Chapter 7
The Importance of Evidence-Based Parenting Intervention to the Prevention and Treatment of Child Maltreatment

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A Public Health Approach to the Prevention and Treatment of Child Maltreatment

Preventing the maltreatment of children should be given priority as a major public health challenge. The number of official reports of child maltreatment in most Western countries continues to rise each year (Australian Institute of Health and Welfare [AIHW], 2008; U.S. Department of Health and Human Services, 2008; World Health Organisation, 2009) and there is a general lack of consensus among researchers, policy makers and support workers about the best approach to take in combating the issue. Evidence clearly indicates that maltreated children are more likely to suffer antisocial outcomes including externalising behaviours (Kotch et al., 2008; Lansford, Berlin, Bates, & Pettit, 2007; Maas, Herrenkohl, & Sousa, 2008), and internalising problems (McHolm, MacMillan, & Jamieson, 2003; Widom, 1999; Widom, Dumont, & Czaja, 2007). Of particular concern, parents account for over 70 % of all persons believed to be responsible for perpetrating the majority of substantiated cases of child maltreatment (AIHW, 2005).

This chapter makes the case that improved parenting is the cornerstone of child maltreatment treatment and prevention and strengthening parenting and family relationships across the entire population is the approach most likely to reduce the unacceptably high rate of child maltreatment. We focus on the role of parenting programs in reducing the prevalence of child maltreatment and document the steps required to achieve population-level reductions in rates of child maltreatment. A parenting intervention, known as Pathways Triple P, is used to illustrate the

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complexities of working with parents at risk of harming their children through examination of a case study. Implications for policy makers, researchers, parents and their children are discussed.

Parents and Child Maltreatment

Maltreating parents tend to differ from non-maltreating parents in their inability to cope with anger provoking situations (Rodriguez & Green, 1997). Fortunately, significant inroads have been made in the last decade towards understanding how parents' cognitive factors influence their affect and behaviour towards their children (Azar & Weinzierl, 2005; Dix, Reinhold, & Zambarano, 1990; Kolko & Swenson, 2002; Sanders et al., 2004). Much of the research has centred on various forms of maladaptive schemas, unrealistic expectations, and negative attributional bias in interpreting child behaviour and negative parenting behaviour (Grusec & Mammone, 1995; Miller & Azar, 1996; Pidgeon & Sanders, 2009; Sanders et al., 2004).

A growing body of evidence has highlighted a clear link between parents who are at-risk of maltreating their children and the extent to which they possess faulty, causal attributional processes towards their explanations of their children's problem behaviours (Milner, 2003; Pidgeon & Sanders, 2009). It is reasoned that faulty attributions indirectly contribute to child maltreatment by increasing parental anger, overactivity and use of severe discipline strategies such as threats, yelling, hitting, grabbing and pushing (Dix, Ruble, & Zambarano, 1989; Nix et al., 1999). Parental anger is also a common factor underlying the act of parents physically abusing children (Kolko, 1996; Mammen, Kolko, & Pilkonis, 2002). It stands to reason, therefore, that if efforts can be made to address parental anger and negative attributional processes then improvements in rates of child maltreatment may occur. Parenting programs that address anger and attributional style, as well as other parenting skills more broadly, hold particular promise in reducing the rates of child maltreatment.

Why Parenting Programs Are Important

The quality of parenting that children receive has a major influence on their development, wellbeing, and life opportunities. Experimental clinical research has clearly demonstrated that structured parenting programs based on social learning models are among the most efficacious and cost-effective interventions available to promote the mental health and well-being of children, particularly children at risk of being maltreated (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000; National Research Council and Institute of Medicine, 2009). Evidence available with maltreating parents suggests that parent training leads to improvements in parenting competence and parent behaviour (James, 1994; Wekerle & Wolfe, 1998). These changes in parenting practice reduce the risk of further abusive behaviour

towards children, reports to protective agencies, and visits to hospital. Beyond younger children, potentially modifiable family risk factors can also be targeted in order to reduce the rates of emotional and behavioral problems in adolescents (Dekovic, Janssens, & Van As, 2003). Although studies on parenting programs for parents of teenagers are far less extensive compared to studies with younger children (Kazdin, 2005), such programs have been demonstrated to improve parent-adolescent communication and reduce family conflict (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Dishion & Andrews, 1995), and reduce the risk of adolescents developing and maintaining substance abuse, delinquent behavior and other externalizing problems (Connell, Dishion, Yasui, & Kavanagh, 2007; Mason, Kosterman, Hawkins, Haggerty, & Spoth, 2003). Of note, parents of adolescents who participate in parenting programs have been found to report higher levels of confidence and use of more effective parenting strategies (Spoth, Redmond, & Shin, 1998).

Positive parenting programs based on social learning and cognitive-behavioral principles are the most effective in reducing problem behaviors in children and adolescents (Dretzke et al., 2009; Kazdin & Blase, 2011; Serketich & Dumas, 1996). These interventions typically provide active skills training to parents involving modeling and practice of skills, feedback, homework assignments in how to apply positive parenting (e.g., descriptive praise, incidental teaching, simple reward charts) and contingency management principles (e.g., logical consequences, non-exclusionary timeout). Different delivery formats have been successfully trialed including individual programs, small group programs, large group seminar programs, self-directed programs, telephone-assisted programs and more recently online parenting programs (see Dretzke et al., 2009; Nowak & Heinrichs, 2008; Sanders, 2012; Sanders, Baker, & Turner, 2012).

Numerous meta-analyses of parenting interventions attest to the benefits that parents and children derive (particularly children with conduct problems) when their parents learn positive parenting skills (Brestan & Eyberg, 1998; de Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008a, 2008b; Nowak & Heinrichs, 2008). These benefits include children having fewer behavioral and emotional problems, more positive interactions with their parents and siblings, improved parental practices, improved mental health, and less parental conflict.

The Triple P System of Population-Level Parenting Intervention

The Triple P-Positive Parenting Program (see Sanders, 2012) is a system of parenting support and intervention that seeks to increase parents' confidence and skill in raising their children, thereby enhancing children's developmental outcomes. Triple P adopts a public health approach to parenting support which aims to make highly reliable, evidence-based parenting support available and accessible to all parents. This multilevel system of parenting support (see Fig. 7.1) is based on a public health model that provides five levels of intervention of increasing intensity geared towards

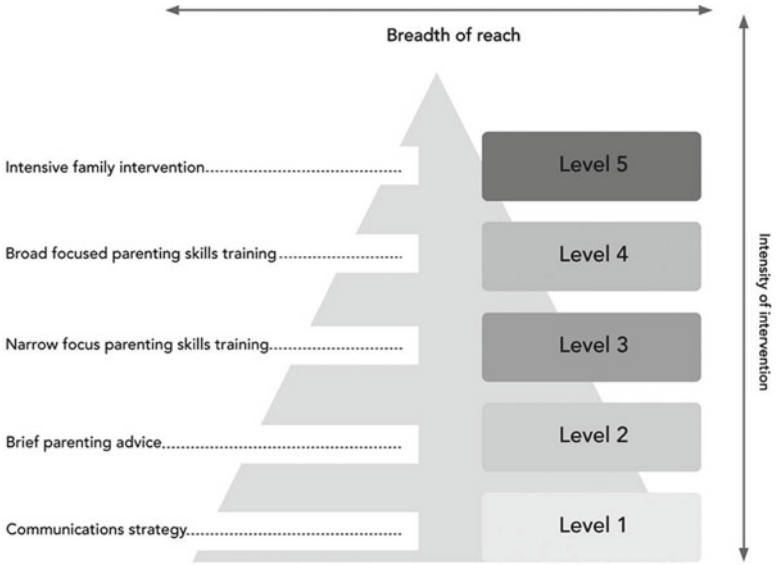

Fig. 7.1 The population multilevel, multiformat Triple P system of parenting support and intervention

normalising and destigmatizing parental participation in parenting education programs. The range of evidence-based tailored variants and flexible delivery options incorporate universal media messages for all parents (level 1), low intensity large group (level 2), topic-specific parent discussion groups and individual programs (level 3), intensive groups and individual programs (level 4), and more intense offerings for high risk or vulnerable parents (level 5). The program targets children at five different developmental stages: infants, toddlers, preschoolers, primary schoolers and teenagers. Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). Triple P targets modifiable family risk and protective factors causally implicated at the onset, and exacerbation or maintenance of adverse child development outcomes.

The rationale for Triple P's multilevel strategy is that there are differing levels of dysfunction and behavioral disturbance in children and adolescents, and parents have different needs and preferences regarding the type, intensity and mode of assistance they may require. The multilevel approach of Triple P follows the principle of selecting the 'minimally sufficient' intervention as a guiding principle to serving the needs of parents in order to maximise efficiency, contain costs, avoid over-servicing, and ensure that the program becomes widely available to parents in the community. The model avoids a one-size-fits-all approach by using evidence-based tailored variants and flexible delivery options (e.g., web, group, individual, over the phone, self-directed) targeting diverse groups of parents. The multidisciplinary nature of the program involves the utilisation of the existing professional workforce in the task of promoting competent parenting.

The Pathways Triple P-Positive Parenting Program

Pathways Triple P (PTP) is a specific variant within the larger Triple P system of intervention designed specifically for families with indicated risk factors for child abuse or neglect. When compared to other Triple P variants, the main variation of PTP is that it hones in on parental attributional and anger processes that place parents at risk of child maltreatment. Although the content of Pathways Triple P is relevant for all parents, this variant of the Triple P system has been developed as an intensive intervention program for parents who have difficulty regulating their emotions and as a result are considered at risk of physically or emotionally abusing their children. Consequently, it is viewed as an intervention for clients who are involved in the child protection system. Parents are generally referred to Pathways Triple P if the initial intake assessment and clinical interview reveal the following: (1) presence of coercive or harsh parenting or other elevated scores on standardized measures such as the Parenting Scale (Arnold, O'Leary, Wolff, & Acher, 1993) or the Parent's Attributions for Child's Behaviour Measure (Pidgeon & Sanders, 2004); (2) presence of dysfunctional attributions; (3) parent reports difficulty implementing positive parenting skills after exposure to either Group or Standard Triple P; (4) suspected or substantiated child abuse and neglect; (5) parent is literate and willing to participate.

Pathways Triple P targets the attributional processes parents have towards their child's and their own behaviour, as well as parental anger management deficits. Parents are taught a variety of skills aimed at challenging and countering their maladaptive attributions for parent-child interactions and to change any negative parenting practices they are currently using in line with these attributions. The attributional retraining strategies focus on teaching parents how to counter their misattributions regarding their child's negative behaviour, and their negative parenting behaviour towards their child. This involves teaching parents how to challenge their misattributions and generate more benign attributions regarding their child's negative behaviour and generate less anger-justifying attributions for their own negative behaviour. These sessions teach parents how to counter and alter not only their anger-intensifying attributional style for their child's behaviour, but also their anger-justifying attributions for their negative parenting behaviour.

As described in Table 7.1, the Pathways Triple P intervention is typically delivered in conjunction with Group Triple P. The PTP specific components consist of four 2-h sessions where parents participate in discussion and exercises designed to orientate them towards the factors which are placing them at risk of maltreatment. Parents are asked to identify the reasons why they can react in negative ways towards children, the impact of negative or harsh discipline practices on children, and the causes of their own negative behaviour towards their child. The exercises are also designed to teach parents how to prevent anger escalation and negative parenting practices; a process which involves teaching parents to challenge and control their anger-intensifying attributions and mistaken explanations for their child's misbehaviour. Parents are also introduced to the emotion of anger, its physical effects, and parents

Table 7.1 The pathways Triple P system of Intervention

Pathways Triple P	Group Triple P sessions			
Intake session	Session 1	Session 2	Session 3	Session 4
Provide overview of program Explain what's involved Obtain commitment Conduct intake interview Complete assessment booklet 1	Principles of positive parenting Identifying causes of child behaviour Monitoring children's behaviour Monitoring own behaviour Setting developmentally appropriate goals Setting practice tasks Self-evaluation of strengths and weaknesses Setting personal goals for change	**Parent-child relationship enhancement skills** Spending quality time Talking with children Physical affection **Encouraging desirable behaviour** Giving descriptive praise Giving non-verbal attention Providing engaging activities **Teaching new skills and behaviours** Setting a good example Using ask, say, do Using behaviour charts	**Manage misbehaviour** Establishing ground rules Using directed discussion Using planned ignoring Giving clean calm instructions Using logical consequences Using quiet time Using time-out	**Preventing problems in high-risk situations** Planning and advanced preparation Discussing ground rules for specific situations Selecting engaging activities Providing incentives Providing consequences Holding follow-up discussions

Pathways Triple P sessions				Group Triple P session
Module 1	Module 1	Module 2	Module 2	
Session 1	Session 2	Session 1	Session 2	Closure session
Parent traps Identifying parent traps Understanding impact of own behaviour on children Identifying dysfunctional attributions	**How to get out of a parent trap** Understanding the reasons parents get caught in parent traps Thought switching Breaking out of a parent trap	**Understanding anger** Recognising and understanding anger Stopping anger from escalating Abdominal breathing and relaxation techniques Planning pleasurable activities	**Coping with anger** Catching unhelpful thoughts Developing personal anger coping statements Challenging unhelpful thoughts Developing coping plans for high risk situations	Family survival tips Phasing out the program Strategies for maintaining change Problem solving for the future Future goals Complete assessment booklet 2

are provided with a variety of techniques and strategies for becoming physically and mentally relaxed. Parents are also introduced to cognitive therapy concepts as they apply to anger management, which includes catching unhelpful thoughts, developing alternative coping statements in arousing situations, and challenging thoughts that lead to aggressive responses. Identifying high-risk anger situations and developing coping plans to manage anger in these situations are also covered.

Parents receive a copy of two workbooks, *Avoiding Parent Traps, and Coping with Anger*, which outline the principles taught in the two modules (focusing on the risk factors countering parents' misattributions for parent-child interactions and anger management). These parent workbooks have been published together with the existing practitioner's workbook (see Pidgeon & Sanders, 2005; Sanders & Pidgeon, 2005).

Evidence for Pathways Triple P

Several studies have demonstrated the effectiveness of Pathways Triple P in improving parenting practices and reducing the risk of child maltreatment. Sanders et al. (2004) randomly assigned 98 parents experiencing significant difficulties in managing their own anger in their interactions with their preschool-aged children to either Pathways Triple P which included attributional retraining, or a standard version of Triple P that provided training in parenting skills alone. At post-intervention, both conditions were associated with lower levels of observed and parent-reported disruptive child behaviour, lower levels of parent-reported dysfunctional parenting, greater parental self-efficacy, less parental distress, relationship conflict and similarly high levels of consumer satisfaction. Whereas the Pathways intervention showed a significantly greater short-term improvement on measures of negative parental attributions for children's misbehaviour, potential for child abuse and unrealistic parental expectation, at 6-month follow-up both conditions showed similarly positive outcomes on all measures of child abuse potential, parent practices, parental adjustment, and child behaviour and adjustment. Importantly, the Pathways intervention resulted in sustained and greater change in negative parental attributions.

In further support of the efficacy of the Pathways intervention, Wiggins, Sofronoff, and Sanders (2009) examined the effects of Pathways Triple P on parents who met the inclusion criteria of borderline to clinically significant relationship disturbance and child emotional and behavioural problems. Participants were randomly allocated into either an intervention or wait-list control group. The intervention was delivered in a group format for 9 weeks and consisted of parent skills training and cognitive behaviour therapy targeting negative attributions for child behaviour. Participants in the Pathways condition reported significantly greater improvement in parent-child relationship quality from pre- to post-intervention compared to participants in the control group with benefits maintained at 3-month follow-up. Participants in the intervention condition also reported a significant

reduction in the use of dysfunctional parenting practices (laxness, verbosity and over-reactivity), blameworthy and intentional attributions for child behaviour and child externalising behaviour problems from pre- to post-intervention with reductions maintained at 3-month follow-up.

In a ground breaking study, Prinz, Sanders, Shapiro, Whitaker, and Lutzker (2009) examined the value of a public health approach to the prevention of child maltreatment in what was known as the US Triple P system population trial. Eighteen counties in South Carolina were randomly assigned to receive either the Triple P system or services-as-usual. Professional training for an existing workforce (over 600 service providers) in the Triple P counties was provided, and universal media and communication strategies pertaining to positive parenting were deployed via local newspapers, radio, school newsletters, mass mailings to family households, publicity at community events, and website information. These strategies implementing the system's universal facet are intended to destigmatize parenting and family support, make effective parenting strategies readily accessible to all parents, and facilitate help-seeking by parents who need higher intensity intervention.

Large improvements in the Triple P counties were found in three measured outcomes: substantiated child maltreatment, child out-of home placements, and child maltreatment injuries. The findings came from three separate sources: the Child Protective Services, the foster care system, and the hospital system respectively. This study is the first to randomize geographical areas and show the preventive impact of evidence-based parenting interventions on child maltreatment at a population level. This population trial demonstrated that offering parenting and family support via a broad system like Triple P, without singling out parents because of risk characteristics, could actually help prevent maltreatment and related problems.

The cumulative evidence clearly supports the efficacy and robustness of a tailored intervention for parents at risk of harming their children. However, the limited reach of most parenting programs ensures that these programs make little impact on prevalence rates of social and emotional problems of children and child maltreatment at a population level. The limited impact of available parenting interventions on children's problems at a population level underpins the need for implementation of Triple P as a public health system of parenting support and intervention (Sanders, 2012; Sanders & Murphy-Brennan, 2010).

The Implementation of Pathways Triple P Within the Child Welfare System

Pathways Triple P is applicable and relevant to the child welfare system services in several ways, including: (a) prevention of child maltreatment; (b) prevention of children's social, emotional, and behavioural problems; (c) family-based treatment of children's mental health problems for those who have endured abuse or neglect; (d) strengthening the parenting competence and confidence of foster parents; (e) treating parents who have maltreated their children or are at high risk of doing so; and

(f) assisting parents who seek voluntary services after having been referred for suspected maltreatment that did not rise to the level of substantiation or mandatory action. Although existing evidence supports the fit and acceptability of Pathways Triple P within the child welfare system (Petra & Kohl, 2010), an effective parenting support strategy needs to address two significant challenges within a robust implementation framework in order to succeed.

First, parenting interventions need to be delivered in a nonstigmatizing way. Currently, parenting interventions are perceived by many vulnerable/at risk parents as being for inadequate, ignorant, failed or wayward parents. To be effective, a whole-of-population approach to parenting support has to emphasise the universal relevance of parenting assistance so that the larger community of parents embraces and supports parents being involved in parenting programs. A nonstigmatized example is found in prenatal (birth) classes, which parents across a broad array of economic and cultural groups (and family configurations) find useful and do not perceive as stigmatizing.

Second, parenting support needs to be flexible with respect to delivery formats (e.g., group, individual, online) to meet the needs of parents in the child welfare system. Having every family receive an intensive intervention at a single location is not only cost ineffective but also unnecessary and undesirable from a family's perspective. Foster, Prinz, Sanders, and Shapiro (2008) estimated that the infrastructure costs associated with the implementation of the Triple P system in the US was $12 per participant, a cost that could be recovered in a single year by as little as a 10 % reduction in the rate of abuse and neglect. Flexibility would also make the intervention useful for mandated services, parenting support for foster and adoptive parents, and support for families within the child welfare system who are not involved with child protective services.

Case Study: James Family

Referral problem: The James family was referred to the first author to participate in Pathways Triple P by a social worker because of ongoing concerns regarding the parents' management of their son's uncooperative and aggressive behaviour. Ryan (aged 7 years) was the eldest child of Jane (36 years) and Edan (40 years). He also had a younger sister Amy (aged 5 years). On presentation, Jane described a recurring pattern of defiant, uncooperative, and aggressive behaviour that often (daily) escalated daily into physical aggression (pushing and punching) and verbal abuse (mainly threats of harm) towards his younger sister Amy. These conflicts usually occurred as a result of Amy trying to have a turn at using the family computer, game or to watch a specific TV program.

The social worker was particularly concerned about the father's coercive and ineffective methods of managing Ryan's behaviours and thought a parenting program may assist and prevent further involvement of the child protection system. Jane reported frequent (three to four times weekly) heated conflict between Ryan and his

father in which the father used a variety of coercive tactics to get Ryan to cooperate. These behaviours included using verbal and gestural threats of physical punishment (closed fist), occasional episodes of severe physical publishment (grabbing around the throats, hitting Ryan with a leather strap), verbal abuse involving putdowns (*stupid, idiot*), and attempts to shame and humiliate Ryan in front of neighbours and his school friends (*You're such a girl. Not such a tough guy now are you?*). The father's conflict with Ryan often resulted in disagreements between the parents that escalated to shouting as Jane tried to become the peace maker and get Edan to calm down and to stop shouting at Ryan.

Relevant history and assessment: An intake interview with both parents and separately with the two children revealed that Edan had been a sergeant-major in the army and had become used to army style discipline since age 18. He expected his own kids to obey his commands immediately without question. He reported having a father who was a bully and unloving who used the belt to get his four brothers and himself to cooperate. Both parents agreed that their current methods of dealing with Ryan's behaviour were not working but were at a loss to know what else to do. Resistance was minimal and rapport was quickly established with the couple.

The clinical assessment comprised both parents completing a routine assessment package recommended for use in the delivery of Pathways Triple P (Sanders & Pidgeon, 2005) involving a selection of standardised measures and a structured within clinic family observation session involving both parents, as well as an interview with both Ryan and Amy. The observation tasks involved a free play activity (5 min), a joint parent and child task (5 min), a parent busy task (2 min), and a tidy away task (5 min). These tasks aimed to capture everyday family activities that could lead to conflict.

The assessment revealed a number of factors potentially contributing to the development or maintenance of Ryan's disruptive behaviour, including accidental rewards for misbehaviour (via attention), using vague, repetitive instructions, voice escalation by the father in particular during tidy up task, and a lack of positive engagement or attention for cooperative behaviour. The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) revealed that Ryan scored in the clinically elevated range on both the intensity and frequency subscales. Out of a possible 36 problem behaviours, 28 were seen as problems by Edan and 24 by Jane. On the Parenting Scale (PS; Arnold et al., 1993) Edan scored in the clinically elevated range for both overreactivity and verbosity and Jane for laxness and verbosity. These findings confirmed verbal reports and observational data showing that both parents had a dysfunctional parenting style. On the Parent Problem Checklist (PPC; Dadds & Powell, 1991) both Ryan and Jane's responses revealed frequent disagreement and arguing about parenting and discipline issues although on the Relationship Quality Index (RQI; Norton, 1983) there was a relatively high level of marital satisfaction.

On the measure of Parents Attributions for Misbehaviour (PACBM; Pidgeon & Sanders, 2004), Edan had a strong negative attributional style that supported quite punitive methods of discipline. Specifically he tended to blame Ryan for his misbehaviour and his attributions tended to be stable and negative. Jane's responses on the PACBM were in the nonclinical range. On the Parental Anger Inventory

(PAI, Hansen & Sedlar, 1998) Edan scored in the clinically elevated range on both the problem and intensity scale. Other notable findings were that both Edan and Jane were clinically elevated on the measures of depression and stress on the Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995).

In summary, it was hypothesised that Ryan's conduct problem occurred in a context of significant family conflict and disharmony where the father's inadequate and highly coercive attempts to discipline Ryan were being maintained by an irrational belief system and family history that supported his use of corporal punishment and retribution, and intermittent success in stopping Ryan's aggressive behaviour. The father's attempts to deal with Ryan lead to frequent conflict with Jane. Jane's consequent compensatory behaviour resulted in inconsistent follow through. Edan had considerable anger management problems, and quite high stress likely resulting from a long history of living with family conflict. Of note, Edan reported considerable parent conflict in his family of origin. Both parents were somewhat depressed and overwhelmed by their struggles in dealing with problems parenting their children. But despite this conflict, both parents reported satisfaction with their marital relationship. This type of family with the combination of coercive parenting difficulties, attributional bias, and anger management problems, was deemed highly suitable for the Pathways Triple P intervention.

Description of the Intervention: Jane and Edan agreed to participate in Group Pathways Triple P with eight other parents. Jane and Edan were the only married couple (all other parents were a mixed gender group of lone parents). Six mothers and two fathers. As per Fig. 7.1, all parents were required to attend the four Group Triple P sessions where they were introduced to the 17 core positive parenting skills, and also to attend the four PTP sessions covering attribution retraining and anger management. The specific session content is described in Table 7.1. The group program made use of a mixture of brief didactic presentations of core content, group discussions, viewing DVD video demonstrations of specific positive parenting skills, role plays to practise specific skills taught and the setting of between session homework assignments.

Using a self-regulation framework each parent was asked to set their own goals and determine which of the skills introduced in the session were particularly relevant and meaningful to them. These goals were revised periodically throughout the intervention as new content was introduced. After the initial session, Edan's goals were to: (1) reduce the number of times per week he shouted at Ryan; (2) reduce the number of days that he lost his temper with anyone in the family; and (3) work with Jane to develop a parenting plan both could use in dealing with Ryan's disobedience and aggressive behaviour. From the initial session Edan realised the current situation was not working and he wanted to try a different way of dealing with the problem. Jane's goals were to: (1) stop criticising Edan for his poor parenting; (2) spend more positive time with Ryan; and (3) try to be more consistent in dealing with Ryan's aggression. After the intake interview Jane had realised that stepping in and rescuing Ryan from his father's anger was leading to very inconsistent ways of dealing with the problem and that they needed to work as a team.

Table 7.2 Evaluation of intervention outcomes[a]

Measures	Jane			Moved to normal range?	Edan			Moved to normal range?
	Time 1	Time 2	Time 3		Time 1	Time 2	Time 3	
ECBI intensity	**145**	112	114	Y	**152**	121	115	Y
ECBI problem	**26**	6	7	Y	**24**	12	8	Y
PS laxness	**3.2**	2.9	2.8	Y	**3.0**	2.8	2.4	Y
PS overreactivity	**3.8**	2.3	2.3	Y	**4.4**	3.0	2.8	Y
PS verbosity	3.0	2.5	2.4	N	**3.9**	3.3	3.2	N
PPC problem	**7.0**	5.0	4.0	Y	**8.0**	4.0	2.0	Y
PPC extent	**5.6**	3.4	3.0	Y	**6.1**	3.0	2.8	Y
PACBM	2.8	2.6	2.1	N	**4.2**	3.2	2.8	Y
DASS depression	**22**	14	9	Y	**18**	8	6	Y
DASS anxiety	6.0	6.0	5.0	N	7.0	7.0	5.0	N
DASS stress	**26**	15	15	Y	**24**	18	7	Y

[a]Bold indicates the score was in the clinical range at pre intervention

Table 7.2 shows the effects of the Pathways Triple P intervention on each scale. Inspection of Table 7.2 indicates that Jane's scores moved into the normal range on both subscales of the ECBI (Intensity and Problem); the Laxness and Overreactivity subscales of the Parenting Scale; both subscales of the Parent Problem Checklist (Problem and Extent); and each of the subscales of the DASS except for the Anxiety subscale. As for Edan, Table 7.2 indicates that he moved from the clinical to the nonclinical range in all outcome measures except for the Verbosity subscale of the PS, and the Anxiety subscale of the DASS. Overall, therefore, the intervention was very successful for both parents. The main findings were that both Edan and Jane developed a calmer, less explosive way of dealing with Ryan's misbehaviour. This in turn prevented conflict escalation with the mother and considerably reduced the level of conduct problems in Ryan. There were three critical moments during the intervention that were identified as major transition points. The first occurred prior to the first group session when the father realised that the approach he was using simply was not working. Prior to this he had not really confronted the issue of whether his parenting strategies actually worked in teaching Ryan to control his behaviour. The second transition point occurred in session one when the parents participated in an exercise that involved viewing video clips depicting possible reasons for a child behaviour problem (Exercise on *Causes of Misbehaviour*). There were three examples of parenting practices that Edan particularly related to (escalation traps, lack of attention for desired behaviour, and conflict between parents). The third transition point occurred in the first module of Pathways in the Module on *Avoiding Parent Traps*. It was a major insight to Edan when he recognised these traps were self-defeating and perpetuating the problem. Edan also found the last two sessions on anger management useful, but mainly to consolidate what he had already learned. By that stage, he had become much better at giving clear, calm instructions to Ryan and had learned to back up with more effective consequences (not threatening). He rarely became angry anymore. The first exercise in the

Avoiding Parent Traps module requires the parent to identify whether they are in any self-defeating parent traps. Edan recognised he was in two such traps: the *YOU'RE DOING IT ON PURPOSE* trap and the *YOU MADE ME DO IT* trap. This exercise involved sessions of attribution retraining. By the conclusion of the Pathways Triple P intervention, Edan's learning of positive parenting skills, and in particular the use of quiet time and time-out, enabled him to provide consistent consequences more calmly for behaviour he did not like, without the abusive escalation evident prior to the intervention. If the situation had not improved, or was making gradual improvements, one of three possibilities would have been considered: (1) Continue same treatment if progress is being made with extra sessions; (2) Explore reasons for non-response and address with other modules within the Enhanced Triple P suite of intervention (e.g., partner support, coping skills, more home feedback/coaching); or (3) Consider referral to specialist mental health service for child, parent, or both. In the current case, no such additional action was required and the intervention was associated with high levels of consumer satisfaction.

Conclusions and Implications

There is considerable scope for parenting interventions to improve children's developmental outcomes for any mental health, physical health, or social problem where potentially modifiable parenting and family variables have been causally implicated in the onset, maintenance, exacerbation or relapse of a problem. However, despite the weight of evidence indicating that parenting programs are among the most efficacious and cost-effective interventions available to promote the mental health and wellbeing of children and adolescents (Biglan, Flay, Embry, & Sandler, 2012), the majority of families who might benefit do not participate in parenting programs. The Triple P system adopted a public health approach to the delivery of universal parenting support with the goal of increasing parental self-efficacy, knowledge and competence in the use of skills that promote positive development in children and adolescents. This change in focus has enabled millions more children around the world to experience the benefits of positive parenting and family environments that promote healthy development and as a consequence fewer children have developed behavioral and emotional problems or episodes of maltreatment.

When parents are empowered with the tools for personal change they require to parent their children positively, the resulting benefits for children, parents and the community at large are immense. The Triple P system is the only parenting program shown to reduce the population level prevalence of child maltreatment. If fully implemented as a public health whole of community initiative it would reduce the level of child maltreatment. Effective dissemination needs to be based on a public health compatible system of interventions. Parents and service providers need intervention systems such as Triple P that transport readily from one setting to another, to better address the needs of children and families who touch the child welfare system.

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