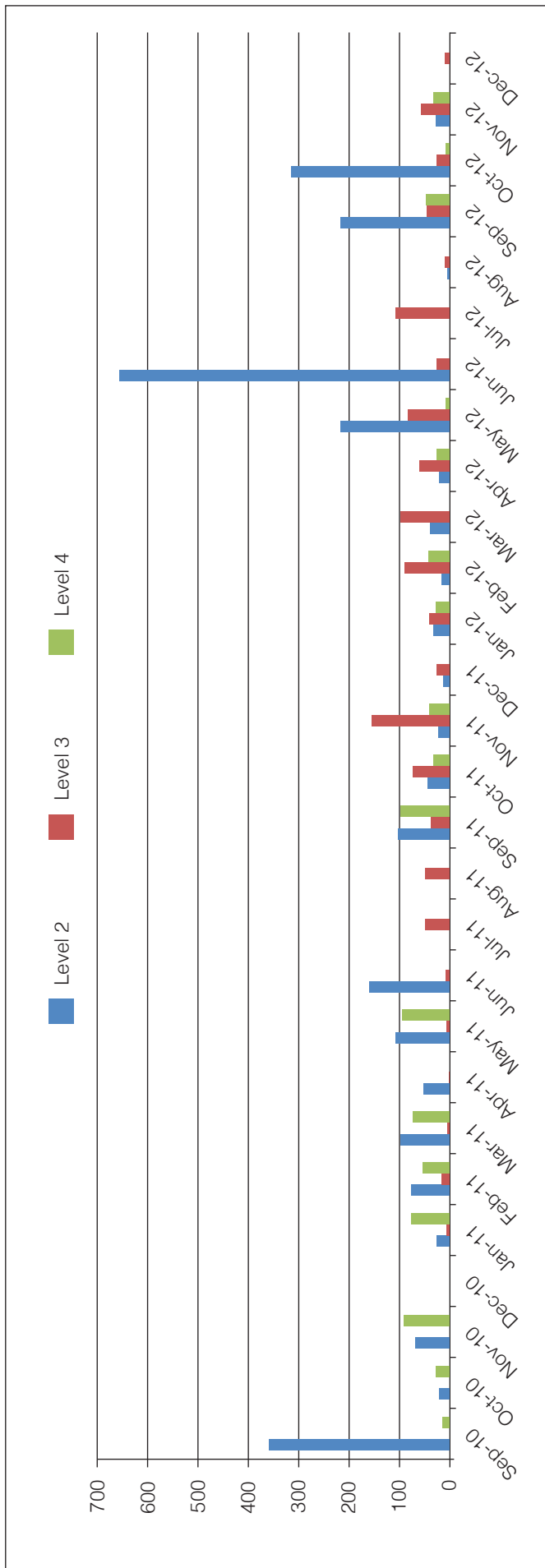
## Progress made towards achieving targets in training practitioners and supporting delivery

Significant progress was made in training practitioners. As planned by the partners, the relatively small number of Panel 1 practitioners (n=8) were responsible for the majority of programme delivery. Among Panel 2 practitioners, more were trained to deliver Group Triple P than Seminars or Workshops. Also, Panel 2 practitioners were more likely to deliver Group Triple P (n=33) and only small numbers delivered Workshop Triple P (n=3) and Triple P Seminars (n=4). The differences in programme delivery between Panel 1 and Panel 2 practitioners reflect the finding of Sanders *et al* (2005, p. 56), that it is ‘a complex task’ to ensure the engagement of the available workforce from different disciplines and agencies required by a population-based approach.

The Project Management Team provided an explanation for the programme delivery levels reported above for Panel 2 practitioners. Practitioners need considerable experience in programme delivery before they will have the capacities needed to successfully deliver the Seminars. Panel 2 practitioners’ commitment in terms of hours to be spent delivering Triple P may be than what is required to develop the necessary levels of experience. Delivery by Panel 2 practitioners will also be affected by many factors, such as organisational readiness and commitment, suitability of the programme to the practitioner and the opportunities for delivery.

There was also a radical revision of the role of Public Health Nurses (PHNs) in programme delivery. Initially, it was intended that all PHNs in the two counties would deliver Triple P. However, the Core Team believed it was an error initially to target all PHNs as potential Panel 2 practitioners and it was decided to target only those with ‘a higher child health caseload’. It was also decided to revise downwards PHN commitments to delivery and to place greater emphasis on the PHNs’ role in recruiting parents.

Figure 4: Timeframe for key decisions/actions and programme delivery



Note: Level 2 = no. of Seminar participants (includes duplicates); Level 3 = no. of unique Workshop participants and Primary Care participants; Level 4 = no. of unique Group participants.

	Sept – Dec 2010	Jan – June 2011	July – Dec 2011	Jan – June 2012	July – Dec 2012
Level 1	Tippaper 1 and 2: Sept and Dec	Tippaper 3: April	Tippaper 4: Sept		Tippaper 5: Sept
Level 2	Matt Sanders public seminar: Sept	Matt Sanders public seminar: June		New strategy: Primary Schools May-June School Induction day	Sept-Oct School Induction Day
Level 3	Training all PHNs: Primary Care	Low Primary Care delivery rate New strategy: (1) PHNs (2) Workshops	Workshops begun		
Level 4	No Groups started in December		No groups started in summer or December	No groups in Easter (March) Minimum of 15 for each group	No groups started in summer or December

# How well the programme was organised and the extent to which the programme was implemented in line with the model as specified

## Programme coordination

The partners created a single, centralised coordination hub in 2010. Programme implementation was facilitated by the Project Management Team, the Core Team and also the wider group of Panel 1 practitioners. The Core Team provided regular feedback to the Project Management Team and this helped ensure both emerging issues and future planning were dealt with in a systematic way. Panel 1 practitioners had the responsibility to support the Core Team to deliver Triple P fidelity training to all members of Panel 2; to promote Triple P; to interact with key stakeholder groups; and to provide peer-to-peer support to members of Panel 2. In addition to being one of the Panel 1 practitioners, the Programme Coordinator had a wide range of additional implementation responsibilities.

As Fixsen *et al* argue, for effective implementation it is necessary that ‘facilitative administration provides leadership and makes use of a range of data inputs to inform decisions, support the overall process and keep staff organised and focused on the desired intervention outcomes’ and its aim is also ‘to ensure alignment ... with the needs of practitioners’. The structures and processes in Longford Westmeath ensured, on the one hand, that key decisions were supported by information from a wide range of sources, including practitioners, while also ensuring, on the other hand, that a dedicated team worked to make sure programme implementation was successful. However, the workload of Panel 1 practitioners needs careful management given the extent to which they have been relied on to deliver, support Panel 2 and coordinate delivery.

## Parents’ satisfaction with Triple P

In focus groups, parents who had attended Group Triple P and Workshops reported many positive experiences of the programme, including programme content, strategies, parenting tips, and the quality of facilitation. They noted that it was an opportunity to meet other parents and they valued the follow-up telephone calls from practitioners post-programme. In questionnaires completed by parents participating in Seminars, Workshops and Group Triple P, satisfaction levels were uniformly high and higher than those reported in Brisbane for Group Triple P and for Seminars (Sanders *et al*, 2005). Good outcomes reported by parents included greater self-awareness of one’s parenting, the capacity to cope with stressful situations and to self-regulate, and realising the importance of taking care of oneself. Parents reported that practitioners who were themselves parents were more understanding and more able to respond to questions and concerns. All parents would recommend the programme to others.

## Practitioners’ views on the quality of programme content and delivery

Practitioners believed that the Triple P Programme was successful for a number of reasons, including that it ‘*kept things simple*’, de-stigmatised help-seeking and encouraged parents to self-regulate and children to be problem-solvers. Practitioners also believed that data collected through the questionnaires were integral to Triple P as a parenting programme. Discussion of the data with parents provided an opportunity to note the areas where parents had been successful as well as to identify areas where further improvement would be possible.

## Support for practitioners and practitioner confidence

A range of supports were developed for practitioners. Supports for Panel 1 practitioners included Trainer Support Forum Meetings, Practitioner Support Forum Meetings, Skype calls from Triple P UK and Core Team meetings. Panel 2 practitioners were also supported by Panel 1 practitioners at Area Team Meetings. In focus groups, practitioners reported high levels of satisfaction with administrative and coordination/clinical support. However, the profile of Panel 1 and Panel 2 practitioners differed significantly since Panel 1 practitioners had much greater involvement in programme delivery. In addition, Panel 1 practitioners felt more confident as practitioners, felt more supported in the workplace, reported receiving more support from LWPP and other practitioners, and perceived the programme to be more helpful. Because Panel 2 practitioners are expected to play a role in programme delivery (although one that is less demanding than for Panel 1 practitioners), successful implementation of Triple P will require facilitator confidence and support among this group of practitioners (Shapiro *et al*, 2010, p. 228).

## Fidelity

Fidelity is important because the Triple P Programme may do agencies, families and the field a '*disservice*' if there is significant programme '*drift*'; in addition, Triple P's '*self-regulation framework*' places responsibility for ensuring fidelity on the '*adoptive organisation*' (Sanders & Prinz, 2008, pp. 131-32). The LWPP partners recognised the importance of programme fidelity, which was to be ensured by a number of means, including accreditation, mentoring of Panel 2 practitioners by Panel 1 practitioners, co-delivery of sessions by Panel 1 and Panel 2 practitioners, support from Triple P International, clinical and administrative support from LWPP and support meetings.

Programme completion is another source of evidence concerning programme fidelity. As was the case in the Western Australia study (Zubrick *et al*, 2005), in the current study the retention of participants in Group Triple P was high. A large majority of parents (85%) who participated in Group Triple P received the recommended programme dosage (i.e. the first Group 4 face-to-face sessions) and over half remained until the penultimate or final session.

However, in contrast to the South Carolina study, in Longford Westmeath fidelity was not ensured through observation of sessions or through completion of a 'content fidelity checklist' by practitioners (Shapiro *et al*, 2010, p. 228). While fidelity was encouraged through observation (co-delivery of sessions by Panel 1 and Panel 2 practitioners), there were no data collected for the express purpose of monitoring programme fidelity and as a result no such data were available to assess programme fidelity. In addition, although fidelity was to be promoted through the supports offered, Panel 2 practitioners reported receiving less support and fewer consultations with other Triple P practitioners.

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## 8. Conclusions

This concluding chapter summarises the main findings from the final evaluation of the Triple P Programme in Longford Westmeath, before drawing out the implications of the findings for practice and policy.

### Summary of findings

Participation in Triple P was associated with statistically significant gains for child and parent outcomes. The partners were successful in achieving their aim of improving parenting attitudes and skills, and in preventing/reducing levels of parental anxiety and depression, as well as bringing about improvements in children's emotional and behavioural problems. There was also a statistically significant reduction in children categorised as 'borderline/abnormal' for child emotional and behavioural problems.

The implementation of Triple P in the two intervention counties of Longford and Westmeath led to statistically significant gains for the whole population when compared with the two comparison counties. There was a population-level impact on children's emotional and behavioural problems, parental distress, parental discipline and parents' relationships with their children. There was also a population effect for those with the highest levels of need since there was a significant difference between intervention and comparison areas in the proportion (number per 100 families) of abnormal or border line cases of emotional and behavioural problems.

The partnership that was successfully established was an integrated and collaborative approach to service delivery. Partnership was seen as necessary so as to reduce child and family problems and also reach many segments of the community in non-stigmatising ways. Although there were high levels of trust among partners and a strong commitment to the partnership, the partnership faced significant challenges including the capacity of partner organisations to meet their programme delivery commitments. Areas where the partnership could be strengthened are through better engagement by all partner organisations and better engagement by Panel 2 practitioners in programme delivery. Given the variation in partner contributions to programme delivery, continued commitment is needed to prevent a perception of inequality between partners, which would damage the existing trust and good relationships that are required for a partnership to prosper.

The evaluation shows the partners successfully met the aim of implementing an evidence-based public health parenting programme. The partners met and exceeded targets for the delivery of Group Triple P. Parents expressed positive views about the quality of programme delivery, having the opportunity of speaking with other parents and receiving parenting tips, while practitioners believed the programme was successful. The positive views expressed by both parents and practitioners about the quality of programme delivery suggest considerable success in ensuring excellence in all the service delivery requirements related to the collaborative initiative. In order to further promote fidelity, the Project Management Team should work to ensure Panel 2 practitioners take up offered supports. In addition to existing methods of fidelity promotion, a written record is needed of programme delivery observations and an objective checklist is required that takes into account both programme content and process.

The partners have also begun to utilise what was learned from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes.

### Implications of findings for practice

The findings from this study have a number of important implications for practice:

- Given the empirical evidence for the gains made by participating parents on parent and child outcomes, the impact for those scoring in the borderline/abnormal category and the impact of the

programme at the population level, the partners should continue to recruit and train practitioners to deliver the Triple P Programme to parents and to guarantee high-quality facilitation.

- The partnership has been successful so far in building trust and good relationships among partners and dealing with inequality between partners. These remain crucial issues for the partnership, in particular when differences in partner contributions are acknowledged.
- The Project Management Team should consider again issues around parent recruitment, including whether some publicity materials are well received in an Irish context.
- The partnership should endeavour to ensure improved engagement by all partner organisations, in particular in the delivery of the programme.
- While acknowledging the obstacles in doing so, the Project Management Team should work to improve the level of engagement by Panel 2 practitioners, wherever this is possible, including the take-up of supports by practitioners and the opportunities to deliver Triple P Seminars and Workshop Triple P.
- The workload of Panel 1 practitioners requires care and consideration, given their centrality to the success of programme implementation and the substantial role they play in programme delivery, parent recruitment, programme coordination and peer support.
- The Project Management Team should continue to prioritise programme fidelity, but should also improve formal procedures for recording fidelity monitoring of programme delivery.
- The Project Management Team should continue to build on the considerable organisational strengths of the Core Team since the evaluation has shown the benefits of the roles of Project Director, Partnership Chair, Coordinator, Panel 1 practitioners, Researcher, Office Administrator and Clerical Officer.

## Implications of findings for policy

The findings from this study also have a number of important implications for policy:

- The newly established Tusla, Child and Family Agency is committed to outcomes-focused and evidence-based parenting support and to interagency collaboration in the provision of family support and parenting programmes. The Triple P Programme and the LWPP partnership fit well with the agency's commitments.
- The continued existence of the partnership and the ongoing implementation of the Triple P Programme require clear commitments into the future regarding statutory support, whether from the Health and Wellbeing Division and/or the Primary, Community and Continuing Care Services (PCCC) Directorate (both within the Department of Health) and/or the new Child and Family Agency, or a combination of these organisations.
- The evidence from this evaluation suggests that a partnership approach can be successful in the implementation of a public health model of parenting support since significant success was enjoyed in engaging practitioners, recruiting parents and improving outcomes for children and families, both among those who participated and in the broader population.
- The evidence from this evaluation suggests that a partnership approach involving statutory and non-statutory organisations can be successful for the provision of parenting support. A successful partnership must address the tensions created by the need for strong partners able to drive the partnership forward, on the one hand, and the commitment to equality between partners, on the other.

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# Glossary

**Agency, The:** Tusla, Child and Family Agency, established in January 2014.

**Analysis of variance (ANOVA):** An analysis of variance (ANOVA) is used when comparing the mean scores of two or more groups. There is a continuous dependent variable and the independent variable can have a number of levels. The test compares the variance (variability in scores) between the different groups (believed to be due to the independent variable) with the variability within each group (believed to be due to chance). It calculates an F ratio: a large F ratio indicates there is more variability between the groups (caused by the independent variable) than there is within each group (caused by chance).

**Effect size:** The effect size in the Parenting Study represents the scores recorded from parents attending Triple P when compared with their scores prior to attending Triple P. It is necessary to represent the effect size in standardised form. The ‘standardised mean difference’ describes the size of the effect in standard deviations and indicates how large the effect is ‘relative to the range of scores found between the lowest and the highest ones in the study’ (Rossi *et al*, 2004, p. 304). The convention recommended for the interpretation of Cohen’s *d* values is that 0.2 is ‘small’, 0.5 is ‘medium’ and 0.8 is ‘large’ (Cohen, 1988, pp. 19-27).

**HSE:** Health Service Executive.

**Medical card holder:** Medical cards allow people to access free of charge to a range of medical services and a range of other benefits. Eligibility is based on an assessment of means.

**Non-completion:** Non-completion of Group Triple P was defined as those who completed the pre-intervention questionnaire and completed less than four sessions.

**Non-responder:** The term ‘non-responder’ for Group Triple P and Workshop Triple P was used to refer to those who completed the pre-intervention questionnaire but did not complete the post-intervention questionnaire.

**Panel 1 and Panel 2 practitioners:** Panel 1 practitioners were referred to as the Principal Programme Delivery Team and were to be comprised of 8 practitioners (representing 5.6 whole-time equivalents). Panel 2 practitioners were to be comprised of 60+ practitioners from a range of different partner organisations, each committed to the allocation of 100 hours to Triple P Programmes on an annual basis, following the successful completion of all Triple P training requirements and the attainment of Triple P accreditation.

**Participants:** Those who provided data are referred to as study participants and include parents who completed questionnaires and/or took part in interviews, practitioners who completed questionnaires, and practitioners, managers and the representatives of partner organisations who took part in interviews.

**PHN:** Public Health Nurse.

**Project Management Team:** Initially, the Project Management Team was composed of the Project Director and the Chairperson of LWPP. It was expanded in 2010 to include the Coordinator and the Researcher

**Statistical significance:** The significance criterion ( $\alpha$ ) is the standard of proof that the phenomenon exists. If the significance criterion ( $\alpha$ ) is set at .05, the conventional level of significance, this means accepting a 5% chance of wrongly rejecting the null hypothesis – i.e. in 5 times out of 100 such a finding could be obtained, but it would be as a result of chance rather than a true reflection of the situation.

