Parenting support for every parent

A population-level evaluation of Triple P in Longford | Westmeath 2010-2013

Full report

United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Children, Youth and Civic Engagement
Ireland
CHILD AND FAMILY RESEARCH CENTRE

Parenting support for every parent:
A population-level evaluation of Triple P in Longford and Westmeath

FINAL REPORT

Prepared by the Triple P Evaluation Team
UNESCO Child and Family Research Centre
National University of Ireland, Galway

June 2014

NUI Galway
OÉ Gaillimh

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- Dr. Andrea Gibbons

About the UNESCO Child and Family Research Centre

The UNESCO Child and Family Research Centre (CFRC) at the National University of Ireland, Galway was established in 2001 as a policy unit and expanded into a Centre, launched by President McAleese, in 2007. The CFRC is a partnership between the Health Service Executive (HSE) and NUI Galway. In 2008, it was awarded the first UNESCO Chair for the Republic of Ireland on the theme of 'Children, Youth and Civic Engagement'. It is widely recognised as being at the forefront of research, education and training in Family Support theory and practice. It engages in research, evaluation and service design relating to practice, policy and interventions in the lives of children. All research undertaken by the CFRC is strongly connected to applied work for children and families, and relevant to a broad range of stakeholders, including service users, policy-makers, politicians, service managers and front-line staff.

The CFRC is strongly concerned with best practice and engaged in the evaluation and delivery of interventions that are altering child welfare services and the market for research on children in Ireland. Through its partnership with the HSE, the CFRC is at the heart of policy, research and evaluation activities that inform the delivery system for child health and welfare, and is engaged in a range of assessments of new and internationally tested interventions and initiatives aimed at targeting social and economic disadvantage among children and families. The CFRC has expanded in response to need in the practice world and is closely aligned with the Atlantic Philanthropies' programme of investment in sites and services to improve outcomes for children in Ireland in the domains of physical and mental health, education and community connectedness.

Across all its teaching, research and education activities, the CFRC's strong links to practice and expertise in the training and support of professionals engaged in service delivery has considerable value for the project proposed. Much of the CFRC's current portfolio of contracted work involves assisting services in designing interventions that are needs-based, flexible, accessible and delivered in partnership. In particular, the CFRC has extensive research and evaluation experience with complex community initiatives involving a broad range of stakeholders and agencies.

For further information, please see www.childandfamilyresearch.ie

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The Research Team would like to thank the participating parents in this study, without whom this evaluation would not have been possible. It would also like to acknowledge and thank the practitioners who participated in the study as well as the partner representatives. Finally, thanks are due to the Project Management Team of the Longford Westmeath Parenting Partnership (LWPP) for their help and assistance throughout, including with respect to research design, protocols and application for ethical approval.

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.

Archways facilitated LWPP as its fiscal agent, offering implementation advice, and was also a member of the EAC.

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).

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. Practitioners (Panel 1) 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.

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). As the study was a pre-test – post-test within-groups design, effect sizes were calculated by dividing the mean difference between the samples by the standard error of the mean (or the standard error of the differences). An important consideration is what impact the relative power of a repeated-measures design has on effect size calculation. Using the same participants across two time points reduces the error variance and increases the power of the analysis. Therefore, larger effect sizes will be reported from a repeated-measures design than from a between-groups design (whether a quasi-experimental or experimental design) even when the relevant means in the two study designs are the same (Field, 2009, p. 342). This is an important consideration when comparing the effect sizes reported here with effect sizes reported from controlled studies, and also the effect sizes for the Population Study.

HSE: Health Service Executive.

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' is used to refer to study participants in the evaluation of Group Triple P or Workshop Triple P 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 delivery of a minimum of two 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 in the study are referred to as study participants and include parents who completed questionnaires, parents who 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 (*see 'Core Team' above*).

Statistical significance: The significance criterion (α) is the standard of proof that the phenomenon exists. If the significance criterion (α) 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.

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1. Introduction

1.1 Purpose, methodology and objectives

The Triple P – Positive Parenting Programme (called hereafter 'Triple P') is a multi-level public health approach to parenting. It was implemented in the Longford Westmeath region by a partnership comprising nine organisations, the Longford Westmeath Parenting Partnership (LWPP). 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 targeting the entire population to promote positive parenting and increase receptivity to parenting programmes.
- **Level 2 – Triple P Seminars:** A series of 3 individual 90-minute presentations.
- **Level 3 – Workshop Triple P:** A series of 4 individual 2-hour workshops.
- **Level 4 – Group Triple P:** An 8-week programme, including 5 group sessions, each of 2 hours, and 3 one-to-one telephone sessions.

This is the final report in the evaluation of the implementation of Triple P in Longford Westmeath. The evaluation was a multi-method, multi-stranded study with 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.

Data were collected from February 2010 to May 2013 as part of the Population Study; from September 2010 to December 2012 as part of the Parenting Study; from May 2011 to May 2013 as part of the Partnership Study; and from May 2011 to June 2013 as part of the Implementation Study. Documentary data from years preceding the evaluation period were also analysed.

The Evaluation Team at the National University of Ireland, Galway was selected through competitive tender.

The objectives of the evaluation were to address the following research questions:

1. What was the prevalence of need in the intervention counties?
2. What gains were made by programme participants for parent and child outcomes?
3. Was the Triple P Programme effective in reducing child behavioural and emotional problems and negative parental strategies, experiences and opinions?
4. How successful was the use of a partnership approach to implement an evidence-based programme using a population approach?
5. To what extent did programme delivery attain required objectives and what obstacles/barriers to implementation of the programme can be identified?

6. Has the partnership succeeded in its objective to utilise what is learned from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes to other counties?
7. To what extent has the partnership succeeded in attaining its aims and objectives?

1.2 Structure of report

This report is structured as follows:

- *Chapter 2* outlines the context for the programme and presents the literature on evidence-based parenting programmes and policy, as well as the literature on programme impacts and programme implementation.
- *Chapter 3* provides an overview of the Longford Westmeath Parenting Partnership and the Triple P – Positive Parenting Programme. It describes the programme's principles and implementation and also discusses the target population.

There are four separate chapters on 'Findings', one for each of the four components of the evaluation:

- *Chapter 4:* **Findings from Parenting Study**
  Data were collected from parents who participated in Level 2 Seminars, and pre-intervention, post-intervention and follow-up data were collected from parents who participated in Level 3 Workshops and Level 4 Groups. This chapter reports on the profile of participating parents and the changes between pre- and post-intervention, and between pre-intervention and follow-up, for child emotional and behavioural problems and parenting strategies, experiences and opinions. The following research questions are addressed:
  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?
  5. Was there any difference in the outcomes achieved between those who completed only one component of the programme and those who completed more than one component of the programme?
- *Chapter 5:* **Findings from Population Study**
  The Population Study adopted a quasi-experimental design. There was a comparison and an intervention study condition, but allocation to study condition was not random. This chapter reports on pre-test survey data collected in Spring 2010 (Time 1) and post-test survey data collected in Spring 2013 (Time 2) from two comparison counties and the two intervention counties. The following research questions are addressed:
  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?
- *Chapter 6:* **Findings from Partnership Study**
  Interviews with representatives from the partner organisations were conducted at four time points and were complemented with documentary data collection. The research questions concerned three phases of partnership working: getting started, delivery, and measuring and reviewing progress. The following research questions are addressed:
  1. Getting started – How successful was the use of a partnership approach to implement an evidence-based programme using a population approach?
  2. Delivery – Has the partnership succeeded in its objective to promote and support the delivery of evidence-based parenting knowledge and skills to the population of Longford Westmeath?

3. Measuring and reviewing progress – Has the partnership succeeded in its objective to utilise what is learned from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes to other counties?

- ***Chapter 7:*** **Findings from Implementation Study**
  In the Implementation Study, focus groups were held with parents and practitioners, a questionnaire was completed by practitioners at two time points, interviews were held with the Core Team, and programme documents were analysed. The following research questions are addressed:
  1. What was the nature and extent of programme take-up (i.e. programme utilisation)?
  2. How well was the programme planned, organised and delivered, and to what extent was the programme implemented in line with the model as specified (i.e. programme organisation and programme fidelity)?

The report concludes with:

- ***Chapter 9:*** **Discussion,** in which the answers to each of the research questions are discussed in light of the relevant literature.
- ***Chapter 10:*** **Conclusions,** in which the extent to which the partnership has succeeded in attaining its aims and objectives is analysed. In addition, the implications of the findings for practice and policy are presented.
- A list of ***References*** that informed the research and a number of ***Appendices*** detailing analyses of the data for each of the four studies in the evaluation, as well as pertinent documents on the partnership arrangements.

2. Context

This chapter presents the literature on evidence-based parenting programmes and policy, as well as the literature on programme impacts and programme implementation.

2.1 Evidence-based parenting programmes and policy

In its grant proposal to The Atlantic Philanthropies, the public policy context for the Triple P Programme was outlined. It noted the commitments under the National Children's Strategy, *Our Children – Their Lives*, to make quality parenting programmes available to all parents and for programmes to focus on alternatives to physical punishment (Department of Health and Children, 2000). In its grant proposal, the Longford Westmeath Parenting Partnership (LWPP) drew attention to the strategy's commitment to improving the quality of children's lives through the integrated delivery of services in partnership with children, young people, their families and their communities. The commitment was also both evidence-based and outcomes-focused.

LWPP's grant proposal also noted *Best Health for Children – Developing a Partnership with Families*, which was commissioned by the Health Service Executive (HSE) and published in 1999. It proposed a programme for child health surveillance and a corresponding training programme for doctors and public health nurses. In 2004, these recommendations were reviewed, resulting in an updating of *Best Health for Children*. The revised strategy emphasised the importance of determinants of child health and the need to work in partnership with parents. It also insisted on the necessity of standardised tools, equipment and facilities to ensure service delivery was both equitable and consistent. The *Investing in Parenthood* strategy document, produced by Best Health for Children (2002), called for the following as part of a strategic approach to support parents:

- universal and targeted supports for parents;
- multi-agency and cross-departmental working;
- people-centred and community development approaches;
- promotion of children's rights.

Children's Services Committees (CSCs) arose as a commitment under *Towards 2016* and the *National Children's Strategy*, and the Longford Westmeath CSC was to be fully functional by the end of 2009. Its objectives are to develop strong cross-agency working relationships, to secure support for joint implementation of policies that require interagency support, and to maximise the integration of service delivery at the local level.

The present study evaluates the implementation of an evidence-based parenting programme adopting a population approach. When a public health or population approach is adopted, both universal and targeted supports are provided with the aim of changing the ecological context for parenting. It is argued that social and environmental factors can be used to facilitate or influence behaviour and to change attitudes (Cohen *et al,* 2000), including to de-stigmatise parental education and increase social and emotional support for parents (Sanders, 1999). A key consideration in the evaluation of a public health parenting programme is the remit of the relevant statutory agencies for such a programme.

In the Irish context, with the establishment of Tusla, Child and Family Agency in 2014, services for children and families became the sole focus of a single dedicated statutory agency. The stated aims of the Agency are to improve outcomes for children and families and also to take an evidence-based approach to parenting and family support programmes (Gillen *et al,* 2013a; Devaney *et al,* 2013). The rationale for supporting families adopted by the Agency is as follows: it leads to better outcomes for children, prevents difficulties

emerging, enhances family functioning, and helps realise children's rights (Gillen *et al,* 2013b). A further aspect of the Agency's family support approach is the integration of programmes through a combination of statutory, voluntary, community and private services (Gillen *et al,* 2013b, p. 9). This fits with long-standing objectives of adopting a multi-agency and cross-departmental approach to parenting, in particular *Investing in Parenthood* (Best Health for Children, 2002), and the objectives of Children's Services Committees (Statham, 2011).

Within the Department of Health, the two sectors of greatest relevance for the governance of parenting programmes such as Triple P are the Health and Wellbeing Division and the Primary, Community and Continuing Care Services Directorate.

As a population or public health approach, Triple P is relevant to the Health and Wellbeing Division created by the Department of Health in 2013. The Division is responsible for implementing *Healthy Ireland*, Ireland's first population health framework (Department of Health, 2013). *Healthy Ireland* is described by the Department of Health as a framework for action to improve the health and well-being of people living in Ireland. Its goals include the reduction of health inequalities and to increase the proportion of people who are healthy at all stages of life. It also includes an emphasis on mental health, including depression and anxiety.

The Primary, Community and Continuing Care Services (PCCC) Directorate has responsibility for the provision of health and personal social services available in the community. The commitments of the PCCC include a 'partnership approach between individuals, families, communities and a range of providers, agencies and organisations to ensure the delivery of person-centred, needs led integrated services' (Department of Health, 2006, p. 20). The services that PCCC has responsibility for and which are directly relevant to Triple P include Primary and Community Care Services (including community nursing), Mental Health Services (including Child and Adolescent Psychiatry and Old Age Psychiatry), Social Inclusion Services (including Homeless, Ethnic Minorities, Travellers and Addiction Services), and Services for Persons with Disabilities.

2.2 Programme impact and Triple P

The literature includes numerous studies on the evidence base for Triple P. A summary of relevant literature is presented in Table 2.1. A recent meta-analysis of 101 Triple P studies reported 'medium' effect sizes for parenting and child outcomes (Parenting and Family Support Centre, 2013). In Brisbane, Workshop Triple P led to 'large' impacts 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).

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 of *Lifestart* is underway, a programme for parents of children aged up to 5 years; and a qualitative study suggested positive outcomes for parenting confidence from *the Marte Meo Method*, which aims to enhance constructive communication for the child and family. In addition, 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). A programme currently implemented in Ireland for socially disadvantaged parents-to-be and parents of pre-school children, *Surestart*, was evaluated in the UK and there were significant impacts on parenting discipline and life satisfaction (Devaney *et al,* 2013).

Table 2.1: Summary of literature on programme impact

Author	Sample size (n)	Programme	Study design	Area of analysis	Programme impacts
Sanders et al, 2005	n=48	Triple P (Brisbane)	Within-groups pre-test–post-test	Group Triple P	Dysfunctional parenting Child behaviour problems Parental mental health, marital adjustment and child rearing conflict
Sanders *et al,* 2008	n=2,999 (T1) n=3,004 (T2)	Triple P (Brisbane)	Quasi-experimental matched two-group design	Population study (Levels 1, 2, 3, 4)	SDQ emotional SDQ Total Parental depression, stress Appropriate and inappropriate parenting
Turner and Sanders, 2006	n=30	Triple P (Brisbane)	Wait list control trial	Primary Care Triple P	Child behaviour problems Dysfunctional parenting Parental anxiety and stress Effects largely maintained at 6 months
Zubrick *et al,* 2005	n=1,610	Triple P (Western Australia)	Quasi-experimental two-group design T2 = 9 weeks T3 = 12 months T4 = 24 months	Group Triple P	Dysfunctional parenting Child behaviour problems Parental mental health, marital adjustment and child rearing conflict
Prinz *et al,* 2009	n=3,639 (T1) n=3,680 (T2)	Triple P (South Carolina)	Clustered RCT 2 year post-test	Population study (Levels 1, 2, 3, 4, 5)	Substantiated child maltreatment Child out-of-home placements Child maltreatment injuries
Morawska *et al,* 2010	n=67	Triple P (Brisbane)	Wait list RCT	Workshop (2-hour discussion group) 'Dealing with disobedience'	Child behaviour problems Use of dysfunctional parenting Parental self-efficacy Parenting experience
Joachim *et al,* 2010	n=46	Triple P (Brisbane)	Wait list RCT	Workshop (2-hour discussion group) 'Hassle free shopping'	Child behaviour problems Dysfunctional parenting styles Parents' confidence in the parenting role
Little *et al,* 2012	n=146	Triple P (Birmingham)	RCT 6 month post-test	Group Triple P Children with potential emotional or behavioural disorder	No statistically significant impacts

2.3 Programme implementation and Triple P

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). To successfully implement Triple P requires the recruitment of parents and also the identification, engagement, training and support of a population of providers (Shapiro *et al,* 2010). The literature highlights a number of key challenges for Triple P implementation (*see Table 2.2*). 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 staff are both confident as Triple P practitioners 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 since the programme may do a 'disservice' if there is significant programme 'drift' (Sanders and Prinz, 2008, pp. 131-32).

A partnership approach was adopted in the implementation of Triple P. One challenge to a partnership approach is that professionals can have a different mode of understanding and intervening in the world (Frost, 2005) and conflicting professional ideologies can occur due to subtle but significant differences in professional culture, linguistic conventions and ethical practices (Johnson *et al*, 2003; Horwath and Morrison, 2007). Also, partners should be aware of what is expected of them and roles and responsibilities have to be clearly identified (Duggan and Corrigan, 2009; Williams Torres and Margolin, 2003). However, ensuring that all partners contribute what is expected of them is a common challenge of partnerships and interagency working can be hindered by an insufficient commitment from services and staff to work together (Valentine *et al*, 2006). Also perceived differences in status and power among agencies can hinder relationships (Milbourne, 2005).

Table 2.2: Summary of literature on programme implementation

Author	Programme	Study design	Area of analysis	Main findings
Shapiro *et al,* 2010	Triple P (US)	Process study	Provider engagement in delivery	Five lessons on programme implementation
Prinz and Sanders, 2007	Triple P (US)	Process study	Stakeholder engagement, recruitment of practitioners, organisational factors, use of media	Need for a population-based approach Adequate office resources
Asgary-Eden and Lee, 2011	Triple P	Process study	Variables that effected implementation	Positive agency characteristics (organisational climate)

3. Longford Westmeath Parenting Partnership and Triple P

In this chapter an overview is provided of the Longford Westmeath Parenting Partnership (LWPP) and the Triple P Programme.

3.1 Operational model for LWPP

The Longford Westmeath Parenting Partnership (LWPP) comprises 9 statutory and non-statutory organisations (*see Table 3.1*). Its purpose is to deliver evidence-based parenting knowledge and skills to the population of Longford Westmeath and to prioritise the delivery of Triple P in the first instance.

Table 3.1: 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

3.1.1 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. **Practitioners** (Panel 1) 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.

3.1.2 Panel 1 and Panel 2

The LWPP 'operational model' also identified two panels of practitioners. Panel 1, the Principal Programme Delivery Team, was to be comprised of 8 practitioners (representing 5.6 whole-time equivalents). Their functions were to:

- deliver the Triple P Programme to parents in Longford and Westmeath;
- support the Core Team to deliver Triple P fidelity training to all members of Panel 2;
- ensure that the fidelity requirements of the programme were maintained at all times;

- contribute to the promotion of Triple P throughout Longford Westmeath;
- interact with key stakeholder groups at local and regional level;
- provide peer-to-peer support to members of Panel 2.

Panel 2 was comprised of 60+ practitioners from a range of partner organisations. Their roles were to deliver Triple P and also to promote Triple P among key stakeholders and organisations.

3.1.3 Logic model

The LWPP Logic Model for the implementation of Triple P in Longford Westmeath is presented in Figure 3.1. It includes a number of inputs, outputs, and short-, medium, and long-term outcomes. The evaluation of the implementation of Triple P will address 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 (these issues are covered in Chapter 6 on the Partnership Study and in Chapter 7 on the Implementation Study), as well as in attaining the intended outcomes for children and parents (these issues are covered in Chapter 4 on the Parenting Study and in Chapter 5 on the Population Study).

3.2 Memorandum of Understanding

From the outset, 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 mediation. The MoU is presented in full in Appendix C.4; its main elements are presented below.

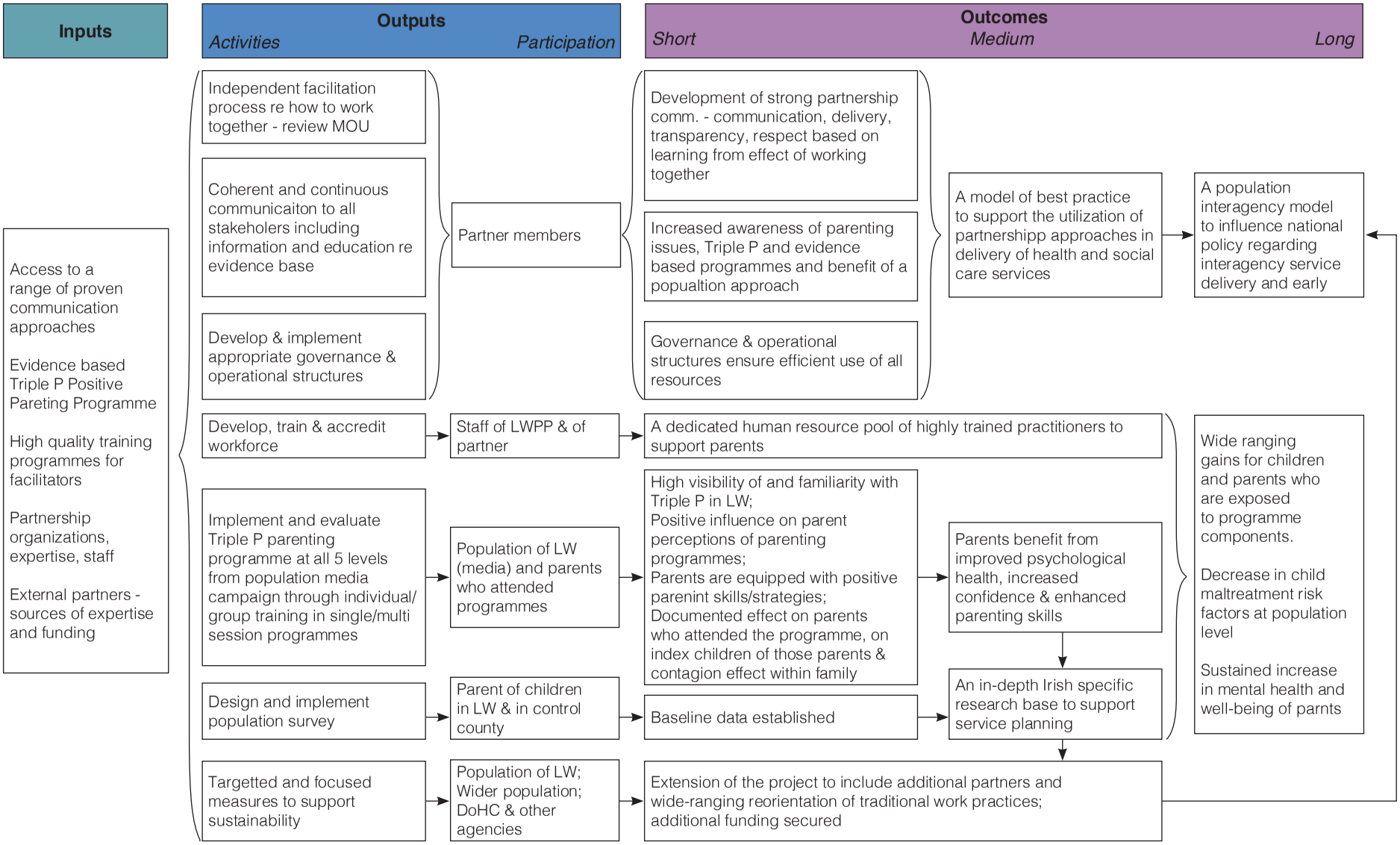
According to the MoU, the **purposes** of LWPP were:

- 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;
- to promote and support the delivery of evidence-based parenting knowledge and skills to the population of Longford and Westmeath.

The MoU also lists the 6 **principles** of LWPP as follows:

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 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.

Figure 3.1: Logic Model for Triple P – Positive Parenting Programme (Longford Westmeath Parenting Partnership)



LWPP listed its **values** as fidelity to proven programmes, integrity, active engagement and participation, mutual respect and honest communication. In its work, LWPP required, and was committed to maintaining, constructive relationships with Children's Services Committees, the Department of Children and Youth Affairs (DCYA), The Atlantic Philanthropies, Archways, Aontacht Phobail Teoranta (APT), the Centre for Effective Services (CES) and Triple P International.

Each of the 9 current members of LWPP was represented on the partnership. Each partner had equal voting rights and the ethos of the partnership was to strive to reach decisions by consensus (*see Appendix C.1 for roles and responsibilities within the partnership*).

The **aims and objectives** of the project are derived from the Logic Model for the delivery of Triple P (*see below*). In Chapter 9 ('Conclusions') of this evaluation report, the success of the partners in attaining these aims and objectives is analysed.

According to the partnership's Project Work Plan (p. 17), the **overall goal** of the project is

> *'to improve outcomes for children with or at risk of developing emotional and behavioural problems by strengthening collaborative relationships and referral pathways for children, their parents, and significant others'*

The agreed 7 **key high-level** aims of the project were as follows:

1. to establish the prevalence of parent-reported emotional/behavioural problems for their children and parenting confidence levels;
2. to implement a community-based intervention focused on reducing childhood emotional and behavioural problems;
3. to implement a community-based intervention focused on supporting parents and families and preventing/reducing levels of parental anxiety and depression that are associated with children's emotional and behavioural problems (e.g. stress and relationship difficulties);
4. to coordinate a media and information campaign focused on promoting positive parenting and healthy family relationships in target areas, including enhanced awareness of childhood social and emotional problems;
5. to investigate the economic case for the implementation of Triple P on a population basis in Longford Westmeath; [1]
6. to evaluate the use of an interagency approach to implement an evidence-based programme using a population approach;
7. to utilise what is learnt from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes to other counties.

The **vision** of the partnership (MoU, p. 18) is:

> *'to provide families with children aged between 3 and 7 … with positive parenting strategies and skills that will result in real social and emotional gains for both children and parents'.*

The **delivery** of this vision is described by the following 7 strategic objectives:

1. to develop an integrated and collaborative approach to service delivery that maximises the use of all core competencies among the partnership members;
2. to ensure that the training requirements of all associated staff are met and exceeded where possible;
3. to ensure excellence in all the service delivery requirements related to this collaborative initiative;
4. to design and construct an Irish evidence base for Triple P that influences and facilitates the planning of future associated services;
5. to deliver clear and coherent messages to all stakeholders in relation to the role, remit and capacity of the collaborative initiative;
6. to advance the sustainability of the collaborative initiative through a range of targeted and focused measures;

1. High-level aim No. 5 is not included in the main document of the MoU, which lists only 6 high-level aims (MoU, p. 4).

7. to implement the necessary structures and processes within the collaborative initiative to enable the achievement of agreed strategic objectives.

3.3 Target population

In its grant proposal to The Atlantic Philanthropies, LWPP refers to the 2005 findings of the World Health Organization (WHO) on the incidence rate for children with behavioural difficulties. The report found that the prevalence rate is approximately 20% worldwide and also can be applied to European countries (WHO, 2005). The LWPP also refers to a 2002 study from the British Columbia Ministry of Children and Family Development (Waddell and Shepherd, 2002), which reported that 20% of children and youth experience mental disorders that cause 'significant distress and impair functioning at home, at school, with peers, or in the community' (Grant Proposal, p. 9).

If the WHO prevalence rate is applied to Ireland, it is estimated that more than 200,000 of 0-18 year-old children in Ireland have a 'behavioural difficulty and/or conduct disorder' (*ibid*). The target population for Triple P of those with behavioural difficulty and/or conduct disorder in the Longford Westmeath region is, therefore, approximately 1,727. The Grant Proposal goes on to state that such difficulties 'incur high psychological and economic costs for the young people who experience them, for their families and for the societies in which they live, study and will work' (*ibid*). It also points out that there is a significant imbalance at present between preventative efforts, on the one hand, and on the other hand efforts to respond to difficulties as they emerge, to treat and to cure, and the latter is what 'the majority of present-day health and social services' are designed to do (*ibid*).

The counties of Longford and Westmeath are situated in the Midlands of Ireland. In 2006, the total population of Co. Longford was 34,391 and the total population of Co. Westmeath was 79,391 (CSO, Census 2006). Of that total population, in Longford 2,601 were between the ages of 3-7 and in Westmeath 6,033 were between the ages of 3-7. The child population of the Midlands region is projected to grow by 14% between 2006 and 2026 (CSO, 2008). The proportion of the population of Longford Westmeath within this age category (7.6%) is higher than the national average (6.9%). The socio-economic profile of Longford and Westmeath is similar to national figures. The one exception is the larger percentage of farmers in Longford (8%) when compared with the national data (4%). Figures regarding household composition show no noticeable differences between national data and data from Longford and Westmeath. However, the number of persons unemployed in the Midlands region (including Longford, Westmeath, Laois and Offaly) is higher than the national average; and the number on the live register in Longford and Westmeath is 4% lower than the national figure.

3.4 About Triple P – Positive Parenting Programme

3.4.1 A population-based approach to parenting

Triple P is defined as a public health or population-based approach to parenting support. 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.

The Triple P population-based approach has a number of other distinguishing features (Sanders, 1999). The *principle of programme 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. A *multidisciplinary approach* is also adopted since the programme can be delivered by different professions.

In addition, the programme can accommodate *varied delivery modalities* since face-to-face, group, telephone or self-directed delivery is possible for the same level of the programme.

3.4.2 Principles of positive parenting

Triple P is based on a 'positive parenting' approach. The aim of this approach is to 'promote children's development and manage children's behaviour in a constructive way' (Turner *et al,* 2002, p. 8). The core principles of positive parenting are as follows (*see also* Sanders, 1999, p. 76):

Ensuring a safe, interesting environment

A safe, supervised and protective environment is necessary to promote healthy development, to explore, experiment and play, and also to avoid accidents and injuries in the home (Turner *et al,* 2002, p. 9).

Creating a positive learning environment

Parents are encouraged to respond positively and constructively to *'child-initiated interactions'* in naturally occurring situations. Parents are encouraged to provide children with uninterrupted attention and to be a source of information for children. *'Incidental teaching'* is encouraged, which involves responding to child-initiated interactions, encouraging them to extend their language by talking about what they are seeing or doing, extend or elaborate their game or play, extend their general knowledge by listening and learning new things, and learn to solve problems for themselves (*ibid*, p. 107). In addition, focusing on the positive involves attending to children's desirable behaviour, through *'contingent positive attention,'* behaviour charts and the use of prompts to teach new skills (*ibid*, p. 9)

Using assertive discipline

'Assertive discipline involves being consistent, responding quickly and decisively when children misbehave, and teaching children to behave in an acceptable manner' (*ibid*, p. 9). Assertive discipline is encouraged in the place of coercive and ineffective discipline practices, including *'shouting, threatening or using physical punishment'* (*ibid*). Parents are encouraged to be consistent and predictable, to select and discuss ground rules for specific situations (such as a shopping trip), use *'directed discussion'* and *'planned ignoring'*, giving clear and calm instructions, and backing up instructions with *'logical consequences, quiet time* (*non-exclusionary time out*)*, and time out'* (*ibid*, pp. 9-10).

Having realistic expectations

Parents are taught to have *'developmentally appropriate'* expectations of their children. Parents are taught that conflicts can arise when parents expect their children to always behave in certain ways or when they have unrealistic expectations of their children's capabilities. Parents are also taught to have realistic expectations of themselves as parents so as to avoid frustration or feelings of inadequacy.

Taking care of oneself as a parent

Parents are encouraged to view parenting *'within a broader context of personal self-care, resourcefulness, and well-being'* (*ibid*, p. 10). The importance of a parent's self-esteem and sense of well-being are emphasised. *'It is much easier for parents to be patient, consistent, and available to children when their own needs are being met'* (*ibid*).

Self-regulation and parental competence

Triple P aims to promote parental competence and central to this is the parent's capacity for self-regulation (*ibid*, p. 18). It involves being taught skills to modify one's own behaviour. For parents, these skills include *'selecting developmentally appropriate goals for their child or personal goals as a parent, monitoring a child's behaviour or their own behaviour, choosing an appropriate method of intervention for a particular problem, implementing the solution, self-monitoring their implementation of solutions … identifying strengths or limitations in their performance, and setting future goals for action'* (*ibid*, p. 19).

The Triple P self-regulatory framework includes parents becoming independent problem-solvers and therefore self-sufficient. Parents also must come to believe in their own self-efficacy in bringing about their aims and goals. Finally, parents must develop various tools of self-management, including self-monitoring, self-determination of goals, self-evaluation of performance and self-selection of change strategies (*ibid*).

3.5 Components of Triple P implemented by LWPP

Triple P is a multi-level intervention. The 5 levels of Triple P are outlined below. The Triple P Levels delivered by LWPP are also highlighted here and discussed in detail in Section 7.2.1 of Chapter 7 on 'Implementation'.

3.5.1 Level 1: Media strategy

This level targets the entire population 'with the aim of preventing the development of adverse outcomes' (Turner *et al,* 2005, p. 20). In particular, Level 1 uses health promotion and social marketing strategies to deter the onset of child behaviour problems. A media strategy can be useful also in creating public awareness of specific issues. The aims of Level 1 include the following: promote positive parenting strategies, increase receptivity towards participating in parenting programmes, and improve community attitudes towards parenting programmes. These aims are to be achieved by de-stigmatising and normalising the process of seeking help for children with behaviour problems, increasing the visibility and reach of the programme, countering a tendency to blame parents and alarmism and sensationalism in the media, and creating a sense of optimism by depicting solutions to common behavioural and developmental concerns (*ibid*).

The Triple P International organisation supports the roll-out of Level 1. It provides a media resource kit, which includes a television commercial, a radio commercial, a series of 'sound capsules' on positive parenting, 52 newspaper columns, printed advertising materials, press releases and sample letters, and a programme coordinator's guide to using the media kit (*ibid*, pp. 20-21).

3.5.2 Level 2: Triple P Seminars

Level 2 Triple P is targeted at sub-groups believed to be at greater risk than others, for example, parents of toddlers. The series comprises 3 presentations, each of 90 minutes, for parents with specific concerns about their child's behaviour or development. 'Tip sheets' are used to provide information on general parenting issues and also the prevention and management of common problems. They are designed to aid the management of discrete child behaviour problems not complicated by other major behaviour management difficulties or family dysfunction. Seminar 1 deals with 'Power of positive parenting'; Seminar 2 is on 'Raising confident, competent children'; and Seminar 3 covers 'Raising resilient children' (Sanders and Turner, 2005, pp. 5-6).

3.5.3 Level 3: Workshop Triple P

In the implementation of Triple P in Longford Westmeath, a decision was made in 2011 to implement the Workshop version of Level 3 and to discontinue the Primary Care version (*see Section 7.2.5*). This level involved delivery of individual topic-based Workshops by trained Triple P practitioners throughout Longford and Westmeath. Parents could select from 4 different topics; each workshop lasted 2 hours and there were up to 15 participants per workshop.

3.5.4 Level 3: Primary Care Triple P

This is a 4-session intervention targeting children with mild to moderate and relatively discrete behaviour difficulties and includes active skills training for parents. Each session lasts approximately 30 minutes and incorporates active skills training and selective use of parenting 'Tip Sheets.' Session 1 (Assessment of the presenting problem) clarifies the history and nature of the problem, sets goals for the intervention and collects baseline data. In Session 2 (Developing a parenting plan), the baseline monitoring data are discussed, a parenting plan is negotiated and possible obstacles are discussed. Session 3 (Review of implementation) monitors the family's progress and discusses possible obstacles. In Session 4 (Follow-up), all progress is reviewed and positive and encouraging feedback is given. If insufficient progress has been made, parents may be referred on to another Triple P level. The decision made by LWPP to discontinue Primary Care Triple P and replace it with Workshop Triple P is discussed in Section 7.2.5.

3.5.5 Level 4: Group Triple P

Level 4 interventions are more intensive than those at lower levels. They are implemented with individual parents or groups of parents, or by guiding parents who are working from a Triple P self-help parenting book. The Level 4 Group intervention comprises 8 sessions: 5 group sessions (2 hours each) and 3 one-to-one telephone sessions. The Group intervention is for parents of children with more severe behaviour difficulties. This LEVEL targets 'high-risk individuals who are identified as having detectable problems but who do not yet meet full diagnostic criteria for a behavior disorder, and also those children who meet diagnostic criteria, with the aim of preventing progression of problem behavior and severe impairment' (Sanders and Turner, 2005, p. 23).

Group Triple P may also be targeted at a particular geographical area, such as a low-income neighbourhood.

The Level 4 sessions cover the following:

- Session 1: Positive parenting
- Session 2: Promoting children's development
- Session 3: Managing misbehaviour
- Session 4: Planning ahead
- Session5-7: Implementing parenting routines (telephone sessions)
- Session 8: Programme close

3.5.6 Level 5: Enhanced Triple P

Level 5 is intended for parents and caregivers experiencing relationship conflict, parental depression or high levels of stress. It is a more intensive family intervention programme. Level 5 is usually delivered to parents in an individual consultation format after they have undertaken a Level 4 intervention. Level 5 is particularly focused on supporting parents who are struggling to cope with child behaviour concerns in

addition to relationship and/or personal difficulties. The programme focuses on marital communication, partner support and mood management, and it stresses coping skills for parents. Although part of the original plan for programme implementation, this level of Triple P was not delivered in Longford Westmeath during the evaluation period.

4. Findings from Parenting Study

4.1 Introduction

Findings from the Parenting Study are presented in this chapter. Section 4.2 presents findings from the evaluation of Group Triple P; Sections 4.3-4.7 present findings from the evaluation of Workshop Triple P; and Section 4.8 presents data collected from participants in Triple P Seminars. In the evaluation of Group Triple P and Workshop Triple P, 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, and changes maintained over time, on key parenting and child behaviour variables and no significant negative changes. While data were not collected to measure gains made by participants in Triple P Seminars, this chapter presents data on the profile of participants in all components of Triple P.

4.1.1 Research questions and method

The evaluation of Group Triple P and Workshop Triple P was a quasi-experimental pre-test – post-test within-groups design (Shadish *et al,* 2002, p. 108). As the study did not include a control group and random allocation of participants, conclusions cannot be inferred with confidence about causality and 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 (as recommended for this type of quasi-experimental design – Shadish *et al,* 2002, p. 110), it is reasonable to infer that changes reported by parents were associated with their participation in the programme.

The Parenting Study was structured around 5 research questions:

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?
5. Was there any difference in the outcomes achieved between those who completed only one component of the programme and those who completed more than one component of the programme?

Findings are presented separately for each level of the programme and are structured around the research questions for the Parenting Study. Within Level 3, findings are presented separately for each workshop evaluated.

4.1.2 Effect size

A repeated-measures design was used to evaluate the effect of the programme over time. For that reason, in this study the effect size represents the difference in mean scores on the dependent variable between one group at two time points. (Note that an effect size in the Population Study represents the difference in mean scores on the dependent variable between the scores of two groups.) It is necessary to represent the effect size in standardised form and to do this the 'standardised mean difference' is used, which 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). For example, an effect size of $d = 0.5$ in the Parenting Study indicates the mean score at post-test is half a standard deviation greater than the mean score at pre-test.

As the Parenting Study was a pre-test – post-test within-groups design, effect sizes were calculated by dividing the mean difference between the samples by the standard error of the mean (or the standard error of the differences). An important consideration is what impact the relative power of a repeated-measures design has on effect size calculation. Using the same participants across two time points reduces the error variance and increases the power of the analysis. Therefore, larger effect sizes will be reported from a repeated-measures design than from a between-groups design (such as the study design in the Population Study) even when the relevant means in the two study designs are the same (Field, 2009, p. 342). This is an important consideration when comparing the effect sizes reported here with effect sizes reported in the Population Study in this evaluation and/or the effect sizes reported from other controlled studies.

Wherever possible, effect sizes have been presented as Cohen's *d* values (in some instances they have been converted from other values, such as 'f' or 'r'). 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).

4.2 Findings: Level 4 – Group Triple P

4.2.1 Introduction

Level 4 interventions are more intensive than those at lower levels. The Level 4 Group intervention comprises 8 sessions: 5 group sessions of 2 hours each and 3 one-to-one telephone sessions. The Group intervention is for parents of children with more severe behaviour difficulties. However, in the LWPP implementation, parents were not screened for acceptance in the programme.

Participants

Participants involved in the current evaluation are those with a target child in the age range 3 years (36 months) to 7 years 11 months (95 months), who self-referred to attend the programme, who consented to the evaluation and who completed at least the pre-intervention questionnaire (n=521). Socio-demographic variables of all participants who attended the programme (and completed the initial questionnaire) are presented in Table A.9, Appendix A.2.

The evaluation of Group Triple P from pre-intervention to post-intervention includes only those for whom data were available at both time points (n=393), which as a percentage of the total number who consented to participate and who had a child in the target age range (36-95 months) (n=531) represents a response rate of 74% (*see Section 7.2.4*). Due to missing data on individual variables, the precise sample size may vary for individual tests.

A sub-sample was recruited to take part in the follow-up (12 months) data collection. A total of 173 questionnaires were issued to parents and 81 were returned. Parents who did not have a child in the target age range for the programme (36-95 months) were not included in the data analysis and the final sample size for the follow-up component of the study was n=59 (response rate = 34%). The results of a power analysis conducted on this sub-sample are given in Section 4.2.4.

Measures

The Assessment Booklets contained 9 questionnaires. Assessment Booklet 1 (Pre-intervention) contains Questionnaires 1-8. Assessment Booklet 2 (Post-intervention) contains Questionnaires 2-9. Questionnaires 7 and 8 are for completion by parents who are in marital or partner relationships. Assessment Booklet 3 (Follow-up) contains Questionnaires 3 and 4. The content of each questionnaire is described below.

1. Family Background Questionnaire

The Family Background Questionnaire (FBQ) is designed to collect family socio-demographic data and has been adapted from Zubrick *et al* (1995). It includes the parent's name, address and date of birth (on the first page to facilitate removal at anonymisation stage), the child's first name only and date of birth, and the parent's marital status, employment status and educational background. Information on other family members by first name only is also included.

2. Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a behavioural screening questionnaire measuring parents' perceptions of pro-social and difficult behaviours in children (Goodman, 1997 and 1999). There are different versions available for parents of children aged 3-4 and 4-16. Age-appropriate versions were used for individual participants. The measure includes 25 items relating to the frequency of positive and negative behaviours, each rated on a 3-point scale. Positively oriented statements were reverse coded before summing scores. The Total Difficulties Scale is comprised of 20 of the SDQ items (all scales except the Pro-social Scale) and the range of scores possible is 0-40.

There are four sub-scales on this measure, each consisting of 5 items: emotional symptoms, conduct problems, peer problems and hyperactivity. For each of these scales, higher scores denoted a greater level of reported emotional or behavioural symptoms. A further sub-scale consisting of 5 items was summed to form the Pro-social Behaviour Scale; for this sub-scale, lower scores denoted social behaviour difficulties.

Clinical categories were defined using banding from the Youth in Mind website SDQ (UK) scoring file (available at http://www.sdqinfo.com/py/doc/c0.py). Categories were defined as follows for each scale:

- Total Difficulties Scale: normal 0-13; borderline 14-16; abnormal 17-40.
- Emotional Symptoms Scale: normal 0-3; borderline 4; abnormal 5-10.
- Conduct Problems Scale: normal 0-2; borderline 3; abnormal 4-10.
- Hyperactivity Scale: normal 0-5; borderline 6; abnormal 7-10.
- Peer Problems Scale: normal 0-2; borderline 3; abnormal 4-10.
- Pro-social Behaviour Scale: normal 6-10; borderline 5; abnormal 0-4.

Dichotomised scales were categorised as 'normal' and 'borderline to abnormal' as follows: borderline to abnormal range scores for the Total Difficulties Scale = 14-40; Emotional Symptoms Scale = 4-10; Conduct Problem Scale = 3-10; Peer Problem Scale = 3-10; Hyperactivity Scale = 6-10.

SDQ – Impact of Difficulties Scale

An impact scale was calculated summing 5 items concerning the impacts of reported emotional and behavioural difficulties on the child's levels of distress, on their home life, friendships, classroom learning and leisure activities. Each item was scored 0 = 'not at all or only a little', 1 = 'quite at lot' and 2 = 'a great deal'. The summed values for these items formed an impact score between 0-10 that was additionally recoded to give categories 1 or more = 'borderline to abnormal', 0 = 'normal' (*for further information, see* http://www.sdqinfo.com/py/doc/c0.py).

3. Eyberg Child Behaviour Inventory

The Eyberg Child Behaviour Inventory (ECBI) is a 36-item measure of parental perceptions of disruptive behaviour in children aged 2-16 (Eyberg and Pincus, 1999). It incorporates a measure of the frequency of

disruptive behaviours; these are rated on a 7-point scale (ranging from 'never' to 'always') and are combined to derive an Intensity score. It also assesses the number of disruptive behaviours that are a problem for the parents on a dichotomous rating scale (Yes/No), which are combined to derive a Total Problem score. Scores greater than 131 on the Intensity Scale and greater than 15 on the Problem Scale are indicative of difficulties in the clinical range and were used as clinical-offs for the purposes of this report.

4. Parenting Scale

The Parenting Scale is a 30-item measure of discipline styles in parents (Arnold *et al,* 1993). Parents indicate on a 7-item rating scale how they would respond. It yields a total score and scores for laxness (permissive discipline), over-reactivity (authoritarian discipline, displays of anger) and verbosity (over-reliance on talking or long reprimands). The total score represents an average of responses on all items. Similarly, sub-scale scores are the average responses on all items relating to that sub-scale. For the total score and for each of these scales, higher scores denoted a greater level of reported problematic parenting discipline style.

5. Depression-Anxiety-Stress Scales

The Depression-Anxiety-Stress Scales (DASS) is a measure of parental adjustment and consists of 42 items that assess symptoms of depression, anxiety and stress in adults over the preceding week (Lovibond and Lovibond, 1995). Each symptom is rated on a 4-point scale (ranging from 0-3). Each sub-scale consists of 14 items, with a scoring range of 0-42. For each of these scales, higher scores denoted a greater level of the reported symptom. The DASS is based on a dimensional, rather than a categorical, conception of psychological disorder.

6. Problem Setting and Behaviour Checklist

The Problem Setting and Behaviour Checklist is a 28-item questionnaire that measures parent confidence in dealing with child behaviour problems and common parenting tasks (Sanders *et al,* 2005). Parents rate their degree of confidence in dealing with their child's difficult behaviour in a range of situations on a 10-point scale (ranging from 0 = 'certain I can't do it' to 10 = 'certain I can do it'). The total score on this measure ranges from 0-280, with higher scores indicating greater confidence.

7. Relationship Quality Index

The Relationship Quality Index is a 6-item index of marital or relationship quality and satisfaction (Norton, 1983). The first 5 items assess relationship strength, stability, and satisfaction on a 7-point scale, ranging from 'very strongly disagree' (1) to 'very strongly agree' (7). The final item assesses overall happiness of the relationship on a 10-point scale, ranging from 'unhappy' (1) to 'perfectly happy' (10). The measure generates a total score ranging from 6-45, with higher scores indicating a more positive relationship.

8. Parenting Problem Checklist

The Parenting Problem Checklist is a 16-item measure that assesses inter-parental conflict over child rearing (Dadds and Powell, 1991). The measure consists of 6 items that assess the extent to which parents disagree over rules and discipline for child misbehaviour; 6 items that rate the amount of open conflict over child rearing issues; and 4 items that assess the extent to which parents undermine each other's relationship with the child. There are two scores generated from this measure – a Problem score and an Intensity score. The Problem score ranges from 0-16 and indicates the number of areas in which parents are experiencing conflict. For clinical purposes, a score of 5 or greater is believed to be in the clinical range. For each issue that parents identify as problematic, they are also asked to rate the extent to which the issue has caused difficulty (ranging from 1 = 'not at all' to 7 = 'very much'). Scores on the Intensity Scale range from 16-112.

9. Satisfaction Questionnaire

The Satisfaction Questionnaire (SQ) is an adaptation of the Therapy Attitude Inventory (Eyberg, 1993) and addresses the quality of service provided, how well the programme met the parent's needs, increased the parent's skills and decreased the child's problem behaviours; it also asks whether the parent would recommend the programme to others. The SQ consists of 13 items measured on a scale of 1-7, with higher scores indicating greater satisfaction. Total satisfaction scores range from 13-91. In addition, participants are also given the opportunity to comment about any aspect of the programme and an analysis of these qualitative data is given in Section 7.3.4.

Procedure

Assessment Booklet 1 was issued pre-intervention at the first session, during which an extra 30 minutes are allocated to allow for information provision, consent and completion of questionnaires. Extra time was taken and help was provided by practitioners where language or literacy difficulties presented. Assessment Booklet 2 was issued 8 weeks later, at the final programme delivery session.

Practitioners scored the assessment measures in the Assessment Booklets and provided feedback to parents at two points: (1) feedback in relation to the pre-intervention measure at the first phone call session (i.e. Session 5); and (2) in a further phone call post-programme to feedback on both pre- and post-intervention measures.

Practitioners returned the Assessment Booklets to the research team at LWPP at their monthly support meetings or the practitioner made arrangements to have them collected by a member of the Core Team.

The Research Team at LWPP applied ID codes and DED areas to the Assessment Booklets for implementation purposes since the DED area information helped to ensure spread of delivery across Longford Westmeath. Where consent had been given for the evaluation, all identifying details were removed from both sets of questionnaires by removing the cover page before forwarding to NUI Galway for analysis.

Assessment Booklet 3, issued for a sub-sample 12 months after pre-intervention, contained Questionnaires 3 and 4. Questionnaires were issued monthly to previous participants in the programme.

Analysis

Full data screening took place with the full data file (*see Tables A.1, A.2 and A.3 in Appendix A.1*). 20% of all questionnaires were randomly checked. The data file was corrected for any mistakes found during data checking. Missing data are less than 10% across all but two variables (age and gender of child number 4).

Some individual variables were not normally distributed (*see Table A.3 in Appendix A.1*), which is one of the core assumptions of repeated-measures ANOVA. When this was the case, data were analysed using non-parametric methods – either a Wilcoxon Signed Rank Test or a Friedman Test.

Cronbach's alpha was calculated to determine the internal reliability of each of the measures. The majority of the variables reached the level required (Cronbach's $\alpha = .80$).

Participant characteristics are presented as either percentages or average and standard deviation scores, as is appropriate (*see Table A.9 in Appendix A.2*). The evaluation component was explored through repeated measures analysis of variance.

4.2.2 What were the characteristics of those participating in Group Triple P?

Child characteristics

Within the overall sample of programme participants, there were a higher proportion of boys to girls (approximately 60% boys). Only parents with a target child aged between 3 years (36 months) and 7 years 11 months (95 months) were included in the study and the average target child age was 5.2 years (62 months) (SD = 16.5 months) (*see Table A.9 in Appendix A.2*). There were on average 2.4 children per household among participants.

Participant characteristics

Participants in the study were predominantly female (almost 86%). In addition, there was a large age range among parents who participated in the programme (21-63 years), with an average age of 37 years. Programme participants were predominantly married (75%). The majority of participants were Irish-born (76%) and the figures are comparable with the national figure for those aged 25-64 (78%) (*see Table 4.3*). There was a mixed educational profile among the sample of participants: approximately 65% had completed further training or education after completion of secondary school, which is higher than the figures for the total population of Longford (20%) and Westmeath (25%) (*see Table 4.1*). As regards employment, approximately 48% of the sample worked outside of the home (either part-time or full-time), which is the same as the figure for the total population of those aged 15 and over in Westmeath and marginally higher than the figure for Longford (46%) (*see Table 4.1*). Also 14% reported not working by choice (*see Table A.9 in Appendix A.2*).

Family characteristics

As regards family characteristics, 82% of children were described as currently living with their original family. Almost 86% were living in two-parent families, which is higher than the national figure (81%) (*see Table 4.2*). Almost 39% of respondents reported having a medical card, which is marginally higher than the national figure of 36% for children aged 0-15 (*see Table 4.4*). 25% stated that they had difficulty meeting essential expenses and 28% reported not having sufficient money to purchase much of what they really wanted after essential expenses are paid (*see Table A.9 in Appendix A.2*).

Table 4.1: Demographic data of residents in Longford Westmeath, 2011

	Longford	Westmeath
Population	39,000	86,164
(as % of populations in both counties combined)	(31.2%)	(68.8%)
Families with children aged 3-7 in 2012*	2,359	4,958
Third-level qualifications	6,025	16,615
(as % of population aged 15+)	(20.1%)	(24.9%)
Social Class 1 (as % of population aged 15+)	10,797 (35.5%)	28,220 (40.5%)
Social Class 2 (as % of population aged 15+)	13,786 (44.5%)	28,834 (41.5%)
Social Class 3 (as % of population aged 15+)	6,173 (20%)	12,514 (18%)
Persons at work (as % of population aged 15+)	13,871 (46%)	32,319 (48%)

* Calculated based on number of families with children aged 2-6 in 2011 Census.
Source: CSO, Census 2011

Table 4.2: Parents of children aged 0-9 – marital status in Republic of Ireland, 2011

Marital status	N	%
Husband and wife with children	452,504	67.5%
Lone mother with children	121,986	18.2%
Co-habiting couple with children	88,033	13.1%
Lone father with children	8,122	1.2%
Total	670,645	100%

Source: CSO, Census 2011

Table 4.3: Ireland as place of birth for residents in Republic of Ireland, 2011

Age	No. of residents	%
All ages	3,758,511	83.1% of total population
Aged 25-64	1,924,857	78.3% of population in age range

Source: CSO, Census 2011

Table 4.4: Children registered for a medical card in Republic of Ireland, 2011

Age	Male	Female
Aged 0-15	35.8%	35.5%

Source: CSO (2012) Women and Men in Ireland, 2011

4.2.3 What improvements were reported by participating parents for child and parent outcomes?

A repeated-measures univariate analysis of variance was used to measure changes over time on each child behaviour measure and the results show statistically significant improvements in scores on all measures between pre-intervention and post-intervention. The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual child behaviour variable in Table 4.5.

At post-intervention, parents' ratings of total difficulties, conduct problems, emotional symptoms, hyperactivity and peer problems (SDQ Scales) were all significantly lower in comparison to pre-intervention. Reports of children's pro-social behaviours increased from pre-intervention to post-intervention. Furthermore, the frequency of problematic behaviours as reported by parents reduced over time (ECBI, Intensity Scale). In addition, parents reported a lower number of perceived problematic behaviours over time (ECBI, Problem Scale).

Table 4.5: Short-term gains on child behaviour – Group Triple P

	Pre-intervention	Post-intervention	p	Cohen's *d*
SDQ Total Difficulties Score (n=391)	12.26 (5.9)	8.77 (4.9)	**.000**	**1.510**
Emotional symptoms* (n=391)	2.62 (2.1)	1.79 (1.8)	**.000**	**0.611**
Conduct problems (n=392)	3.07 (1.9)	1.97 (1.5)	**.000**	**1.347**
Hyperactivity (n=392)	4.71 (2.7)	3.6 (2.2)	**.000**	**1.164**
Peer problems* (n=392)	1.86 (1.8)	1.37 (1.5)	**.000**	**0.466**
SDQ Pro-social Sub-scale (n=392)	7.25 (1.9)	8.12 (1.7)	**.000**	**0.991**
SDQ Impact Score (n=385)	1.04 (1.7)	0.46 (1.1)	**.000**	**0.817**
ECBI Intensity (n=385)	116.24 (32.0)	92.88 (27.2)	**.000**	**1.755**
ECBI Problem (n=358)	13.11 (7.8)	6.48 (6.5)	**.000**	**1.888**

* = Wilcoxon Signed Rank Test (non-parametric data).
Statistically significant findings are in bold.

The majority of the baseline average scores on the child behaviour measures were within the 'normal' range. However, baseline scores on the Conduct Problems Sub-scale of the SDQ were within the 'borderline' range and the SDQ impact score at baseline was also in the 'borderline/abnormal' range.

A repeated-measures univariate analysis of variance was used to measure changes over time on the set of parenting measures (including discipline style and parenting self-efficacy) and the results show statistically significant improvements in scores on all measures between pre-intervention and post-intervention. The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual variable in Table 4.6.

Table 4.6: Short-term gains on parenting scales (self-efficacy and discipline) – Group Triple P

	Pre-intervention	Post-intervention	p	Cohen's *d*
Parenting Scale – Total (n=393)	3.33 (0.63)	2.66 (0.72)	**.000**	**1.992**
Parenting Scale – Laxness (n=393)	3.05 (0.92)	2.43 (0.87)	**.000**	**1.507**
Parenting Scale – Over-reactivity (n=393)	3.17 (0.92)	2.39 (0.89)	**.000**	**1.741**
Parenting Scale – Verbosity (n=393)	3.92 (0.75)	3.21 (0.89)	**.000**	**1.436**
Problem Setting and Behaviour Checklist (n=389)	211.58 (39.4)	238.01 (38.9)	**.000**	**1.328**

Statistically significant findings are in bold.

Reports of problematic discipline styles reduced over time. This was demonstrated on the Total Parenting Scale and each of the sub-scales (permissive/laxness approach; over-reactivity/authoritarian approach; and verbosity/reprimanding approach). In addition, parents' self-efficacy improved over time. The baseline mean score on the Problem Setting and Behaviour Checklist was 211.58 (out of a maximum score of 280), which indicates a high level of initial confidence among parents in dealing with difficult behaviours in their children when they arise in various situations.

A repeated-measures univariate analysis of variance was used to measure changes over time on the set of personal and marital adjustment measures (including relationship satisfaction, inter-parental conflict over child-rearing, and measures of stress, anxiety and depression) and the results show statistically significant improvements in scores on all measures between pre-intervention and post-intervention. The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual variable in Table 4.7.

Table 4.7: Short-term gains on personal and marital adjustment – Group Triple P

	Pre-intervention	Post-intervention	p	Cohen's *d*
DASS Depression Scale (n=393)	5.65 (7.4)	2.82 (5.2)	**.000**	**0.745**
DASS Stress Scale (n=393)	10.72 (8.1)	6.57 (6.8)	**.000**	**0.885**
DASS Anxiety Scale (n=393)	3.99 (5.96)	2.28 (4.6)	**.000**	**0.598**
Relationship Quality Index	3.92 (0.75)	3.21 (0.89)	**.000**	**1.436**
(n=352)	37.13 (8.3)	38.82 (7.5)	**.000**	**0.429**
Parent Problem Checklist – Problem (n=351)	4.95 (3.8)	3.05 (3.3)	**.000**	**0.740**
Parent Problem Checklist – Intensity (n=351)	32.08 (14.8)	25.37 (11.04)	**.000**	**0.785**

Statistically significant findings are in bold.

Each sub-scale on the Depression, Anxiety and Stress measure demonstrated improvement over time (despite initial low levels at baseline). Inter-parental conflict (PCC) also reduced over time. Initial levels on the PPC Problem Scale indicated that average scores were within the normal range. Scores on the Relationship Quality Index (RQI) also demonstrated improvement from pre-intervention to post-intervention. Average scores at baseline on the RQI indicate positive assessments of the relationships on the whole, and they did show improvement across time.

Caseness results: Children's emotional and behavioural characteristics

McNemar's Test is a non-parametric test used for examining whether there was a change in the proportion of children who scored above clinical cut-off rates on individual child behaviour measures from pre-intervention to post-intervention. When this test was applied to the SDQ-Total Difficulties score, there was a significant change in the proportion of children who were classified as borderline/abnormal since 66% of those categorised as borderline/abnormal at pre-intervention were in the normal range at post-intervention (*see Table 4.8*). There was also a significant reduction in the proportion in the borderline/abnormal range on the emotion (59%), conduct problems (51%), hyperactivity (60%), peer problems (60%) and pro-social (73%) sub-scales, as well as the impact score (56%).

The authors suggest these bandings of normal, borderline and abnormal are a 'rough and ready' method for detecting 'caseness'. In addition, the current classification system is based on a very broad category including both borderline and abnormal cases. However, the results show indications of emotional and behavioural problems are improving over time following parental participation in the programme.

The proportion of children who scored above the clinical cut-offs on the Eyberg Child Behaviour measure pre-intervention and post-intervention was also explored using the McNemar's Test (*see Table 4.9*). There was a significant reduction in the proportion in the borderline/abnormal range on both the intensity (80%) and problem (73%) variables.

Table 4.8: Short-term gains on child behaviour (SDQ) – Normal *versus* Borderline/Abnormal

	Pre-intervention	Post-intervention		Total	p
		Normal	Borderline/ Abnormal		
SDQ Total Score	Borderline/Abnormal	99 **(66%)**	50 (34%)	(100%)	**.000**
SDQ Emotional symptoms	Borderline/Abnormal	68 **(59%)**	47 (41%)	(100%)	**.000**
SDQ Conduct problems	Borderline/Abnormal	115 **(51%)**	110 (49%)	(100%)	**.000**
SDQ Hyperactivity	Borderline/Abnormal	84 **(60%)**	56 (40%)	(100%)	**.000**
SDQ Peer problems	Borderline/Abnormal	73 **(60%)**	49 (40%)	(100%)	**.000**
SDQ Pro-social	Borderline/Abnormal	55 **(73%)**	20 (27%)	(100%)	**.000**
SDQ Impact Score	Borderline/Abnormal	90 **(56%)**	72 (44%)	(100%)	**.000**

In bold are the percentages of those in the borderline/abnormal range at pre-intervention who moved out of that range at post-intervention. Statistically significant findings are in bold.

Table 4.9: Short-term gains on child behaviour (ECBI) – Normal *versus* Clinical

	Pre-intervention	Post-intervention		Total	p
		Normal	Borderline/ Abnormal		
Eyberg Intensity	Borderline/Abnormal	97 **(80%)**	24 (20%)	(100%)	**.000**
Eyberg Problem	Borderline/Abnormal	110 **(73%)**	41 (27%)	(100%)	**.000**

In bold are the percentages of those in the borderline/abnormal range at pre-intervention who moved out of that range at post-intervention. Statistically significant findings are in bold.

4.2.4 Were the improvements maintained over time?

While post-intervention (T2) data were collected 8 weeks after pre-intervention data (T1), follow-up data (T3) were collected 12 months after pre-intervention from a sub-sample of participants (n=59; response rate = 34%).

Follow-up sample

Data were collected at the follow-up time point from only a sub-sample of participating parents (n=59). Were there any differences in key characteristics between the follow-up sample and the main study sample? Chi-square tests showed no significant differences between the samples for gender of parent, gender of child, social class and attendance of other components of Triple P. However, there was a non-significant difference in the age of participants. While the median age of parents in the total sample was 37, 64% of parents who completed the follow-up sample were 37 years of age or older and 36% were 36 years of age or younger, although the difference was not statistically significant (p = .098, phi = .073).

With one exception, no statistically significant differences were observed in pre-intervention scores for child behaviour and parenting experience measures. The sub-sample who went on to complete the follow-up survey had less positive pre-intervention scores for SDQ pro-social behaviour (mean difference = 0.691, p = .009).

A post-hoc power analysis was run using G*Power 3.1.7 for a paired-samples t-test based on the results of the comparison between pre-intervention and follow-up scores on the Eyberg Intensity score. There was an effect size of $d = 2.25$ (t = 8.51), a sample size of n=58 and an alpha value of p = .05. The results of the power analysis were as follows: Power = 1.00, Critical t = 2.002. Therefore, there was sufficient power to run the analysis with the sub-sample of participants in the follow-up sample.

Results

A paired-samples t-test was used to measure the maintenance of gains over time for the sub-sample who completed questionnaires at all three time points (*see Table 4.10*).

Table 4.10: Maintenance of gains over time. Results of paired-samples t-test – Group Triple P

	n	T1	T2	T3	Mean difference T1-T2	Mean difference T1-T3	Cohen's *d* effect size T1-T3
ECBI Intensity	58	120.5 (31.7)	91.43 (28.1)	92.5 (24.6)	**29.069 (p = .000)**	**27.983 (p = .000)**	**2.25**
ECBI Problem	58	13.61 (7.9)	5.5 (6.4)	4.19 (5.9)	**8.111 (p = .000)**	**9.426 (p = .000)**	**2.37**
Parenting Scale Total	59	3.35 (0.6)	2.58 (0.7)	2.77 (0.7)	**0.771 (p = .000)**	**0.579 (p = .000)**	**2.17**
Parenting Scale Laxness	59	3.07 (0.9)	2.40 (0.9)	2.55 (0.9)	**0.671 (p = .000)**	**0.519 (p = .000)**	**1.31**
Parenting Over-reactivity	59	3.19 (0.8)	2.30 (0.8)	2.60 (0.8)	**0.897 (p = .000)**	**0.640 (p = .000)**	**1.64**
Parenting Verbosity	59	3.94 (0.7)	3.06 (0.8)	3.21 (0.9)	**0.879 (p = .000)**	**0.736 (p = .000)**	**1.82**

Statistically significant findings are in bold.

The data show the parents participating in the programme reported long-term (i.e. 12 month) improvements on all measures (see Table 4.10 and Figures 4.1 and 4.2). Significant gains were observed after 12 months for both the frequency and number of disruptive behaviours. Significant gains were made between T1 and T3 also for the Total Parenting Scale score and for scores on all sub-scales: laxness, over-reactivity and verbosity. The effects of the Group were greater at T3 (12 month follow-up) than T2 (6 week post-intervention) for the number of disruptive behaviours that were a problem for parents.

Figure 4.1: Maintenance of improvements (child outcomes) – Group Triple P

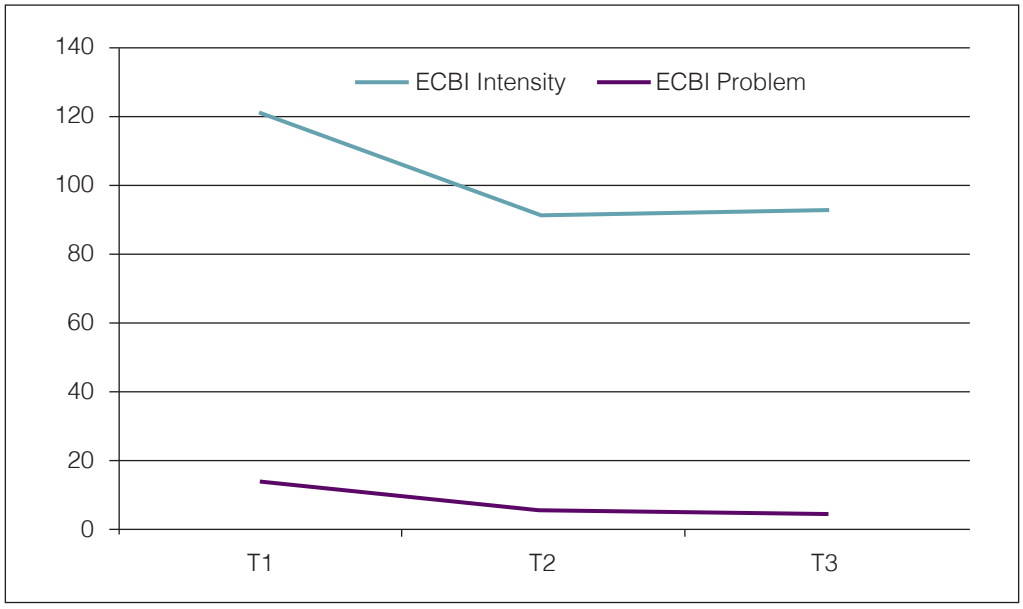
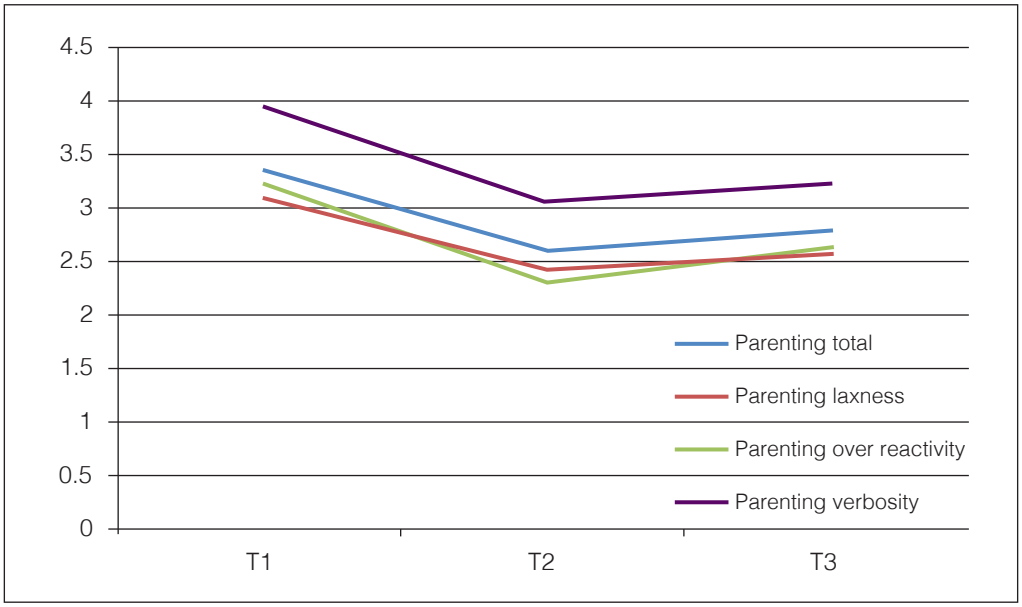


Figure 4.2: Maintenance of improvements (parent outcomes) – Group Triple P



4.2.5 Were improvements made by all groups?

A repeated-measures univariate analysis of variance was used to explore whether improvements were made by all groups at post-intervention. Gains in scores on key outcomes between pre-intervention and post-intervention were compared for different participant groups: male *versus* female participants; male *versus* female target child; younger *versus* older parents; higher *versus* lower SES; and financial circumstances. In the majority of comparisons, there were no statistically significant differences in gains made by the different sub-groups.

Male (n=54) *versus* female (n=339) participants

There was a statistically significant difference in gains made on SDQ Impact scores, with greater gains reported by fathers than mothers (p = .04). In contrast, there was a statistically significant difference in gains made on the Verbosity Sub-scale of the Parenting Scale, with greater gains reported by mothers than fathers (p = .04) (*see Tables A.10 and A.11 in Appendix A.2*).

Male (n=234) *versus* female (n=159) target child

There was a statistically significant difference in gains made on the SDQ Emotional Symptoms Sub-scale (p = .04) and for the number of behaviours that were a problem for parents (Eyberg Problem) (p = .05), with greater gains reported by the parents of boys than the parents of girls. In contrast, greater gains were reported by parents of girls than boys on the Relationship Quality Index (RQI), but the difference was not statistically significant (p = .14) (*see Tables A.13 and A.15 in Appendix A.2*).

Younger (n=167) *versus* older (n=223) parents

There was a statistically significant difference (p = .042) in gains made on the SDQ Pro-Social Sub-scale, with greater gains reported by younger parents (≤36 years) (*see Table A.16 in Appendix A.2*).

Higher *versus* lower SES

Social Group 1 (n=87) was defined as those belonging to the 'professional' or 'managerial and technical' occupations; Social Group 2 (n=86) was defined as those belonging to 'non-manual' or 'skilled manual' occupations; and Social Group 3 (n=13) was defined as those belonging to the 'semi-skilled' or 'unskilled' occupations. There was a statistically significant difference in gains made on the SDQ Pro-social Sub-scale (p = .011), with greater gains reported by parents from the lowest socio-economic groups (*see Table A.19 in Appendix A.2*).

Financial circumstances

Gains in scores on key outcomes between pre-intervention and post-intervention were compared for participants who were unable (n=86) to meet essential expenses in the preceding 12 months and those who were able to do so (n=288). No statistically significant differences were observed (see Tables A.22, A.23 and A.24 in Appendix A.2).

4.2.6 Was there any difference in the outcomes achieved in Level 4 Group Triple P between those who completed Level 4 only versus those who completed Level 4 plus another Triple P component?

Greater gains were made by those who had not attended another component of Triple P (n=252) when compared with those who had attended another component of Triple P (n=136) on only a minority of outcomes (*see Tables A.25, A.26 and A.27 in Appendix A.2*). The difference in gains was outside the parameters of statistical significance on the SDQ Inattention/Hyperactivity Sub-scale

(p = .053) and the frequency of disruptive behaviours (ECBI Intensity) (p = .059). Therefore, there were no statistically significant differences in gains between those who did and did not attend another component of Triple P.

4.2.7 Key characteristics of those who did and did not complete both questionnaires

Further analysis explored differences between those categorised as responders (i.e. completed the pre-intervention and post-intervention questionnaires) and non-responders (those who completed only the pre-intervention questionnaire). In total, 393 parents completed both questionnaires while 130 completed only the first questionnaire.

There were no statistically significant differences between responders and non-responders for social class (phi = .034, p = .871) or parent's gender (phi = .005, p = .446). However, a greater proportion of older parents (79.5%) completed the post-intervention questionnaire than among younger parents (69.5%) (phi = .115, p = .009) and a greater proportion of those who had no expenses problems in the preceding 12 months (78%) completed the post-intervention questionnaire than those who did experience financial difficulties (68%) and the difference was approaching statistical significance (phi = .104, p = .066).

There were statistically significant differences for child and parent outcomes for those who did and did not complete the post-intervention questionnaires. For ECBI Intensity, non-responders reported higher levels of child problems for the frequency of problematic behaviours (M = 127.76, SD = 37.7) than responders (M = 115.61, SD = 32.4) and the differences were statistically significant (t = 3.518, p = .000). In addition, for the ECBI Problem Scale, non-responders reported higher levels of child problems for the number of

perceived problematic behaviours (M = 15.23, SD = 8.6) than responders (M = 13.04, SD = 7.8) and the differences were statistically significant (t = 2.613, p = .009).

For the overall score on the Parenting Scale, non-responders reported worse scores for parenting style (M = 3.45, SD = 0.7) than responders (M = 3.32, SD = 0.6) and the difference was approaching statistical significance (t = 1.807, p = .071). Non-responders reported worse scores for parenting laxness (M = 3.28, SD = 1.1) than responders (M = 2.05, SD = 0.9) and the difference was statistically significant (t = 2.208, p = .023); and non-responders reported worse scores for parenting verbosity (M = 4.09, SD = 0.8) than responders (M = 3.92, SD = 0.8) and the difference was statistically significant (t = 2.339, p = .020).

Statistically significant differences were also observed on the measure of parental depression, stress and anxiety. Non-responders reported worse scores for parental depression (M = 8.35, SD = 9.1) than responders (M = 5.68, SD = 7.5) (t = 3.328, p = .001); worse scores for parental stress (M = 12.52, SD = 9.4) than responders (M = 10.72, SD = 8.1) (t = 2.098, p = .036); and worse scores for parental anxiety (M = 5.57, SD = 7.4) than responders (M = 4.00, SD = 5.9) (t = 2.432, p = .015).

KEY FINDINGS: Level 4 – Group Triple P

Sample size and response rate

- The sample size for this component was made up of those for whom data were available at pre-intervention and post-intervention (n=393), which represents a response rate of 74%.

What were the characteristics of those participating in Level 4 Group Triple P?

- There were a higher proportion of boys to girls (approximately 60% boys) and the average age of the index child was 5.2 years (62 months).
- Respondents were predominantly female (almost 86%), married (75%) and Irish-born (76%). There was a large age range among parents (21-63 years), with an average age of 37 years.
- Approximately 65% had completed further training or education after secondary school. Approximately 48% of the sample worked outside of the home.
- The majority of children (82%) were described as currently living with their original family and almost 86% were living in two-parent families. Almost 39% of respondents reported having a medical card. 25% stated they had difficulty meeting essential expenses and 28% reported not having sufficient money to purchase much of what they really wanted after essential expenses are paid.

What improvements were reported by participating parents for child and parent outcomes?

- Following completion of Level 4 Group Triple P, there were statistically significant improvements on all outcome measures.
- Parents reported significant improvements in their children's behaviour for total difficulties (Cohen's d = 1.510), and for conduct problems (Cohen's d = 1.347), emotional symptoms (Cohen's d = 0.611), hyperactivity (Cohen's d = 1.164), and peer problems (Cohen's d = 0.466). These gains were in the 'large' range based on Cohen's criteria.
- Parents also reported significant, 'large' improvements in children's pro-social behaviour (Cohen's d = 0.991) and the SDQ Impact score (Cohen's d = 0.817).
- The frequency of problematic behaviours as reported by parents (Cohen's d = 1.755) and the number of perceived problematic behaviours (Cohen's d = 1.888) reduced significantly over time and again the effect sizes were 'large'.

- Reports of problematic discipline styles reduced significantly over time. This was demonstrated on the Parenting Scale total score (Cohen's $d = 1.992$) and the sub-scales for laxness/permissive discipline (Cohen's $d = 1.507$), over-reactivity/authoritarian discipline (Cohen's $d = 1.741$) and verbosity/reprimanding (Cohen's $d = 1.436$). In addition, parents' self-efficacy improved over time (Cohen's $d = 1.328$). In each instance, the effect size was 'large'.
- There were significant improvements in the 'medium' to 'large' range for measures of parental depression (Cohen's $d = 0.745$), anxiety (Cohen's $d = 0.598$) and stress (Cohen's $d = 0.885$).
- Inter-parental conflict (PCC) also reduced over time for both frequency (Cohen's $d = 0.740$) and the number of perceived problems (Cohen's $d = 0.785$). Improvements in parental relationships were between 'small' and 'medium' (Cohen's $d = 0.429$).

Caseness results

- There was a statistically significant reduction ($p<.01$) in children categorised as borderline/abnormal for the frequency of problematic behaviours (80%), the number of perceived problematic behaviours (73%), the measures of total difficulties (66%) and the emotion (59%), conduct problems (51%), hyperactivity (60%), peer problems (60%) and pro-social (73%) sub-scales, as well as the impact score (56%).

Were the improvements maintained over time?

- Among a sub-sample of participants (n=59), significant gains were observed after 12 months on all measures ($p<.01$). Long-term gains were reported for both the frequency (Cohen's $d = 2.25$) and number (Cohen's $d = 2.37$) of disruptive behaviours. Significant gains were made between T1 and T3 also for the Total Parenting Scale (Cohen's $d = 2.17$) score and for scores on all sub-scales: laxness (Cohen's $d = 1.31$), over-reactivity (Cohen's $d = 1.64$), and verbosity (Cohen's $d = 1.82$).
- The effects of the Group were greater at T3 (12 month follow-up) than T2 for the number of disruptive behaviours that were a problem for parents.

Were improvements made by all groups?

- Overall there were very few differences in gains made by different sub-groups.
- Younger parents reported greater gains for their children's pro-social behaviour ($p<.05$).
- Parents from the lowest socio-economic groups reported greater gains for their children's pro-social behaviour and peer problems ($p<.01$).
- While fathers reported greater gains on SDQ Impact scores ($p<.05$), mothers enjoyed greater gains for parental verbosity ($p<.05$).
- Parents of boys reported greater gains for their children's emotional symptoms ($p<.05$) and the number of perceived problematic behaviours ($p = .05$).

Differences between responders and non-responders

- A greater proportion of older parents completed the post-intervention questionnaire ($p<.01$).
- Non-responders reported higher levels of child problems for the frequency of problematic behaviours ($p<.01$) and number of perceived problematic behaviours ($p<.01$).
- On the Parenting Scale, non-responders reported worse scores for parenting laxness ($p<.05$) and parenting verbosity ($p<.05$).
- Non-responders reported worse scores for parental depression ($p<.01$), parental stress ($p<.05$) and parental anxiety ($p<.05$).

Was there any difference in the outcomes achieved in Level 4 Group Triple P between those who completed Level 4 only *versus* those who completed Level 4 plus some other component of Triple P?

- Parents who attended another component of the Triple P Programme did not achieve any additional significant gain.

4.3 Findings: Level 3 – Workshop Triple P

4.3.1 Introduction

This section presents findings from data collected on participants of the individual topic-based Workshops delivered by trained Triple P practitioners throughout Longford Westmeath. Parents (up to 15 per workshop) self-selected to participate in the individual workshops and could select from

4 different topics. Level 3 targets parents of children with mild to moderate behavioural difficulties. The individual workshops explored the following topics:

- Workshop 1: Dealing with disobedience.
- Workshop 2: Managing fighting and aggression.
- Workshop 3: Hassle-free shopping with children.
- Workshop 4: Developing good bedtime routines.

This study did not evaluate the effectiveness of Workshop 3: Hassle-free shopping with children because only 3 parents completed the pre- and post-intervention questionnaires for this workshop.

Analysis

Data screening took place with the full data file. 20% of all questionnaires were randomly checked and the data file was corrected for any mistakes found during data checking. Missing data was less than 15% across all variables (*see Tables A.5 and A.6 in Appendix A.1*).

Some individual variables were not normally distributed (*see Table A.7 in Appendix A.1*), which is one of the core assumptions of repeated-measures ANOVA. When this was the case, data were analysed using non-parametric methods, either a Wilcoxon Signed Rank Test or a Friedman Test.

Cronbach's alpha was calculated to determine the internal reliability of each of the measures. All the variables reached the level required (Cronbach's $\alpha = .80$).

Data are presented for each workshop separately. Data are presented for only 3 of the 4 workshops due to the low participation rate in Workshop 3: Hassle free shopping with children (n=3). Data are not presented for those who attended Level 3 Primary Care (n=60).

Effect sizes

See Section 4.1.2.

Measures

The Assessment Booklets contained 4 questionnaires. Assessment Booklet 1 (Pre-intervention) contains Questionnaires 1, 2 and 3. Assessment Booklet 2 (Post-intervention) contains Questionnaires 2, 3 and 4. Assessment Booklet 3 (Follow-up) contains Questionnaires 2 and 3. The content of each questionnaire is described below.

1. **Family Background Questionnaire** (FBQ) – *see Section 4.2.1.*
2. **Eyberg Child Behaviour Inventory** (ECBI) (Eyberg and Pincus, 1999) – *see Section 4.2.1.*
3. **Parenting Experience Survey** (Sanders *et al,* 1999). This is a brief measure that provides information about the perceived difficulty of the child's behaviour and parents' subjective experience of their parenting role (e.g. rewarding, demanding, stressful), how confident they feel as a parent and how supported they felt in their role as parents. These items are each assessed on a 5-point scale. For participants who have a partner, an additional 3 items are included which examine the extent of agreement over discipline, the extent of partner support in relation to parenting and an overall assessment of the relationship. The two former items are assessed on a scale of 1-5 and the latter item is assessed on a scale of 0-6.
4. **Satisfaction Questionnaire** (SQ) – *see Section 4.2.1.*

Procedure

All those who attended the workshops were invited to take part in the programme evaluation. Parents were provided with information on the study and if consent was provided, assessment Booklet 1 was issued by LWPP practitioners at the workshop prior to the commencement of the programme. Following the completion of questionnaires, practitioners returned Assessment Booklet 1 to the research team at LWPP. The research Team at LWPP applied ID codes and DED areas to the questionnaires. Practitioners contacted participants 3 weeks following the completion of the programme to discuss their progress and remind them that the post-questionnaires would be delivered in 3 weeks.

The post-programme Assessment Booklet 2 was posted out to parents **6 weeks** following the final delivery session and parents were invited to return the questionnaire within one week. A freepost envelope was provided for the return of the questionnaires and follow-up phone calls were made within 2 weeks of the return date. All identifying details were removed from both sets of questionnaires by removing the cover page before forwarding to NUI Galway for analysis.

Assessment Booklet 3 was completed **6 months** after pre-intervention by a sub-sample of participants. Follow-up data were only collected from participants in the 'Dealing with disobedience' workshop since this was the most well-attended workshop. Follow-up data were collected at only one time point (May/June 2012) from those who had participated in the programme 6 months previously (November 2011).

Participants

Out of a total of 1,065 participants in the Workshop Triple P Programme, 838 consented to take part in the evaluation. Of these, 562 had a child in the target age range of 36 months to 95 months. Further discussion of participants will be presented on a workshop-by-workshop basis in Sections 4.4.1, 4.5.1 and 4.6.1.

4.4 Workshop 1: Dealing with disobedience

4.4.1 Introduction

Participants

Participants involved in the current evaluation were those with a target child in the age range of between 3 years (36 months) and 7 years 11 months (95 months), who volunteered to attend this workshop, who consented to the evaluation and who completed at least the pre-intervention questionnaire (n=408). Socio-demographic variables of all participants who completed the 'Dealing with disobedience' workshop (and the initial questionnaire) are presented in Tables A.30 and A.31 in Appendix A.3.

The evaluation of the programme from pre-intervention to post-intervention focused only on those for whom data were available at both time points. This constituted a sample of 191 for the 'Dealing with disobedience' workshop. Due to missing data on individual variables, the precise number may vary for individual tests. The total number of participants in the workshop who consented to participate in the study and who had a child in the target age range was 408, giving an overall response rate for post-intervention data collection of 47% (*see Section 7.2.4*). This figure is lower than in the evaluations of Workshop Triple P in Brisbane, where 85% of the intervention group and 90% of the control group in one study (Joachim *et al*, 2010) and 82% in another study (Morawska, 2010) completed post-intervention data collection.

A sub-sample of 80 participants were approached monthly during the period April 2012 to September 2012 to complete follow-up data collection 6 months after their participation in the study (i.e. between November 2011 and May 2012). Since parents who did not have a child in the target age range (36-95 months) were excluded, the final size for this sub-sample was n=21 (response rate = 26%). The results of a power analysis conducted on this sub-sample are given in Section 4.4.4.

4.4.2 What were the characteristics of those participating in the workshop?

A descriptive summary of participant characteristics is presented first, followed by the results of the programme evaluation. Detailed tables on child and family demographics and background variables are provided in Appendix A.3.

Child characteristics

Table A.30 in Appendix A.3 provides a summary of target child characteristics. Broadly similar proportions of boys and girls were the focus of parental concern (50.5% boys, 49.5% girls). For the purposes of the evaluation, data were included only from parents of children in the target age group of 3 years (36 months) and 7 years 11 months (95), and the average age was 5.2 years. There were on average 2.3 children per household among participants.

Respondent characteristics

The average age of participants was 36 years (age range 21-65). The majority of the sample was female (87.5%), married (80%) and born in Ireland (78%), which corresponds with national figures for those aged 25-64 (78%) (*see Table 4.3*).

The sample had a mixed educational profile, with approximately 62% undergoing further training or education following completion of secondary school, which is higher than the figures for the total population of Longford (20%) and Westmeath (25%) (*see Table 4.1*). The sample is also drawn from a broad social class spectrum. In addition, approximately 61% of the sample reported working outside of the home (either part-time or full-time), which is greater than the figure for the total population of Longford (46%) and Westmeath (48%) (*see Table 4.1*).

Family characteristics

Children were typically identified as currently living with their 'original family' (85%). 33% of respondents reported having a medical card, which corresponds with the national figure of 36% for children aged 0-15 (*see Table 4.4*). Over 77% had no difficulty meeting essential expenses, but approximately 24% did not have sufficient money to purchase much of what they really wanted after essential expenses were paid.

4.4.3 What improvements were reported by participating parents for child and parent outcomes?

A repeated-measures univariate analysis of variance was used to measure improvements over time on the measure of child behaviour problems (ECBI) and the results show statistically significant improvements in scores between pre-intervention and post-intervention. The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual child behaviour variable in Table 4.11. The frequency with which problems occurred (ECBI Intensity score) showed a decline over time and this decline was significant (Cohen's $d = 1.096$, $p = .000$). Parents also reported a lower number of child problems from pre- to post-intervention (Cohen's $d = 1.093$, $p = .000$). Therefore, the behaviour itself was less frequent, but also parents were less likely to see the behaviour as problematic when it did occur.

A repeated-measures univariate analysis of variance was used to measure improvements over time on the Parenting Experience Survey (PES) and the results show statistically significant improvements in scores between pre-intervention and post-intervention. The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual child behaviour variable in Table 4.13. There were statistically significant improvements in scores for 'parenting is stressful' (Cohen's $d = 0.429$), 'How difficult has your child's behaviour been in the last 6 weeks?' (Cohen's $d = 0.703$), 'Parenting is rewarding' (Cohen's $d = 0.444$), 'Parenting is depressing' (Cohen's $d = 0.549$) and 'In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?' (Cohen's $d = 0.340$). Improvements were observed for 'How supported have you felt in your role as a parent?' and 'Parenting is fulfilling', but the gains were outside the parameters of statistical significance.

There are two potential issues to consider for the results. Firstly, the nature of measurement and secondly, the baseline levels of parenting experiences. Based on the advice of a member of the Triple P Research Team in the University of Queensland, analysis took place at an individual item level. However, there is limited variability within single-item measures rated on a 5-point scale. In addition, consideration also needs to be given to the scope for change and the pre-intervention scores. Baseline scores suggest a relatively positive picture of the parenting experience for the current sub-sample. Pre-intervention scores suggest high levels of fulfilment and reward among parents. Parents' confidence to undertake responsibilities was also quite high. While parenting was rated as moderately demanding and stressful, ratings of parenthood as depressing were relatively low.

Caseness results: Children's emotional and behavioural characteristics

The proportion of children who scored above the clinical cut-offs on the Eyberg Child Behaviour measure pre-intervention and post-intervention was explored using the McNemar's Test. There was a significant change in the proportion of children who were classified as borderline/abnormal since 61% of those categorised as borderline/abnormal at pre-intervention for 'intensity' and 67% of those categorised as borderline/abnormal at pre-intervention for 'problems' were in the normal range at post-intervention (*see Table 4.12*).

Table 4.11: Short-term gains on child behaviour (ECBI) – Workshop Triple P: Dealing with disobedience

Measure	Pre-intervention	Post-intervention	p	Cohen's *d*
ECBI Intensity (n=184)	109.84 (29.9)	98.45 (24.4)	**.000**	**1.096**
ECBI Problem (n=176)	10.08 (7.7)	6.73 (6.0)	**.000**	**1.093**

ECBI = Eyberg Child Behaviour Inventory. Statistically significant findings are in bold.

Table 4.12: Short-term intervention effects on child behaviour (ECBI) Normal *versus* Clinical

Measure	Pre-intervention	Post-intervention		Total	p
		Normal	Borderline/ Abnormal		
Eyberg Intensity	Borderline/Abnormal	27 **(61%)**	17 (39%)	(100%)	**.000**
Eyberg Problem	Borderline/Abnormal	29 **(67%)**	14 (33%)	(100%)	**.000**

ECBI = Eyberg Child Behaviour Inventory. In bold are the percentages of those in the borderline/abnormal range at pre-intervention who moved out of that range at post-intervention. Statistically significant findings are in bold.

Table 4.13: Short-term intervention gains on parenting experience – Workshop Triple P: Dealing with disobedience

Measure		Pre-intervention	Post-intervention	p	Cohen's *d*
How difficult has your child's behaviour been in the last 6 weeks?	(n= 176)	2.70 (0.9)	2.43 (0.8)	**.000**	**0.703**
Parenting is rewarding	(n= 170)	3.88 (0.9)	4.08 (0.8)	**.004**	**0.444**
Parenting is demanding	(n= 169)	3.76 (0.9)	3.73 (0.9)	.626	0.063
Parenting is stressful	(n= 175)	3.29 (1.1)	3.06 (1.0)	**.005**	**0.429**
Parenting is fulfilling*	(n=168)	4.03 (1.0)	4.13 (0.8)	.094	0.187
Parenting is depressing*	(n=166)	1.83 (1.1)	1.58 (0.8)	**.000**	**0.417**
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	(n=182)	3.71 (0.8)	3.85 (0.7)	**.023**	**0.340**
How supported have you felt in your role as a parent?	(n=183)	3.60 (0.9)	3.70 (0.9)	.087	0.255
To what extent do you both agree over the methods of disciplining your child?	(n=179)	4.01 (1.1)	3.92 (1.1)	.184	0.201
How supportive has your partner been towards you in your role as a parent?	(n=179)	4.13 (1.1)	4.04 (1.1)	.207	0.191
How happy do you consider your relationship to your partner to be?	(n= 180)	4.34 (1.4)	4.28 (1.3)	.364	0.142

* Wilcoxon Signed Rank Test (non-parametric data). Statistically significant findings are in bold.

4.4.4 Were the improvements maintained over time?

While post-intervention data were collected 6 weeks after pre-intervention data, a sub-sample of 80 participants were approached monthly during the period April 2012 to September 2012 to complete follow-up data collection 6 months after their participation in the study (i.e. between November 2011 and May 2012). As parents who did not have a child in the target age range (36-95 months) were excluded, the final size for this sub-sample was n=21 (response rate = 26%).

A post-hoc power analysis was run using G*Power 3.1.7 for a paired-samples t-test based on the results of the comparison between pre-intervention and follow-up scores on the Eyberg Intensity score. There was an effect size of $d = 1.14$ (t = 2.50), a sample size of n=20 and an alpha value of p = .05. The results of the power analysis were as follows: Power = .99, Critical t = 2.093. Therefore, there was sufficient power to run the analysis with the sub-sample of participants in the follow-up sample.

The analysis also explored whether there were any differences in key characteristics between the follow-up sample and the main study sample. Chi-square tests showed no significant differences between the samples for gender of parent, gender of child, social class or attendance at other components of Triple P. However, there was a significant difference in the age of participants. While the median age of parents in the total sample was 38, in the follow-up sample 77% were 37 years of age or younger, while 23% were 38 years of age or older. No statistically significant differences were observed in pre-intervention scores for child behaviour and parenting experience measures.

A paired-samples t-test was used to measure the maintenance of programme effects over time (*see Table 4.14*). Significant gains were observed after 6 months for both the frequency and number of disruptive behaviours (*see Figure 4.3*), and for 1 of the 11 items on the Parenting Experience Survey: 'How supported have you felt in your role as a parent?' Table 4.14 also shows where the effects of the workshop were greater at T3 (6 month follow-up) than at T2 (6 week post-intervention) and where the mean difference between T1 and T3 was statistically significant. This was the case for the frequency of disruptive behaviours and the number of disruptive behaviours that were a problem for parents, and for one item on the Parenting Experience Scale: 'How supported have you felt in your role as a parent?'

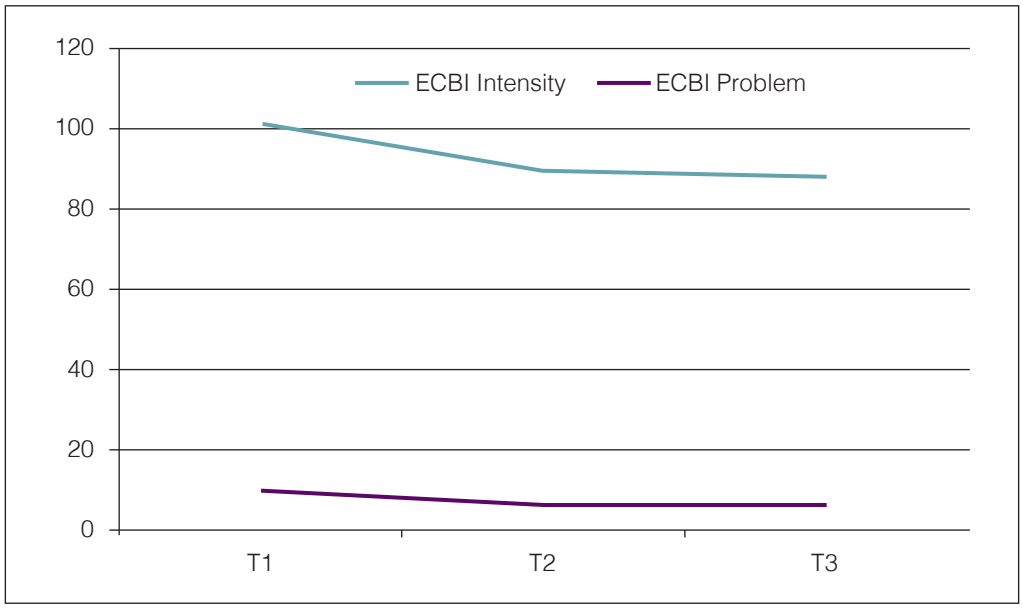
Table 4.14: Maintenance of gains over time – Workshop Triple P: Dealing with disobedience

Measure	T1: Pre	T2: 6 week Post	T3: 6 month Follow-up	Paired-samples t-test		
				Mean difference T1 – T2	Mean difference T1 – T3	Cohen's *d* effect size T1 – T3
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity (n=20)	100.80 (29.7)	90.30 (22.9)	87.85 (25.9)	**10.500 (p = .011)**	**12.950 (p = .021)**	**1.15**
ECBI Problem (n=18)	9.72 (6.9)	5.89 (4.5)	5.61 (5.9)	**3.883 (p = .001)**	**4.111 (p = .031)**	**1.15**
Parenting Experience Scale						
How difficult has your child's behaviour been in the last 6 weeks? (n=21)	2.81 (0.9)	2.43 (0.7)	2.38 (0.9)	**0.381 (p = .042)**	0.429 (p = .119)	0.72
Parenting is rewarding (n=21)	3.90 (0.9)	4.05 (0.7)	4.19 (0.5)	0.143 (p = .379)	0.286 (p = .110)	0.75
Parenting is demanding (n=21)	3.90 (0.8)	3.76 (0.9)	3.57 (1.0)	0.147 (p = .452)	0.333 (p = .167)	0.64
Parenting is stressful (n=21)	3.33 (0.9)	3.10 (1.0)	3.05 (1.0)	0.238 (p = .261)	0.286 (p = .186)	0.61
Parenting is fulfilling* (n=21)	4.05 (1.1)	4.24 (0.8)	4.48 (0.6)	0.19 (p = .234)	0.43 (p = .070)	0.58
Parenting is depressing* (n=21)	1.55 (1.0)	1.50 (0.7)	1.30 (0.5)	0.05 (p = .748)	0.25 (p = .236)	0.02
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent? (n=21)	3.86 (0.7)	3.71 (0.6)	4.05 (0.6)	0.143 (p = .329)	0.190 (p = .384)	0.39
How supported have you felt in your role as a parent? (n=21)	3.48 (0.9)	3.57 (0.9)	3.90 (0.8)	0.095 (p = .576)	**0.429 (p = .016)**	**1.18**
To what extent do you both agree over the methods of disciplining your child? (n=21)	4.05 (0.9)	3.95 (1.1)	4.10 (1.0)	0.095 (p = .576)	0.048 (p = .771)	0.13
How supportive has your partner been towards you in your role as a parent? (n=21)	4.10 (1.2)	4.10 (1.0)	4.19 (1.0)	0.000 (p = 1.00)	0.095 (p = .428)	0.36
How happy do you consider your relationship to your partner to be? (n=21)	4.57 (0.9)	4.33 (1.1)	4.48 (1.2)	0.238 (p = .171)	0.095 (p = .666)	0.20

* Wilcoxon Signed Rank Test (non-parametric data). Statistically significant findings are in bold.

Statistically significant gains were made between T2 and T3 on one item from the Parenting Experience measure: 'How supported have you felt in your role as a parent?' (mean difference = 0.333, p = .049). Gains were also made between T2 and T3 on 'In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?' (mean difference = 0.333, p = .069), but the results were outside the parameters of statistical significance.

Figure 4.3: Maintenance of gains over time (6 months) for child outcomes – Workshop Triple P: Dealing with disobedience



4.4.5 Were improvements made by all groups?

A repeated-measures univariate analysis of variance was used to explore whether the programme was equally effective for all groups at post-intervention. Gains in scores on key outcomes between pre-intervention and post-intervention were compared for different participant groups: male *versus* female participants; male *versus* female target child; younger *versus* older parents; higher *versus* lower SES; and financial circumstances. In the majority of comparisons made, there were no statistically significant differences in gains made by the different sub-groups.

Male (n=92) *versus* female (n=92) target child

The gains reported by parents of girls were statistically greater than the gains reported by parents of boys on the following items from the Parenting Experience Scale: 'Parenting is demanding' ($p = .049$) and 'Parenting is stressful' ($p = .053$) (*see Table A.39 in Appendix A.3*).

Male (n=18) *versus* female (n=166) participants

There was a statistically significant difference in gains made by male and female participants (s*ee Table A.38 in Appendix A.3*). Participating mothers made greater gains than fathers for the number of disruptive behaviours that are a problem for the parents (ECBI Problem) ($p = .005$) and the following item from the Parenting Experience Scale: 'Parenting is demanding' ($p = .014$).

Younger (n=99) *versus* (n=74) older parents

Greater gains were made by parents in the younger age bracket (≤37). There was a statistically significant difference in gains made on the ECBI Problem Sub-scale for the frequency of disruptive behaviours ($p = .043$) (*see Table A.37 in Appendix A.3*).

Financial circumstances

Gains in scores on key outcomes between pre-intervention and post-intervention were compared for participants who were unable (n=37) to meet essential expenses in the preceding 12 months and those who were able to do so (n=136). Greater gains were reported by parents who were unable to meet essential expenses in the preceding 12 months on one item from the Parenting Experience Scale: 'To what extent do you both agree over the methods of disciplining your child?' (p = .059). However, the result was outside the parameters of statistical significance (*see Table A.36 in Appendix A.3*).

Higher *versus* lower SES

Gains in scores on key outcomes between pre-intervention and post-intervention were compared for participants from lower and higher social groups (*see Table A.40 in Appendix A.3*). Social Group 1 (n=43) was defined as those belonging to the 'professional' or 'managerial and technical' occupations; Social Group 2 (n=52) was defined as those belonging to 'non-manual' or 'skilled manual' occupations; and Social Group 3 (n=7) was defined as those belonging to the 'semi-skilled' or 'unskilled' occupations. There were no statistically significant differences in gains made by parents from different socio-economic groups.

4.4.6 Was there any difference in the outcomes achieved in Level 3 between those who completed a specified workshop in Level 3 *versus* those who completed the same workshop, plus another Level 3 workshop or a Level 2 Seminar or the Level 4 programme?

There were no statistically significant differences in scores between parents who had attended another Triple P component previously and those who had not done so (*see Table A.41 in Appendix A.3*). Although the scores of those who had attended another Triple P component worsened on one item of the Parenting Experience Scale: 'How happy do you consider your relationship to your partner to be?' (p = .097), the difference was not significant.

KEY FINDINGS: Workshop Triple P: Dealing with disobedience

Sample size and response rate

- The sample size for this component was made up of those for whom data were available at pre-intervention and post-intervention (n=191), which represents a response rate of 47%.

What were the characteristics of those participating?

- Broadly similar proportions of boys and girls were the focus of parental concern. The average age of children was 5.2 years. The average age of participants was 36. The majority were female (87.5%), married (80%) and born in Ireland (78%).
- Approximately 62% had undergone further training or education after secondary school. Approximately 61% worked outside of the home.
- Children were typically identified as currently living with their 'original family' (85%). 33% had a medical card. Over 77% had no difficulty meeting essential expenses, but approximately 24% did not have sufficient money to purchase much of what they really wanted after essential expenses were paid.

What improvements were reported by participating parents for child and parent outcomes?

- Both measures of child behaviour improved following participation in Workshop 1: the frequency of disruptive behaviours (Cohen's $d = 1.096$) and the number of disruptive behaviours that were a problem for parents (Cohen's $d = 1.093$). These gains were in the 'large' range based on Cohen's criteria (Cohen's d ≥0.80).
- Statistically significant improvements were observed on the Parenting Experience Survey. Using Cohen's criteria, there were gains in the 'medium' to 'large' range for 'How difficult has your child's behaviour been in the last 6 weeks?' (Cohen's $d = 0.703$) and 'Parenting is depressing' (Cohen's $d = 0.549$). There were improvements in the 'small' to 'medium' range in scores for 'Parenting is stressful' (Cohen's $d = 0.429$), 'Parenting is rewarding' (Cohen's $d = 0.444$) and 'In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?' (Cohen's $d = 0.340$).

Caseness results

- The number of children identified as above the clinical cut-off reduced following participation in the workshop. There was a statistically significant ($p<.01$) reduction in children categorised as borderline/ abnormal for the frequency of problematic behaviours (61%) and the number of perceived problematic behaviours (67%).

Were the improvements maintained over time?

- Among a sub-sample of 21 participants (response rate = 26%), significant gains ($p <.05$) were observed after 6 months for both the frequency (Cohen's $d = 1.15$) and number (Cohen's $d = 1.15$) of disruptive behaviours, and for 1 of the 11 items on the Parenting Experience Survey: 'How supported have you felt in your role as a parent?' (Cohen's $d = 1.18$).

Were improvements made by all groups?

- Greater gains were enjoyed by mothers on one item on the Parenting Scale: 'Parenting is demanding' ($p<.01$). Greater gains were reported by mothers for the frequency of disruptive behaviours ($p<.01$).
- Greater gains were enjoyed by parents of girls on one item on the Parenting Scale: 'Parenting is demanding' ($p<.05$).
- Greater gains were made by parents in the younger age bracket (≤37) for the frequency of disruptive behaviours ($p<.05$).
- No statistically significant differences were observed on outcomes for parents who had or had not experienced difficulty meeting essential expenses in the preceding 12 months.
- No statistically significant differences were observed on outcomes for parents from different socio-economic classes.

Was there any difference in the outcomes achieved in Level 3 between those who completed a specified workshop in Level 3 only versus those who completed the same workshop, plus some other component of Triple P?

- No statistically significant differences were observed between parents who had attended another Triple P component previously and those who had not.

4.5 Workshop 2: Managing fighting and aggression

4.5.1 Introduction

Participants

Participants involved in the current evaluation are those with a target child in the age range 3 years (36 months) and 7 years 11 months (95 months), who self-selected to attend this specific workshop, who consented to the evaluation and who completed at least the pre-intervention questionnaire (n=122). Socio-demographic variables of all participants who completed the workshop (and the initial questionnaire) are presented in Tables A.32 and A.33 in Appendix A.3.

The evaluation of the programme from pre-intervention to post-intervention focused only on those for whom data were available at both time points. This constituted a sample of 64 for Workshop 2: Managing fighting and aggression. The total number of participants in this workshop who consented to participate in the evaluation and who had a child in the target age range was 123, giving an overall response rate of 52% (*see Section 7.2.4*). Due to missing data on individual variables, the precise number may vary for individual tests.

Data were collected at pre-intervention and 6 weeks later, at post-intervention.

4.5.2 What were the characteristics of those participating in the workshop?

Child characteristics

Table A.32 in Appendix A.3 provides a summary of target child characteristics. Parents whose focus of concern was a boy were more likely to attend this workshop than parents whose focus of concern was a girl (59% boys, 41% girls). For the purposes of the evaluation, data were included only from parents of children in the target age range of 3 years (36 months) and 7 years 11 months (95 months) and the average age was 5.4 years. There were on average 2.4 children per household among participants.

Respondent characteristics

The average age of participants was 38 years (age range 23-65). The majority of the sample was female (94%), married (83%) and born in Ireland (80%), which is comparable with national figures for those aged 25-64 (78%) (*see Table 4.3*).

The sample had a mixed educational profile, with approximately 72% undergoing further training or education following completion of secondary school, which is higher than the figures for the total population of Longford (20%) and Westmeath (25%) (*see Table 4.1*). The sample was also drawn from a broad social class spectrum. In addition, approximately 48% of the sample reported working outside of the home (either part-time or full-time), which is the same as the figure for the total population of Westmeath and marginally higher than for Longford (46%) (*see Table 4.1*).

Family characteristics

Children were typically identified as currently living with their 'original family' (88%). 39% of respondents reported having a medical card, which is higher than the national figure of 36% for children aged 0-15 (*see Table 4.4*). Over 73% had no difficulty meeting essential expenses, but approximately 21% did not have sufficient money to purchase much of what they really wanted after essential expenses were paid.

4.5.3 What improvements were reported by participating parents for child and parent outcomes?

A repeated-measures univariate analysis of variance was used to measure improvements over time on the measure of child behaviour problems (ECBI) and the results show statistically significant improvements in scores between pre-intervention and post-intervention. The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual child behaviour variable in Table 4.15. The frequency with which problems occurred (ECBI Intensity score) showed a decline over time and this decline was significant (Cohen's $d = 0.667$, $p = .015$). Parents also reported a lower number of child problems from pre- to post-intervention assessment (Cohen's $d = 0.924$, $p = .001$).

A repeated-measures univariate analysis of variance was used to measure gains over time on the Parenting Experience Survey (PES) and the results show statistically significant improvements in scores between pre-intervention and post-intervention (*see Table 4.17*). There were statistically significant improvements in scores for 'Parenting is stressful' (Cohen's $d = 0.602$), 'How supported have you felt in your role as a parent?' (Cohen's $d = 0.514$), 'How difficult has your child's behaviour been in the last 6 weeks?' (Cohen's $d = 0.924$), 'Parenting is rewarding' (Cohen's $d = 0.830$), 'Parenting is depressing' (Cohen's $d = 0.527$), 'In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?' (Cohen's $d = 0.749$), 'To what extent do you both agree over the methods of disciplining your child?' (Cohen's $d = 0.590$) and 'How supportive has your partner been towards you in your role as a parent?' (Cohen's $d = 0.735$). No significant improvements were observed for 'Parenting is demanding,' 'Parenting is fulfilling' or 'How happy do you consider your relationship to your partner to be?'

Caseness results: Children's emotional and behavioural characteristics

The proportion of children who scored above the clinical cut-offs on the Eyberg Child Behaviour measure pre-intervention and post-intervention was explored using the McNemar's Test. There was a significant change in the proportion of children who were classified as borderline/abnormal since 63% of those categorised as borderline/abnormal at pre-intervention for 'problems' were in the normal range at post-intervention (*see Table 4.16*).

Table 4.15: Short-term gains on child behaviour (ECBI) – Workshop Triple P: Managing fighting and aggression

Measure	Pre-intervention	Post-intervention	p	Cohen's *d*
ECBI Intensity (n=58)	112.72 (24.3)	104.74 (24.3)	**.015**	**0.667**
ECBI Problem (n=56)	11.32 (6.8)	8.29 (6.6)	**.001**	**0.924**

ECBI = Eyberg Child Behaviour Inventory. Statistically significant findings are in bold.

Table 4.16: Short-term intervention effects on child behaviour (ECBI) Normal *versus* Clinical

Measure	Pre-intervention	Post-intervention		Total	p
		Normal	Borderline/ Abnormal		
Eyberg Intensity	Borderline/Abnormal	6 **(46%)**	7 (54%)	(100%)	.508
Eyberg Problem	Borderline/Abnormal	12 **(63%)**	7 (37%)	(100%)	**.013**

In bold are the percentages of those in the borderline/abnormal range at pre-intervention who moved out of that range at post-intervention. Statistically significant findings are in bold.

Table 4.17: Short-term gains on parenting experience – Workshop Triple P: Managing fighting and aggression

Measure	Pre-intervention	Post-intervention	p	Cohen's *d*
How difficult has your child's behaviour been in the last 6 weeks? (n=59)	3.00 (0.8)	2.53 (0.8)	**.001**	0.924
Parenting is rewarding (n=56)	3.77 (1.0)	4.07 (0.8)	**.003**	0.830
Parenting is demanding (n=57)	3.86 (0.9)	3.84 (0.9)	.878	0.000
Parenting is stressful (n=55)	3.46 (0.9)	3.18 (0.9)	**.031**	0.602
Parenting is fulfilling* (n=54)	3.85 (1.0)	3.89 (0.9)	.734	0.068
Parenting is depressing* (n=54)	1.83 (1.0)	1.56 (0.7)	**.011**	0.527
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent? (n=60)	3.57 (0.9)	3.88 (0.6)	**.006**	0.749
How supported have you felt in your role as a parent? (n=61)	3.49 (1.1)	3.72 (0.7)	**.051**	0.514
To what extent do you both agree over the methods of disciplining your child? (n=61)	3.87 (1.0)	4.16 (0.9)	**.025**	0.590
How supportive has your partner been towards you in your role as a parent? (n=61)	3.85 (1.1)	4.20 (0.9)	**.006**	0.735
How happy do you consider your relationship to your partner to be? (n=61)	4.31 (1.0)	4.44 (1.0)	.220	0.320

* Wilcoxon Signed Rank Test (non-parametric). Statistically significant findings are in bold.

KEY FINDINGS: Workshop Triple P: Managing fighting and aggression

Sample size and response rate

- The sample size for this component was made up of those for whom data were available at pre-intervention and post-intervention (n=64), which represents a response rate of 52%.

What were the characteristics of those participating?

- Parents whose focus of concern was a boy were more likely to attend this workshop and the average child age was 5.4 years.
- The average age of participants was 38 years (age range 23-65). The majority of the sample was female (94%), married (83%) and born in Ireland (80%).
- Approximately 72% had undergone further training or education following secondary school. The sample was also drawn from a broad social class spectrum. Approximately 48% of the sample reported working outside of the home.
- Children were typically identified as currently living with their 'original family' (88%). 39% had a medical card. Over 73% had no difficulty meeting essential expenses, but approximately 21% did not have sufficient money to purchase much of what they really wanted after essential expenses were paid.

What improvements were reported by parents for child and parent outcomes?

- Both measures of child behaviour improved following participation in Workshop 2. Using Cohen's criteria, there were 'medium' to 'large' gains for the frequency of disruptive behaviours (Cohen's $d = 0.667$) and 'large' gains for the number of disruptive behaviours that were a problem for parents (Cohen's $d = 0.924$).

- There were statistically significant improvements in scores on the Parenting Experience Survey. Using Cohen's criteria, there were 'large' gains for 'How difficult has your child's behaviour been in the last 6 weeks?' (Cohen's $d = 0.924$) and 'Parenting is rewarding' (Cohen's $d = 0.830$). There were 'medium' to 'large' gains for 'Parenting is stressful' (Cohen's $d = 0.602$), 'Parenting is depressing' (Cohen's $d = 0.527$), 'In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?' (Cohen's $d = 0.749$), 'How supported have you felt in your role as a parent?' (Cohen's $d = 0.514$), 'To what extent do you both agree over the methods of disciplining your child?' (Cohen's $d = 0.590$) and 'How supportive has your partner been to you in your role as a parent?' (Cohen's $d = 0.735$).

Caseness results

- The number of children identified as above the clinical cut-off reduced following participation in the workshop. There was a statistically significant ($p<.05$) reduction in children categorised as borderline/ abnormal for the number of perceived problematic behaviours (63%)

4.6 Workshop 4: Developing good bedtime routines

4.6.1 Introduction

Participants

Participants involved in the current evaluation are those with a target child in the age range 3 years (36 months) and 7 years 11 months (95 months), who self-selected to attend this specific workshop, who consented to the evaluation and who completed at least the pre-intervention questionnaire (n=42). Socio-demographic variables of all participants who completed the workshop (and the initial questionnaire) are presented in Tables A.34 and A.35 in Appendix A.3.

The evaluation of the programme from pre-intervention to post-intervention focused only on those for whom data were available at both time points. This constituted a sample of 24 for Workshop 4: Developing good bedtime routines. The total number of participants in this workshop who consented to take part in the evaluation and who had a child in the target age range was 42, giving an overall response rate of 57%. Due to missing data on individual variables, the precise number may vary for individual tests.

Data were collected at pre-intervention and 6 weeks later, at post-intervention.

4.6.2 What were the characteristics of those participating in the workshop?

Child characteristics

Table A.34 in Appendix A.3 provides a summary of target child characteristics. Broadly similar proportions of boys and girls were the focus of parental concern (52% boys, 48% girls). For the evaluation, data were included only from parents of children in the target age group of 3 years (36 months) and 7 years 11 months (95 months) and the average age was 5 years. There were on average 2.3 children per household among participants.

Respondent characteristics

The average age of participants was 37 years (age range 21 to 50). The majority of the sample was female (89%), married (69%) and born in Ireland (90.5%), which is higher than the national figures for those aged 25-64 (78%) (*see Table 4.3*).

The sample had a mixed educational profile, with approximately 48% undergoing further training or education following completion of secondary school, which is higher than the figures for the total population of Longford (20%) and Westmeath (25%) (*see Table 4.1*). The sample was also drawn from a broad social class spectrum. In addition, approximately 67% of the sample reported working outside of the home (either part-time or full-time), which is higher than the figures for the total populations of Longford (46%) and Westmeath (48%) aged 15 and over (*see Table 4.1*).

Family characteristics

Children were typically identified as currently living with their 'original family' (83%). 27% of respondents reported having a medical card, which is lower than the national figure of 36% for children aged 0-15 (*see Table 4.4*). 78% had no difficulty meeting essential expenses, but approximately 25% did not have sufficient money to purchase much of what they really wanted after essential expenses were paid.

4.6.3 What improvements were reported by participating parents for child and parent outcomes?

A repeated-measures univariate analysis of variance was used to measure the gains over time on the measure of child behaviour problems (ECBI). The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual child behaviour variable in Table 4.18. The frequency with which problems occurred (Intensity score) showed a decline over time, but the difference was not statistically significant (Cohen's $d = 0.652$, $p = .172$). Parents also reported a lower number of child problems from pre- to post-intervention assessment and the difference was statistically significant (Cohen's $d = 1.146$, $p = .016$). The behaviour itself was less frequent, but also parents were less likely to see the behaviour as problematic when it did occur.

A repeated-measures univariate analysis of variance was used to measure gains over time on the Parenting Experience Survey (PES). The pre- and post-intervention means and standard deviations along with univariate statistics are displayed for each individual child behaviour variable in Table 4.20. There were statistically significant improvements in scores for 'To what extent do you both agree over the methods of disciplining your child?' (Cohen's $d = 0.912$, $p = .039$), while gains that were outside the parameters of statistical significance were observed for 'Parenting is stressful' (Cohen's $d = .0860$, $p = .069$), 'How supported have you felt in your role as a parent?' (Cohen's $d = 0.837$, $p = .057$) and 'How supportive has your partner been towards you in your role as a parent?' (Cohen's $d = 0.742$, $p = .088$).

Caseness results: Children's emotional and behavioural characteristics

There was no statistically significant change in the proportion of children who were in the 'borderline/ abnormal' range for child behaviour. The results are reported in Table 4.19.

Table 4.18: Short-term intervention effects on child behaviour (ECBI) – Workshop Triple P: Developing good bedtime routines

Measure	Pre-intervention	Post-intervention	p	Cohen's *d*
ECBI Intensity (n=20)	112.20 (33.1)	102.55 (32.0)	.172	0.652
ECBI Problem (n=22)	10.05 (7.0)	6.73 (7.4)	**.016**	**1.146**

ECBI = Eyberg Child Behaviour Inventory. Statistically significant findings are in bold.

Table 4.19: Short-term intervention effects on child behaviour (ECBI) Normal *versus* Clinical

Measure	Pre-intervention	Post-intervention		Total	p
		Normal	Borderline/ Abnormal		
Eyberg Intensity	Borderline/Abnormal	1 **(20%)**	4 (80%)	(100%)	1.00
Eyberg Problem	Borderline/Abnormal	3 **(60%)**	2 (40%)	(100%)	1.00

In bold are the percentages of those in the borderline/abnormal range at pre-intervention who moved out of that range at post-intervention.

Table 4.20: Short-term intervention effects on parenting experience – Workshop Triple P: Developing good bedtime routines

Measure	Pre-intervention	Post-intervention	p	Cohen's *d*
How difficult has your child's behaviour been in the last 6 weeks? (n=22)	2.59 (0.9)	2.55 (1.1)	.847	0.090
Parenting is rewarding (n=22)	4.3 (0.8)	4.30 (0.8)	1.00	0.000
Parenting is demanding (n=20)	3.95 (1.0)	3.55 (0.7)	.148	0.692
Parenting is stressful (n=21)	3.33 (1.1)	2.76 (1.1)	.069	0.860
Parenting is fulfilling (n=20)	4.50 (0.5)	4.45 (0.6)	.763	0.096
Parenting is depressing (n=18)	1.28 (0.5)	1.33 (0.5)	.564	0.193
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent? (n=23)	3.78 (0.9)	3.87 (0.8)	.575	0.283
How supported have you felt in your role as a parent? (n=24)	3.33 (1.2)	3.75 (1.0)	.057	0.837
To what extent do you both agree over the methods of disciplining your child? (n=24)	3.67 (1.5)	4.21 (1.2)	**.039**	**0.912**
How supportive has your partner been towards you in your role as a parent? (n=24)	4.04 (1.3)	4.38 (1.2)	.088	0.742
How happy do you consider your relationship to your partner to be? (n=24)	4.46 (1.3)	4.71 (1.0)	.185	0.570

Statistically significant findings are in bold.

KEY FINDINGS: Workshop Triple P: Developing good bedtime routines

Sample size and response rate

- The sample size for this component was made up of those for whom data were available at pre-intervention and post-intervention (n=24), which represents a response rate of 57%.

What were the characteristics of those participating in the programme?

- Broadly similar proportions of boys and girls were the focus of parental concern and the average age of the children was 5 years.
- The average age of participants was 37 years. The majority of the sample was female (89%), married (69%) and born in Ireland (90.5%).
- Approximately 48% had undergone further training/education after secondary school. The sample was from a broad class spectrum. Approximately 67% worked outside the home.
- Children were typically identified as currently living with their 'original family' (83%). 27% of respondents had a medical card. 78% had no difficulty meeting essential expenses, but approximately 25% did not have sufficient money to purchase much of what they really wanted after essential expenses were paid.

What improvements were reported by parents for child and parent outcomes?

- Following completion of the workshop, parents reported a lower number of child problems and the difference was statistically significant and 'large' (Cohen's $d = 1.146$, $p<.05$).
- There was a statistically significant and 'large' improvement in scores for 'To what extent do you both agree over the methods of disciplining your child?' (Cohen's $d = 0.912$, $p<.05$).

Caseness results

- There was no statistically significant change in the proportion of children who were in the 'borderline/abnormal' range for child behaviour.

4.7 Key characteristics of those who did and did not complete both questionnaires

In the evaluation of Level 3 Workshop Triple P, more than half of participants who completed questionnaires at T1 (n=299) did not complete questionnaires at T2. The two groups were compared on socio-demographic variables and outcome variables to evaluate if there were significant differences between those who did and did not remain in the study (*see Tables A.42 and A.43 in Appendix A.3*).

Fathers were more likely to not complete both questionnaires (63.5%, n=40) when compared with mothers (52.5%, n=273), but the difference was not statistically significant ($p = .098$). Those who remained in the evaluation had recorded worse scores (higher level of need) for the item 'Parenting is depressing' and the difference was statistically significant ($p = .002$), but they also recorded better scores on the item 'To what extent do you both agree over the methods of disciplining your child?' and the difference was outside the parameters of statistical significance ($p = .057$).

4.8 Findings: Level 2 – Seminars

4.8.1 Introduction

Level 2 interventions provide topic-specific guidance to parents of children with mild behaviour difficulties or developmental issues. Three individual topic-based seminars were provided to parents and caregivers by trained Triple P practitioners throughout Longford Westmeath. The aims of the seminars were to promote positive parenting and promote children's health, development and well-being. 'Tip sheets' were provided to parents who attended and videotapes were used to demonstrate specific parenting strategies. The three seminars available were:

- Seminar 1: Power of positive parenting.
- Seminar 2: Raising confident competent children.
- Seminar 3: Raising resilient children.

The evaluation of Level 2 Seminars was structured around the following research question:

- What were the characteristics of those participating in the programme?

Method

Data were collected from Seminar participants at two time points. The questionnaire was completed at one time point only (post-Seminar) and this constituted a cross-sectional study design. Section 4.8.2 below presents the findings on the profile of parents. Chapter 7 on the Implementation Study describes how parents heard about the programme (*see Section 7.2.3*) and on their satisfaction with it (*see Section 7.3.4*). Data were also collected from follow-up one-to-one interviews with 5 parents; the interviews focused on parents' views of the quality of programme content and delivery (*see Section 7.3.4*).

Participants

Participants for Level 2 were parents and caregivers who attended individual seminars and volunteered to complete questionnaires. Since some people may have attended more than one seminar and since data were anonymous, all data are presented on an individual seminar basis.[2]

Of the parents who attended the individual seminars, the following number agreed to take part in the evaluation: 1,086 participants for Seminar 1; 677 for Seminar 2; and 121 for Seminar 3 (*see Table 4.21*). While 1,981 in total agreed to participate in the research, the total number of participants in the seminars (i.e. including those who did not agree to take part in the evaluation) was 2,699 (see Section 7.2.4). The figures do not include 32 participants who reported not having children.

Table 4.21: Number of parents attending individual seminars who participated in the evaluation

No. of participants in Seminar 1	No. of participants in Seminar 2	No. of participants in Seminar 3
1,086 (57.6%)	677 (35.9%)	121 (6.4%)

Measures

A 9-item Client Satisfaction Questionnaire (*see Section 7.3.4 for findings*) and a 9-item Participant Profile Questionnaire were used to record socio-demographic information (*see below for findings*).

2. It was not possible to combine the data for the three seminars as the data would not be independent.

Procedure

Both questionnaires were anonymous and were completed on a voluntary basis following each seminar. Questionnaires were collected by Triple P practitioners and returned to the LWPP office in Athlone for forwarding to NUI, Galway for analysis.

Analysis

Participant characteristics are presented as either percentages or average and standard deviation scores, as appropriate. For example, variables such as age, number of children and scores on rating scales are presented according to means and standard deviations, whereas categorical variables such as gender, having a medical card or not, and educational level are presented according to the percentages of participants falling into the various categories. Results from the Client Satisfaction Questionnaire are reported in Section 7.3.4.

Missing values analyses indicated that missing data was less than 10% across all variables (*see Appendix A.1*).

4.8.2 What were the characteristics of those participating in the programme?

A descriptive summary of participant characteristics is provided in this section (*see also Tables A.44, A.45 and A.46 in Appendix A.4*). The majority of participants were married (over 80% in each group) and over 83% of participants in each group were female. From a geographical point of view, the sample was predominantly from Westmeath, with attendance from Longford participants in the three individual seminars at 10%, 26% and 26% respectively. Figures from the 2011 Census show the population of Westmeath (86,164) was over twice that of Longford (39,000) (*see Table 4.1*). The average number of children for the participant group was 2 (*see Table 4.22*).

Table 4.22: Number of children in the participants' families

	Seminar 1	Seminar 2	Seminar 3
Number of children in family	2.35 (1.06)	2.48 (1.04)	2.14 (1.04)

Figures represent mean number of children followed by standard deviations in parentheses.

The sample had a mixed educational profile. Over two-thirds of participants in each seminar (68%, 73% and 76% in the three seminars) had completed further training or education after completion of secondary school. Of these, the percentage with a University degree or postgraduate qualification (45%, 50% and 53% in the three seminars) was higher than the figures for the total population of Longford (20%) and Westmeath (25%) (*see Table 4.1*).

The majority of participants in each seminar worked outside of the home, either part-time or full-time (56%, 65% and 68%), which is higher than the figures for the total population of Longford (46%) and Westmeath (48%) (*see Table 4.1*). Participants were drawn from a broad spectrum of social classes: the most numerous occupational grouping of participants was 'managerial and technical' (17%, 24% and 25%), followed by 'non-manual workers' (15%, 17% and 18%). Of those who participated, 23%, 27%, and 27% in the individual seminars had a medical card, which is lower than the national figure for children aged 0-15 (36%) (*see Table 4.1*).

Parents' satisfaction with the seminars is reported in Chapter 7, along with their perceptions of the benefits of the seminars (*see Section 7.3.4*).

KEY FINDINGS: Level 2 – Seminars

What were the characteristics of those participating in the programme?

- The majority of the participants were married (over 80% in each group) and over 83% in each group were female.
- The majority of participants were from Co. Westmeath, varying between 74% and 90% depending on the seminar.
- Over two-thirds of participants in each seminar had completed further training or education after secondary school.
- The majority of participants in each seminar worked outside of the home, either part-time or full-time (56%, 65% and 68%).
- 23%, 27% and 27% in the individual seminars had a medical card.
- On average, participants had 2 children.

5. Findings from Population Study

Findings from the Population Study are presented in this chapter. The aim of this element of the evaluation was to document baseline need in the intervention counties, to consider the exposure of the target population to elements of the broader Triple P Programme and to investigate programme effects. The presentation of the findings is structured according to the research questions posed for the Population Study, detailed below.

5.1 Research questions and methodology

Three research questions were developed for this part of the evaluation in partnership with the Triple P Core Team, as follows:

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?

5.1.1 Setting and sampling frame

The sample frame comprised populations in the two intervention counties plus two counties that acted as comparison populations. The intervention counties were Longford and Westmeath. Comparison counties were selected based on a number of criteria. The socio-economic data of potential comparison counties were matched to Cos. Longford and Westmeath with respect to overall affluence/deprivation (2006 Relative Index Score: 4.5 and 1.7 respectively – Haase and Pratschke, 2008). Other attributes of the comparison counties were also considered, including: similarity of rural/urban continuum, percentage engaged in farming, current or past participation in parenting programmes in the locality, proximity to the intervention counties and exclusion of major urban areas (Watson *et al,* 2005). The comparison counties chosen were Tipperary North and Tipperary South (2006 Relative Index Score: 2.3 and -0.7 respectively – Haase and Pratschke, 2008).

5.1.2 Sample selection

The baseline population survey was conducted by Millward Brown Lansdown in Autumn 2010, while the follow-up Time 2 survey was executed by Amárach in Spring 2013. The same sample selection and data collection protocols were followed in both areas at both time points. A sample size of 1,500 per experimental condition, per phase, was determined to provide a confidence interval of 2.8%. The target population was families with children aged 4-8 years at their next birthday within the intervention and comparison counties. Samples were stratified geographically into aggregate Electoral Districts (EDs) comprising geographically contiguous EDs. Both samples were drawn from 84 sample points, which were distributed across these EDs. The number of sample points selected was based on size of the target population within the aggregate ED areas (Census 2006 data, adjusted for collection period in 2010, and Census 2011, adjusted for the collection period 2013, Central Statistics Office). Thus aggregate ED areas with larger population had more sampling points.

5.1.3 Data collection

In urban areas, a number of estate/street names were allocated for each sampling point and interviewers chose randomly from these. Interviewers then randomly selected households within the streets/estates selected. In rural areas, interviewers randomly selected households at the level of ED within each aggregate ED area.

Quotas were based on socio-economic group (SEG). These were based on the Joint National Readership Survey[3] at the regional (provincial) level, with a rural/urban breakdown applied. Child age and gender weights were also created using Census 2006 and 2011 data in cross-tabulations of child age by child gender by aggregate area to calculate the distribution within counties. In a similar manner, SEG weighting was created using cross-tabulations of Census data for number of families with children by SEG by aggregate area. The final sample weights were created by multiplication of the SEG by the age and gender weights.

As part of the data collection process, interviewers used filter questions to ensure that the appropriate sample was targeted (i.e. parents whose children will be 4-8 years on their next birthday and therefore 3-7 years of age at the time of interview). These were:

- *Do you have any children aged between 3 and 7?*
- *For these next questions, please answer in relation to your child who is aged between 3 and 7 years old. If you have more than one child aged 3 to 7, please answer in relation to the child whose birthday is next.*

The child for whom the respondent was answering was known as **the index child**.

Participants were sampled from 302 electoral districts: intervention: 139; comparison: 165.

- Time 1: 200 electoral districts: intervention: 93 comparison: 107; Sample range n=1 to n=186
- Time 2: 284 electoral districts: intervention: 127 comparison: 157; Sample range n=1 to n=194

Geographically adjacent EDs were combined into 26 aggregated areas (13 in the intervention: comparison: 13), with group sizes ranging from 22 to 293.[4]

5.1.4 Data management

All collected data were divided into sub-sections, including demographic variables, child problems (the Strengths and Difficulties Questionnaire and sub-scales), 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, opinion on parenting scale, and 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 included. Details on how each of these were determined, including scale construction and data quality issues, are provided in Appendix B.1.

5.1.5 Data analysis

SPSS Version 20 for Mac (IBM Corporation) was used throughout for statistical analyses. Inter-item reliability was analysed for all scales using Cronbach's alpha. Pearson's chi-square tests were used to compare distributions of socio-demographic factors between intervention and comparison samples and to test for associations between clinical/normal categories of SDQ scales and various demographic factors. Comparisons of mean scores between intervention and comparison samples for various scales were conducted using independent samples t-tests. Tarone's chi-square was used to test for homogeneity of odds ratios between intervention and comparison samples for parenting strategies *versus* SDQ scales.

3. The Joint National Readership Survey demographic data was derived from the 2006 Census and the Quarterly Household National Surveys. Available at: http://www.jnrs.ie/survey.htm
4. Despite the design of the sample, it should be noted that intraclass correlation coefficients were less than 0.05 for all dependent variables. This negated the need to adopt a multi-level approach to data analyses.

5.1.6 Sample characteristics

The Time 1 sample comprised 1,501 parents of children aged 3-7 and the comparison sample comprised 1,495. These reflect samples of 20% and 17% of the total eligible population. At Time 2, the samples included 1,521 parents in the intervention sample and 1,544 in the comparison sample, reflecting 21% and 17% of the total eligible population. The geographic distribution of the samples and the numbers of interviews achieved per aggregate ED area are presented in Appendix B.2.

A number of socio-demographic factors differed significantly between intervention and comparison groups. At Time 1, the index children for the intervention sample were younger, while at Time 2 they were more likely to be male. In contrast to the comparison samples, the Time 1 intervention sample parents were more likely to be single, of higher social class and more urban, while intervention sample parents at Time 2 were more likely to be married, fathers, of higher social class, more urban, own their own homes, be living in an original family (with both biological or adoptive parents), currently looking for a job, with more children in the household and less likely to be University-educated or to have a medical card. Although these multiple differences between the samples were statistically significant, it is important to note that the relationships (Phi or Crammer's V) were generally weak (< 0.13).

5.2 Research Question 1: What was the prevalence and baseline comparison of child emotional and behaviour problems and negative parental strategies, experiences, and opinions?

5.2.1 Children's behaviour and emotional problems

The data employed to answer this question are drawn from the Time 1 baseline data collected before the implementation of LWPP in the intervention counties.

Approximately 18% of parents reported that their child had some emotional or behavioural difficulties, while 3.5% reported definite or severe problems (*see Table 5.1*). No significant differences were found between the frequencies of reported difficulties in the intervention and comparison samples (p>0.05, Pearson's chi-square test, 5.1).

Table 5.1: Respondent reports on whether the index child has emotional and behavioural difficulties, at Time 1

Child has emotional or behavioural difficulties	Intervention	Comparison	Total
Yes	267 (17.8%)	268 (17.9%)	535 (17.9%)
No	1,234 (82.2%)	1,227 (82.1%)	2,461 (82.1%)
p		0.26	

p = probability of Pearson's chi-square test comparing intervention and comparison samples.

Children's strengths and difficulties

The Strengths and Difficulties Questionnaire (SDQ) comprising 25 items was used to assess parental report of children's emotional and behavioural problems (Goodman, 1997). Parents were asked to consider whether statements were 'not true', 'somewhat true' or 'certainly true' based on the behaviour of their child over the past 6 months. The Total Difficulties Scale is comprised of 20 of these items. Four sub-scales are also derived from this scale, each consisting of 5 items: emotional symptoms, conduct problems, peer problems

and hyperactivity sub-scales. A further sub-scale consisting of 5 items forms the Pro-Social Scale. Internal consistency was found to be reasonable to good (Cronbach's alpha ≥0.6) for these scales, with the exception of the Peer Problems Sub-scale (0.53) (*see Appendix B.1 for details*).

Overall patterns

Table 5.2 presents comparisons of intervention and comparison sample means for the SDQ sub-scales. All scales showed statistically different means ($p<0.05$, independent samples t-test) with the exception of emotional symptoms. In each case, the respondents in the intervention countries reported more negatively than those in the comparison counties.

Table 5.2: Intervention and comparison sample means and standard deviations for each emotional and behavioural difficulties scale, at Time 1

Scale	Intervention Mean ± SD	Comparison Mean ± SD	Standardised mean difference	t value	p
Total Difficulties Scale	8.46 ± 5.49	7.85 ± 5.48	0.11	3.013	0.003**
Emotional Symptom Sub-scale	1.83 ± 1.86	1.80 ± 1.90	0.02	0.439	0.661
Conduct Problem Sub-scale	1.77 ± 1.66	1.60 ± 1.64	0.10	2.749	0.006**
Peer Problem Sub-scale	1.49 ± 1.59	1.31 ± 1.55	0.12	3.253	0.001**
Hyperactivity Sub-scale	3.36 ± 2.17	3.14 ± 2.18	0.10	2.786	0.005**
Pro-social Scale	7.83 ± 2.00	8.25 ± 1.87	-0.22	-5.866	0.000***

Standardised mean difference (effect size) calculation: (MeanI - MeanC)/pooled standard deviation, where I = intervention and C = comparison samples. Effect sizes refer to the strength of the relationship between two variables or the standardised difference between two variables.

p = probability of the independent samples t-test.

* statistically significant differences between intervention and comparison sample scale means at $p<0.05$;

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

Clinical significance

Categorising the Total Difficulties Scale scores according to banding defined by UK normative SDQ data [5] as normal or borderline to abnormal (also referred to as 'clinical') revealed that overall 9% of children were in the abnormal category (*see Table 5.3*). Differences between comparison and intervention samples were not statistically significant ($p= 0.112$; Pearson's chi-square test).

Using this dichotomised scoring system, 17.2% of children in the intervention sample and 14.4% in the comparison sample were reported to have elevated scores, indicating borderline to clinical emotional or behavioural problems.

Table 5.3: Percentages and frequencies of children categorised abnormal, borderline and normal according to SDQ symptom scoring bands for the total difficulties scale, at Time 1

	Intervention n (%)	Comparison n (%)	Total
Abnormal	154 (10.3)	125 (8.4)	279 (9.3)
Borderline	104 (6.9)	91 (6.1)	195 (6.5)
Normal	1243 (82.8)	1279 (85.6)	2522 (84.2)
p		0.112	

Total Difficulties Scale categories: normal = 0-13; borderline 14-16; abnormal = 17-40.

p= probability of Pearson's chi-square test.

5. Youth in Mind website SDQ (UK) scoring file, available at: http://www.sdqinfo.com/py/doc/c0.py

Table 5.4: Frequency and percentage of children scoring in the borderline to clinical range§ for behaviour and emotional problems as reported by parents, at Time 1

	Intervention n (%)	Comparison n (%)	p	Phi	Total n (%)
Total Difficulties Scale	258 (17.2)	216 (14.4)	0.040*	0.038	474 (15.8)
Emotional Symptom Sub-scale	273 (18.2)	246 (16.5)	0.210	0.023	519 (17.3)
Conduct Problem Sub-scale	406 (27.0)	352 (23.5)	0.027*	0.040	758 (25.3)
Peer Problem Sub-scale	327 (21.8)	287 (19.2)	0.079	0.032	614 (20.5)
Hyperactivity Sub-scale	242 (16.1)	210 (14.0)	0.112	0.029	452 (15.1)
Pro-social Scale	235 (15.7)	161 (10.8)	0.001**	0.072	396 (13.2)

§ 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.

p = probability of Pearson's chi-square test.

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

Differences between comparison and intervention samples were statistically significant (p<.05, Pearson's chi-square test) for the Total Difficulties, Conduct Problem and Pro-social Scales. These all showed higher percentages of scores in the borderline to abnormal range among the intervention sample compared to the comparison sample. The highest percentages of borderline to abnormal cases were reported for the Conduct Problem Scale in both samples. In all cases, however, the differences between the two samples were small (Phi <0.1), as seen in Table 5.4.

Gender

There were few differences between boys and girls on the emotional symptoms or the peer problems sub-scales. The overall Total Difficulties Scale and the conduct problem, hyperactivity and pro-social sub-scales showed greater proportions of boys with higher scores than girls (p < 0.05, Pearson's chi-square test; *see Table B.4a in Appendix B.4*).

In general, scores for SDQ sub-scales were not associated with age, with two exceptions. Higher proportions of younger children aged 4-6 in the comparison sample were reported to show conduct problems compared to older children, aged 7-8. In the intervention sample, higher proportions of younger children (4-5 years) were reported to have pro-social problems when compared to older children.

Social class

With the exception of conduct problems, all sub-scales showed higher percentages of borderline to abnormal range scores with lower class status. The highest percentages were found in the 'unemployed/welfare' and the 'unknown' categories, and the lowest in the 'higher professional' categories. Nevertheless, the percentage of participants reporting child total difficulties with emotional and behavioural problems ranged from 13.3% to 15.8% across the categories of managerial and technical, non-manual, skilled blue collar and semi-skilled blue collar (*see Figure B.4a in Appendix B.4*), demonstrating need across the socio-economic spectrum. With the exception of the Pro-social Scale and Hyperactivity Scale in the comparison sample, dichotomised scores for SDQ scales in both intervention and comparison samples showed significant associations with social class. However, all of these associations were weak (Cramers's V < 0.2).

Statistical differences were found between intervention and comparison samples within the skilled and non-manual class for the Total Difficulties Scale and in the professional and managerial class for conduct problem, hyperactivity and pro-social sub scales, with a higher percentage of children in the borderline to abnormal range reported in the intervention sample (p <0.05, Pearson's chi-square). These significant relationships were similarly very weak (Phi < 0.1).

5.2.2 Parenting strategies: Experiences, practices and opinions

Responses to questions on parenting experiences, practices, opinions and family climate were summed to form a number of scales (*see Appendix B.1 for details*). There were differences between the intervention and comparison samples on most parenting strategy scales ($p < 0.05$, independent samples t-test) (*see Table 5.5*). Exceptions were the experience of parenting, parental psychological distress, appropriate discipline and parental responsibilities scales ($p > 0.05$, independent samples t-test). Where differences were found, higher scores were evident in the comparison group, with the exception of inappropriate opinions on parenting and smacking. The sizes of the differences were, however, very low.

The pattern of reported use of inappropriate parenting strategies for child misbehaviour (i.e. shout, spank, threaten) was investigated across social classes, and while there were variations, 'shouting' was reported by more than 50% of respondents from each social class group, while use of 'threat' was reported by more than 40% and use of a single 'spank' by more than 30% of each social class group (*see Figures B.4b and B.4c in Appendix B.4*). Similarly, more than 90% of parents in each social class group reported allowing 'avoidance' as a strategy for dealing with fearful or anxious behaviour in their child. These patterns demonstrate inappropriate parenting behaviours across socio-economic groups.

Table 5.5: Intervention and comparison sample means ± standard deviations and mean differences for parenting strategies, experience and opinion scales, at Time 1

Scale	Intervention Mean ± SD	Comparison Mean ± SD	Standardised *d* mean difference	Independent t-test p
Confident parenting	35.5 ± 5.9	36.0 ± 5.7	-0.08	0.032*
Good experience of parenting	19.1 ± 2.8	19.2 ± 2.8	-0.02	0.532
Parental psychological distress	13.2 ± 4.8	13.3 ± 5.4	-0.01	0.829
Positive family climate	22.6 ± 4.0	23.0 ± 4.0	-0.09	0.015*
Good relationship with child	18.0 ± 2.5	18.3 ± 2.4	-0.12	0.001**
Engage in positive parenting	12.8 ± 2.1	13.2 ± 2.1	-0.19	0.001**
Likely to use appropriate discipline	21.0 ± 3.4	21.2 ± 3.3	-0.06	0.106
Unlikely to use inappropriate discipline	19.1 ± 3.5	19.4 ± 3.6	-0.10	0.009**
Engage in parental responsibilities	21.8 ± 3.8	21.6 ± 4.0	0.05	0.232
Unlikely to use inappropriate parenting for anxious behaviour	18.4 ± 2.5	18.7 ± 2.3	-0.10	0.008**
Inappropriate opinions on parenting	15.5 ± 4.2	15.1 ± 4.3	0.10	0.004**
Inappropriate opinions on smacking	10.9 ± 4.9	10.3 ± 4.6	0.12	0.002**

Standardised mean difference (effect size) calculation: (MeanI - MeanC)/pooled standard deviation, where I = intervention and C = comparison samples.

p = probability of independent samples t-test.

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

Scores for the Psychological Distress Scale were dichotomised into 'moderately to severely distressed' (scores 16-50) and 'no to low distress' (scores 10-15). Overall, 19.7% were found to be in the 'moderate to severe distress' category, with no significant difference between samples ($p = 0.69$; Pearson's chi-square).

In total, 40.3% of responding parents reported feeling stressed during the previous 2 weeks (intervention 41.3%; comparison 39.4%, $p = 0.317$, Pearson's chi-square). Asked whether they felt supported in their role as parents over the last month, 16.7% reported that they felt 'not at all or slightly' supported, with significant differences between the intervention (18.9%) and comparison (14.4%) samples ($p = 0.001$, Pearson's chi-square).

KEY FINDINGS: Population Study

What was the prevalence and baseline comparison of child emotional and behaviour problems and negative parental strategies, experiences and opinions?

- In the intervention counties, 17.8% of parents reported that their child had emotional or behavioural difficulties at Time 1. In the comparison counties, the rate was 17.9%.
- Overall, 9.3% of parents reported that their child was in the abnormal range and 6.5% in the borderline range for clinical symptoms on the Strengths And Difficulties Questionnaire, with no significant difference (p = 0.112) between the intervention and comparison counties.
- Parents in the comparison counties reported more positively on confident parenting (p = 0.032), positive family climate (p = 0.015), good relationship with child (p = 0.001) and engaging in positive parenting (p = 0.001), use of inappropriate parenting for anxious or fearful behaviour (p = 0.008), inappropriate opinions on parenting (p = 0.004) and smacking (p = 0.002).
- Almost 20% of parents in both the intervention and comparison counties reported moderate to severe psychological distress.

5.3 Research Question 2: What was the extent of exposure to Triple P in the intervention counties?

At Time 1, 19% of respondents in the intervention counties (n=282) reported that they had previously heard of the Triple P – Positive Parenting Programme, while 1.6% (n=30) reported that they had participated in Triple P within the last 12 months. Overall, of those who would recommend a parenting programme to a friend, 30.6% (n=34) reported that they would recommend Triple P.

The situation had changed substantially by Time 2, when 60% of the intervention sample (n=905) reported that they had heard of Triple P compared to 12.7% (n=195) of those in the comparison sample; 14.7% (n=224) had taken part in Triple P over the previous 12 months compared to 1.8% (n=28) of the comparison group; and 20.6% (n=313) of the respondents from the intervention counties reported that they had participated in Triple P over the previous 2 years compared to 2.5% (n=39) of the comparison sample. Those in the intervention sample reported significantly greater exposure to Triple P than those in the comparison sample, with p<0.01 in each case. These rates should also be compared with the numbers reporting participation in other programmes (*see Table 5.6*).

Table 5.6: Participation in a child development, child behaviour, or parenting programme within the past 12 and 24 months, at Time 2

Participation in programme	Intervention n (%) for last 12 months	Comparison n (%) for last 12 months	Intervention n (%) for last 2 years	Comparison n (%) for last 2 years
Triple P – Positive Parenting Programme	224 (14.7)	28 (1.8)	313 (20.6)	39 (2.5)
Incredible Years Programme	9 (0.6)	19 (1.2)	14 (0.9)	20 (1.3)
Parents Plus	23 (1.5)	70 (4.5)	33 (2.2)	76 (4.9)
Other (specify)	2 (0.1)	1 (0.1)	21 (1.4)	76 (4.9)
Could not recall programme name	10 (0.7)	40 (2.6)	18 (1.2)	26 (1.7)

In total, 36.1% (n=521) of those in the intervention sample reported that they knew someone who had participated in Triple P and 68% (n=347) of them did receive parenting tips or information from that person. This compares positively to those in the comparison sample, 6.7% (n=95) of whom reported that they knew someone who had taken part in Triple P and 77.2% (n=71) of those had received tips or information on parenting from that person.

As described in Chapter 3, exposure to Triple P can take a range of forms, from hearing discussions on local radio, seeing an advertisement, reading a Tippaper (all Level 1) or attending a talk or seminar (Level 2), workshop (Level 3) or more intensive level of intervention (Level 4). Table 5.7 shows the reported exposure to the core Triple P activities.

Table 5.7: Reported exposure to Triple P, at Time 2

	Intervention n (%)	Comparison n (%)	p
Read Tippaper	344 (22.6)	74 (4.8)	<0.000***
Attended a Triple P talk	144 (9.5)	27 (1.7)	<0.000***
Attended a Triple P once-off 2-hour workshop	69 (4.5)	19 (1.2)	<0.000***
Attended a Triple P 8-week parenting course	114 (7.5)	22 (1.4)	<0.000***
None of these	1,008 (66.3)	1,411 (91.4)	<0.000***

Note that multiple selections were possible.

p = probability of Pearson's chi-square test comparing intervention and comparison samples.

*** statistical significance at p<0.001

Based on these figures from the Time 2 population survey, it appears that the sample achieved under-represents those who had attended a Triple P workshop. This should be considered when interpreting the findings laid out below; if there is an effect, it would be to underestimate the impact of Level 3 workshop attendance, and thus the intervention as a whole on the population.

Socio-demographic differences in exposure to Triple P in the intervention countries

Within the intervention sample, the socio-demographic characteristics of those who reported exposure to Triple P were compared with those who had not (*see Table 5.8*).

Those who have heard of Triple P are less likely to have younger children, more likely to be female, have a higher level of education, own their own home and not to have a medical card.

Those who reported that they have received tips or information from someone who had participated in Triple P did not significantly differ from those who did not on any of the socio-demographic characteristics tested. Respondents who said that they had participated in Triple P over the last 2 years were more likely to be female and to own their own homes.

Those who reported that they had read a Tippaper were more likely to be female, married, have a higher level of education, be working outside the home, own their own homes and less likely to have a medical card than those who did not read a Tippaper. Respondents who said that they had attended a Triple P talk were more likely to be female, have a higher level of education and own their own homes than those who had not attended a talk, while those who reported that they had attended a 2-hour workshop with Triple P were more likely to be female than those who did not.

Finally, those who reported that they had attended an 8-week Triple P parenting course were more likely to be female, have a higher level of education and own their own homes than those who did not attend such a course.

Table 5.8: Socio-demographic correlations with Triple P exposure, intervention sample, at Time 2

	Heard of Triple P	Received tips or information from person who had attended Triple P	Participated in Triple P in last 2 years	Read a Tippaper	Attended a Triple P talk	Attended a once-off 2-hour workshop	Attended an 8-week parenting course
Gender of child	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
Age of child	p<0.001[d]	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
Marital status	*ns*	*ns*	*ns*	p<0.05[m]	*ns*	*ns*	*ns*
Gender of respondent	p<0.001[f]	*ns*	p<0.001[f]	p<0.001[f]	p<0.001[f]	p<0.01f	p<0.01[f]
Level of education	p<0.001[h]	*ns*	p<0.01[h]	p<0.001[h]	p<0.01[h]	ns	p<0.05[h]
Working outside home	*ns*	*ns*	*ns*	p<0.05[w]	*ns*	*ns*	*ns*
Household tenure	p<0.001[o]	*ns*	p<0.05[o]	p<0.001[o]	p<0.01[o]	*ns*	p<0.05[o]
Social class	p<0.05	*ns*	*ns*	*ns*	*ns*	*ns*	*ns*
Medical card status	*ns*	*ns*	*ns*	p<0.001[n]	*ns*	*ns*	*ns*

Statistically significant findings are in bold.

ns = not statistically significant.

[d] Those who had heard of Triple P were more likely to have younger rather than older children.

[m] Those who had read a Tippaper were more likely to be married than single or any other marital status;

[f] Those who had heard of Triple P, participated in Triple P in the last 2 years, read a Tippaper, attended a Triple P talk, attended a once-off 2-hour workshop and those who attended an 8-week parenting course were more likely to be female than male.

[h] Those who had heard of Triple P, participated in Triple P in the last 2 years, read a Tippaper, attended a Triple P talk, and those who attended an 8-week parenting course were more likely to have a higher level of education than those who had not.

[w] Those who had read a Tippaper were more likely to work outside the home than not to do so.

[o] Those who had heard of Triple P, participated in Triple P in the last 2 years, read a Tippaper, attended a Triple P talk, and those who attended an 8-week parenting course were more likely to own their own homes than to be in rented accommodation.

[n] Those who had read a Tippaper were less likely to have a medical card than to have one.

KEY FINDINGS: Population Study

What was the extent of exposure to Triple P in the intervention counties?

- At Time 1, 19% of parents reported that they had heard of the Triple P programme and this increased to 60% at Time 2.
- At Time 2, 14.7% of the parents in the intervention counties reported that they had taken part in Triple P over the previous 12 months and 20.6% that they had taken part over the previous 2 years.
- At Time 2, 36.1% of parents in the intervention counties reported that they knew somebody who had taken part in Triple P and of them 68% reported that they had received parenting information or tips from that person.
- Respondents from the intervention counties were most likely to have read a Tippaper (22.6%), followed by attending a Triple P talk (9.5%), attending an 8-week parenting course (7.5%) and attending a once-off 2-hour parenting workshop (4.5%).
- Those who reported that they took part in Triple P over the previous 2 years were more likely than those who had not to be female ($p<0.001$), have a higher level of education ($p<0.01$) and to own (or be in the process of purchasing) their own home ($p<0.05$).

5.4 Research Question 3: Was there an intervention effect on child emotional and behaviour problems and negative parental strategies, experiences and opinions?

A series of ANCOVA models were used to examine intervention and location effects on child strengths and difficulties, parenting strategies and help-seeking behaviours adjusted for demographic factors.

5.4.1 Model building

In order to identify relevant covariates, correlations between all socio-demographic variables [6] and child behaviour, parenting, and parenting support variables were examined (Spearman rho was used for ordinal variables, Point-Biserial where there was at least one dichotomous variable). All socio-demographic variables that were statistically significantly correlated with the dependent variables at $p<0.05$ were included in subsequent analyses. The range of covariates included in each model was consistent and details can be found in Appendix B.5. Model building proceeded according to a series of steps as outlined below:

1. Pre- and post-intervention scores on outcome scales were compared for intervention and comparison area without controlling for clustering or other socio-demographic variables.
2. ANCOVA models were conducted controlling for socio-demographic variables (excluding the aggregated area clustering variable).
3. ANCOVA models were conducted controlling only for aggregated area clustering variable.
4. ANCOVA models were conducted controlling for socio-demographic variables including aggregated area clustering variable.

Fixed effects recorded include the F values, partial Eta (η^2) and statistical significance for each independent variable and the interaction between them (*see Tables B.5a-B.5v in Appendix B.5*).

6. Age of index child, gender of index child, relationship to child, age of respondent, marital status, highest level of education, working outside of the home, number of children in the household, ethnic or cultural background, current household tenure, type of household (e.g. single parent, reconstituted family, original family), medical card status, urban or rural – based on density per square kilometer.

5.4.2 Intervention effects

In order to demonstrate a positive population impact, the intervention must have a more positive effect than any change found between the population surveys conducted in the comparison counties. The data show there was a significant programme impact at the population level (*see Table 5.9, and also Tables B.5a-B.5v and Figure B.5a in Appendix B.5*). There was a significant positive population effect on child outcomes for the SDQ Total Difficulties score and for the Emotional Symptoms Sub-scale. For these measures, participants from the intervention counties reported lower levels of problems or difficulties post-intervention than pre-intervention, and did so significantly more than did participants from the comparison counties.

There was no significant difference between comparison and intervention counties for conduct problems and peer problems, although scores improved more on these sub-scales in the intervention counties. No significant patterns were observed on the Hyperactivity Scale.

There was a significant population effect on parent outcomes for parental psychological distress, reporting a good relationship with the index child, engaging in positive parenting, being likely to use appropriate discipline and being unlikely to use inappropriate discipline for anxious behaviour. In all cases, there were significant improvements in the intervention counties and those improvements were significantly greater and more positive than any changes noted in the comparison counties.

There were no significant differences between comparison and intervention counties for confident parenting, good experience of parenting or positive family climate, although scores improved more in the intervention counties than in the comparison counties. No significant patterns were observed for parenting consistency, where responses post-intervention were generally similar to those pre-intervention.

Significant population effects were also found for satisfaction with parenting information available and satisfaction with parenting services. Finally, there was a significant difference in the likelihood of participation in future parenting programmes between intervention and comparison counties: participants in the comparison counties were less likely to report that they would participate in future parenting programmes post-intervention, whereas there was no change in the intervention counties.

Table 5.9 presents the key population impact findings for LWPPP. Included are the mean scores on the range of outcome variables, both pre- and post-intervention, for the intervention and comparison counties. These means have been adjusted for covariates as outlined in Section 5.4.1 above and are accompanied by their standard errors. For each outcome variable, the overall value of the effect, effect size (Cohen's *d*) and probability estimate are provided. The probability estimates in the column entitled 'Overall' refer to the significance of the time by location interaction.

Table 5.9: Summary of population-level impact of Triple P Programme – Child and parent outcomes

Group	Intervention		Comparison		Overall		
	Means (SE)§		Means (SE)§		Effect estimateΦ	Effect size (Cohen's dΔ)	p
	Pre	Post	Pre	Post			
Child outcomes							
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
Parenting outcomes							
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

'Caseness' by location pre- and post-intervention

While general population patterns are central to a population level intervention, the population sub-group of most interest to clinicians and health service managers is those greatest in need, who are or may become patients or clients. This section considers the impact of Triple P on the rates of such reported need in the population. Weighted proportions of clinical or borderline-level symptoms among children in the intervention and comparison areas pre- and post-intervention are shown in Table 5.10a and Figure B.5b in Appendix B.5. These include the proportion (number per 100 families) of abnormal or borderline cases, the differences in number of cases (per 100 families) and the percentage change in these cases post-intervention compared to pre-intervention in each location. In addition, weighted odds for children having abnormal or borderline symptoms on the SDQ scales by location were calculated and the significance with which these odds differed pre- and post-intervention were tested using Tarone's Chi.

In the intervention counties, pre-intervention, 16 per 100 families with children in the target age range reported abnormal to borderline symptoms on the Total Difficulties Scale. Post-intervention, 6 fewer cases per 100 families were reported, representing a 37.5% reduction in cases. Comparison counties report an increase of 1 case per 100 families on this scale post-intervention. Odds ratios (ORs) were calculated to show the odds of having abnormal to borderline symptoms in the intervention counties compared to the comparison counties. Pre-intervention, the odds ratio for the Total Difficulties Scale was 1.2 (95% CI 1.0-1.5), but had reduced to 0.7 (95% CI 0.5-0.8) post-intervention. Comparison of these odds pre- and post-intervention (using Tarone's Chi = 17.4, p=0.000) shows this was a significant post-intervention reduction in the odds of cases being reported in intervention counties. Similar changes were reported for the SDQ Problem Sub-scales; however, changes in the Pro-social Scale are not significantly different over time when adjusted for changes in the comparison counties (Tarone's Chi = 1.1; p= 0.305).

Table 5.10a: Proportion of children with elevated (clinically abnormal or borderline cases[§]) scores on child outcomes in intervention and comparison areas pre- and post-intervention

	Percentage of abnormal or borderline cases		No. of cases (per 100[1]) difference Post – Pre	% difference Pre – Post
	Pre	Post		
Total difficulties				
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)			
Emotional symptoms				
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)			
Conduct problems				
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)			
Peer problems				
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)			

Hyper-activity				
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)			
Pro-social				
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)			

[1] 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

These population-level patterns of impact reflect those described for changes to mean scores derived from ANCOVA model outcomes presented in Table 5.9, with the exception of the Hyperactivity Scale which shows a similar direction of change with higher odds of clinical cases in the intervention area pre-intervention (OR = 1.32, 95%CI 1.07-1.63) and lower odds (OR = 0.69, 95%CI 0.57-0.84) post-intervention, as well as a significant difference between these (Tarone's Chi = 19.73, p = <0.001). 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.

Weighted parenting outcomes are presented in Table 5.10b as the proportion (number per 100 families), the differences in number of cases (per 100 families) and the percentage change in these cases post-intervention compared to pre-intervention in each location, odds ratio pre- and post-intervention by location and Tarone's Chi outcomes for comparison of odds pre- and post-intervention. Significant changes post-intervention were found in intervention counties (relative to comparison counties) for a number of these outcomes.

Table 5.10b: Proportion of parents likely to engage in parenting strategies, behaviours and opinions in intervention and comparison areas pre- and post-intervention

	Percentage of parents reporting strategies, behaviours, outcomes or opinions		No. of cases (per 100[1]) difference Post – Pre	% difference Pre – Post
	Pre	Post		
Confident parenting§				
Intervention	99.3	97.4	-0.8	-2.0
Comparison	99.3	98.1		-1.2
Odds ratio	1.1	0.7		
Tarone's Chi (p)	0.7 (p=0.402)			
Good experience of parenting§				
Intervention	99.0	99.7	+0.6	+0.8
Comparison	99.4	99.5		+0.1
Odds ratio	0.6	2.0		
Tarone's Chi (p)	2.6 (p=0.106)			
Parental psychological distress (mild to moderate distress, below 20 on the K10 scale)				
Intervention	9.08	6.19	-2.9	-31.8
Comparison	8.98	8.99		+0.1
Odds ratio	1.0	0.7**		
Tarone's Chi (p)	4.9* (p=0.027)			
Positive family climate∞				
Intervention	98.7	98.8	-0.4	+0.2
Comparison	98.7	99.4		+0.6
Odds ratio	1.0	0.5		
Tarone's Chi (p)	1.3 (p=0.264)			
Good relationship with child∞				
Intervention	99.5	99.7	+1.0	+0.3
Comparison	99.7	99.0		-0.7
Odds ratio	0.6	3.9*		
Tarone's Chi (p)	5.7* (p=0.017)			
Engage in positive parenting§				
Intervention	98.5	98.8	+0.5	+0.4
Comparison	98.2	98.1		-0.1
Odds ratio	1.2	1.6		
Tarone's Chi (p)	0.6 (p=0.428)			
Engage in parental responsibilities§				
Intervention	98.8	99.1	+2.5	+0.4
Comparison	99.3	97.1		-2.2
Odds ratio	0.6	3.5***		
Tarone's Chi (p)	13.0* (p=0.000)			
Consistent parenting (always and usually consistent)				
Intervention	83.8	85.9	+8.4	+2.5
Comparison	87.7	81.4		-7.2
Odds ratio	0.7**	1.4**		
Tarone's Chi (p)	20.2*** (p=0.000)			

Engage in appropriate discipline§				
Intervention	99.2	98.4	-0.4	-0.8
Comparison	98.6	98.2		-0.4
Odds ratio	1.8	1.1		
Tarone's Chi (p)	1.1 (p=0.295)			
Unlikely to engage in inappropriate discipline§				
Intervention	98	98.7	+2.5	+0.8
Comparison	98.5	96.8		-1.8
Odds ratio	0.7	2.6***		
Tarone's Chi (p)	10.9* (p=0.001)			
Appropriate parenting for anxious/fearful behaviours§				
Intervention	99.2	99.6	+0.6	+0.4
Comparison	99.5	99.3		-0.2
Odds ratio	0.7	1.8		
Tarone's Chi (p)	2.1 (p=0.144)			
Appropriate opinions on parenting§				
Intervention	81.6	82.9	+6.2	+1.5
Comparison	84.8	79.8		-5.9
Odds ratio	0.8*	1.2*		
Tarone's Chi (p)	10.1** (p=0.002)			
Appropriate opinions on smacking§				
Intervention	94.2	99	+5.3	+5.1
Comparison	96.9	97.4		+0.6
Odds ratio	0.5***	2.7**		
Tarone's Chi (p)	22.3*** (p=0.000)			
Felt stressed (Yes)				
Intervention	41.8	27.7	-10.7	-33.8
Comparison	39.5	36.1		-8.6
Odds ratio	1.1	0.7***		
Tarone's Chi (p)	19.5*** (p=0.000)			
Felt supported (moderately to extremely supported)				
Intervention	80.8	88.7	+7.3	+9.8
Comparison	86.7	87.3		+0.7
Odds ratio	0.6***	1.1		
Tarone's Chi (p)	14.6*** (p=0.000)			

[1] This refers to the numbers out of 100 (or per cent) from the general population survey.

§ Parenting scale items averaged and dichotomised at a mean score of above 2 (where items consisted of responses to 5 point scales).

∞ Parenting scale items averaged and the scale dichotomised at a score of above 3 (where items consisted of responses to 7 point scales).

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

Reports of parental psychological distress and of stress both showed approximately 30% reduction post-intervention in the number of cases in intervention counties (-2 cases and -14 per 100 families respectively). The odds for reporting psychological distress in intervention counties compared with comparison counties were 1.0 (95% CI 0.8-1.3) pre-intervention and 0.7 (95% CI 0.5-0.9) post-intervention. Comparison of these odds using Tarone's Chi (4.874, p = 0.027) showed this was a significant reduction in odds post-intervention. Report of parental stress showed a similar reduction in odds post-intervention (Tarone's Chi = 19.49, p = <0.0001), with an approximate reduction of

8 cases per 100 families in the intervention counties. Significant improvements (increases in odds) post-intervention were found for good relationship with child (Tarone's Chi = 5.725, p = 0.017); engaging in parental responsibilities (Tarone's Chi = 13.042, p = 0.000); consistency of parenting (Tarone's Chi = 20.199, p<0.0001); being unlikely to engage in inappropriate discipline (Tarone's Chi = 10.938, p = 0.001); having appropriate opinions on parenting and smacking (Tarone's Chi = 10.075, p = 0.002 and Tarone's Chi = 22.337, p<0.0001 respectively); and parents reporting they felt supported (Tarone's Chi = 14.646, p<0.0001). These patterns reflect those described for changes to mean scores derived from ANCOVA model outcomes for parenting strategies presented in Table 5.9 above, with the exception of consistency of parenting which showed no change in either intervention or comparison counties over time. Of particular note are those parenting outcomes that have demonstrated particularly substantial changes over time in favour of the intervention group; these are not only statistically significant, but are also likely to be of practical importance and comprise the following: consistent parenting, appropriate opinions on parenting and smacking, feeling stressed and feeling supported in the parenting role.

KEY FINDINGS: Population Study

Was there an intervention effect on child emotional and behaviour problems and negative parental strategies, experiences and opinions?

- There was a clear and significant population effect of Triple P on total difficulties as measured by the Strengths and Difficulties Questionnaire (SDQ) (Cohen's d = -0.11, p<0.05), as well as for the SDQ sub-scale Emotional Symptoms (Cohen's d = -0.12, p<0.05).
- There was also a population effect on a range of parenting outcomes: these included parental psychological distress (Cohen's d = -0.17, p<0.01), reporting a good relationship with the index child (Cohen's d = 0.30, p<0.001), engaging in positive parenting (Cohen's d = 0.13, p<0.05), being likely to use appropriate discipline (Cohen's d = 0.23, p<0.001) and being unlikely to use inappropriate discipline for anxious behaviour (Cohen's d = 0.21, p<0.001).
- There was a significant population effect in terms of a reduction in the numbers and
- proportions of children falling within the clinical ranges for abnormally high levels of symptoms, including total difficulties (-7.2%, p<0.001), emotional problems (-5.8%, p<0.01), conduct problems (-7.2, p<0.01), peer problems (-4.7%, p<0.05) and hyperactivity (-8.2, p<0.001).
- A population effect of Triple P was identified for satisfaction with parenting information available (Cohen's d = 0.56, p<0.001), satisfaction with parenting services (Cohen's d = 0.46, p<0.001) and likelihood to seek parenting help in the future (Cohen's d = 0.18, p<0.01).

6. Findings from Partnership Study

The aim of the Partnership Study was to explore the views of the partner representatives concerning the establishment of the partnership, the partnership's support of programme delivery and what the representatives have learned about partnership working. The presentation of the findings in this chapter is structured according to the three research questions addressed.

While the purpose of this component of the study is to evaluate the partnership in Longford and Westmeath, where it is appropriate in terms of commenting on the learning from the current partnership and the replication of the partnership, reference will also be made to the newly established and independent partnership in the two neighbouring counties of Laois and Offaly.

6.1. Research questions and methodology

6.1.1 Research questions

The research questions in the Partnership Study were derived from a review of literature on partnership working. The literature suggests that the following issues are pertinent to the development of successful partnerships (Hardy *et al,* 1992; Wistow and Barnes, 1995; Johnson *et al,* 2003; Williams *et al,* 2003; Wildridge *et al,* 2004; Wagemakers *et al,* 2010; Jones and Barry, 2011):

- shared vision and goals;
- clarity on rights, roles, and responsibilities;
- history of partnership working and of relationships between partners;
- flexible and participatory structure and process;
- clear and consistent communication;
- skills and attributes of members, including seniority within organisation, ability to manage change, leadership and ability to work across boundaries;
- ownership of process/task;
- sufficient resources.

According to the literature, there are three stages in partnership development (Wildridge *et al,* 2004). These may be summarised as getting started; delivery; and measuring and reviewing progress (Percy-Smith, 2005). The Partnership Study was structured around three research questions that explored the stages of LWPP's development. In addition, under each main research question, the pertinent issues for the development of the partnership were also investigated.

Research Question 1: Getting started – How successful was the use of a partnership approach to implement an evidence-based programme using a population approach?

- How was the partnership established?
- What is meant by 'partnership' from the perspective of each representative?
- What factors facilitated the development of a partnership programme from the perspective of each representative?
- How effective was the implementation within each partner agency perceived to be by all the representatives?

Research Question 2: Delivery – Has the partnership succeeded in its objective to promote and support the delivery of evidence-based parenting knowledge and skills to the population of Longford and Westmeath?

- Has the partnership supported delivery of Triple P by all partners?
- Has the adoption of Triple P impacted on attitudes to evidence-based programmes?
- What 'added value' has been offered by partnership working?
- Has partnership working improved across agencies as a result of the experience of developing LWPP?

Research Question 3: Measuring and reviewing progress – Has the partnership succeeded in its objective 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 counties?

- Did partner contributions change since the start of their involvement?
- Did the initial reasons for joining the partnership still hold?
- Did the Memorandum of Understanding help in running the partnership?
- What were the strengths and weaknesses of the partnership?
- In what way could the partnership be improved?

Interview schedules were developed based on a combination of the agreed research questions and the issues arising in the academic literature on partnership working (*see Appendix C.2 for schedules*).

6.1.2 Data collection

As part of the Partnership Study, 43 interviews were conducted with 17 participants representing the 9 partner agencies.[7] Data were collected at the following four time points:

Time 1 (May 2011)

- 12 participants (8 HSE; 4 Statutory, Community, and Voluntary sector; 5 non-respondents) in 12 telephone interviews (from a total sample of 17). In addition, a telephone interview was held with the External Facilitator for the process of constituting the terms of reference for how the partnership should conduct its business (i.e. the Memorandum of Understanding or MoU).

Time 2 (November 2011)

- 12 participants (6 HSE; 6 Statutory, Community, and Voluntary sector; 5 non-respondents) in 10 face-to-face interviews and 2 telephone interviews.

Time 3 (September 2012)

- 11 participants (5 HSE; 6 Statutory, Community, and Voluntary sector; 6 non-respondents) in 11 telephone interviews.

Time 4 (May 2013)

- 8 participants (6 HSE, 2 Statutory, Community, and Voluntary sector, 9 non-respondents) in 2 face-to-face interviews and 6 telephone interviews.

Data from all four time points were employed to address each of the three research questions. However, in addressing the first research question about 'getting started', data from the first round of data collection

7. One further interview was conducted with the External Facilitator for the process of developing the MoU.

were most relevant, while data from the final two time points were most informative for answering the final research question about 'measuring and reviewing progress'.

Given the low number of people involved, anonymity was to be protected by assigning only 'HSE', 'Statutory, Community, and Voluntary sector' or 'Project Management Team' to individual quotes. In the event that a participant waived anonymity in regard to a particular contribution, more specific detail is given concerning the source of a quote or comment.

Documentary data were also analysed as part of the Partnership Study. Documents from the LWPP were analysed to provide an overview of the establishment of the partnership and also the MoU.

6.1.3 Analysis of qualitative data

The overall research questions for the evaluation shaped the questions asked in interviews with participants. Therefore, the interview questions addressed the evaluation concerns of 'getting started', 'delivery' and 'measuring and reviewing progress'. The question format in the interviews was open-ended and as a result participants were encouraged to be expansive. This facilitated the emergence of new themes that were not dictated by the researchers' prior aims.

Analysis of the qualitative data was structured by two overarching objectives:

- First, the Research Team wanted to know whether a partnership approach to programme implementation could be applied successfully to Triple P in the context of Longford and Westmeath. Therefore, it was important to come to an understanding of a partnership approach within its social context.
- The second objective was to give a voice to participants. In collecting qualitative data as part of the Partnership Study, partner representatives had an opportunity to present the partnership from their own point of view and in their own terms. Therefore, 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 LWPP.

The Research Team also employed a number of approaches to validate findings. Alternative explanations of findings were considered and negative cases were also identified. In discussing the findings, careful consideration has been given to the data and the methods used. For example, when a view or statement was attributable to only one participant, it was important to clarify the context for the view or statement and its significance for the overall findings. In this way, the researchers sought to provide corroboration for the findings.

6.1.4 Selection and recruitment of participants (Partner representatives)

All representatives from each partner organisation of LWPP were invited to participate in the four rounds of interviews. Contact details for partner representatives were sourced from the Project Management Team. Partner representatives were then contacted by the Research Team and invited to participate in the evaluation. All interviews were recorded, with the permission of participants, and audio files were subsequently transcribed.

6.1.5 Profile of respondents

The HSE had the largest number of representatives on the partnership and this was reflected in the profile of respondents. There was a range of disciplines and departments represented from within the HSE: Public Health, Public Health Nursing, Health Promotion, Child Care, Family Support, Psychology, Social Work and Disability Services.

Participants from the Statutory, Community, and Voluntary sector represented the following 8 partner organisations: Carrick-on-Shannon Education Centre; Athlone Education Centre; Athlone Community Services Council; Longford Community Resources Ltd; Longford Vocational Educational Committee; Longford County Childcare Committee; Westmeath Community Development; and Westmeath County Childcare Committee.

The majority of respondents had a managerial role in their organisation, although they varied in terms of seniority and size of organisation. The MoU specifies that representatives should be of appropriate seniority.

6.1.6 Participation in the Partnership Study

At any single time point, participants were recruited from the list of representatives of the various partner organisations. The group of participants was made up of representatives (21 people across the time span of the evaluation) from the 9 partner organisations. The 8 Statutory, Community, Voluntary organisations each had a single representative, while the HSE had 9 representatives. As Table 6.1 and Figure 6.1 show, 2 representatives did not participate in any of the 4 interviews and a further 8 representatives participated in only one of the 4 interviews.

Table 6.1: Participation in the Partnership Study, at Times 1-4

	Participant	T1	T2	T3	T4
HSE					
1	A	✓	X	X	X
	B	✓	✓	✓	✓
	C	X	X	X	✓
	D	X	X	X	X
	E	✓	✓	✓	✓
	F	✓	✓	✓	✓
	G	✓	✓	✓	X
	H	✓	✓	✓	✓
	J	✓	✓	X	✓
Statutory, Community, and Voluntary sector					
2	K	✓	X	✓	X
3	L	X	X	X	X
4	M	*n/a*	*n/a*	✓	X
	N	X	✓	*n/a*	*n/a*
5	O	X	✓	X	✓
6	P	X	✓	X	X
7	Q	✓	✓	✓	X
	R	✓	✓	*n/a*	*n/a*
8	S	✓	✓	✓	✓
9	T	*n/a*	*n/a*	✓	X
	U	✓	X	*n/a*	*n/a*
External Facilitator		✓	*n/a*	*n/a*	*n/a*

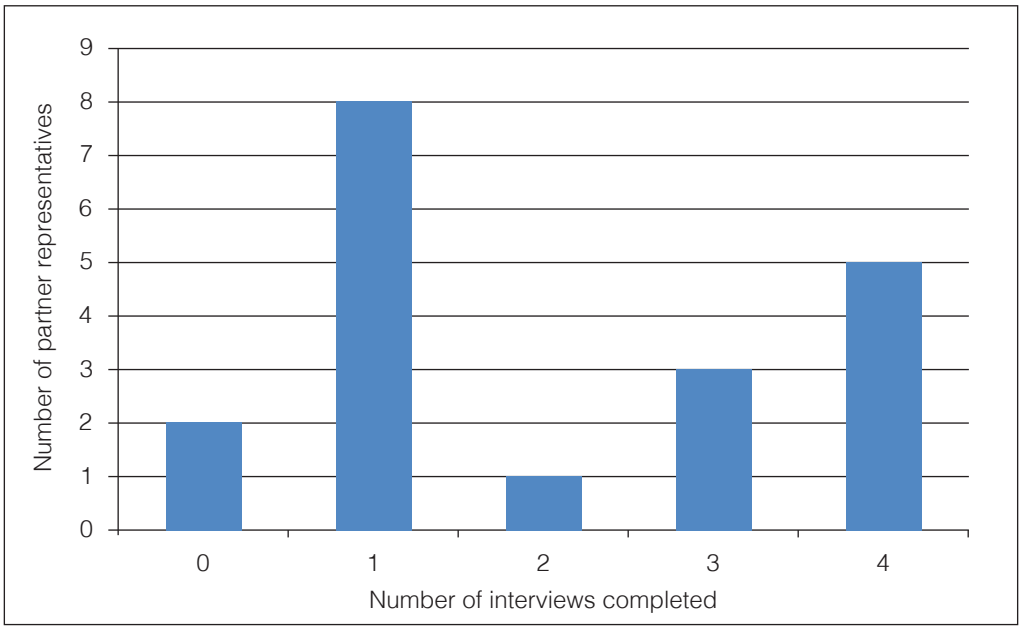
✓ = participation

X = non-participation

n/a = not applicable (i.e. not invited to participate at that time)

Participants are coded by partner organisation number (1 – 9) and personal letter (A – U).

Figure 6.1: Number of interviews completed



Some representatives were unwilling to take part in interviews for the Partnership Study. One HSE representative who had participated in only one interview did not agree to take part in subsequent interviews for the reason that they no longer saw themselves as a partner due to workload pressures in recent times. Another HSE representative did not respond to invitations to participate in the study. One Statutory, Community, and Voluntary sector representative who had not participated in any interview also did not agree to take part for the reason that their organisation had 'a limited role' in the partnership. The percentage of Statutory, Community, and Voluntary sector partners who participated at T4 (25%) was lower than at previous time points (*see Figure 6.2*). This decline in participation may be due to research fatigue. Alternatively, or in addition, it may be explained by financial pressures within Statutory, Community, and Voluntary sector partner organisations, which participants had noted were forcing them to cut back on 'non-core' activities such as the partnership (*see Section 6.4.2 for data on the latter point*).

Figure 6.2: Participation in evaluation as percentage of representatives (HSE and Statutory, Community and Voluntary sector)

6.2 Research Question 1: Getting Started – How successful was the use of a partnership approach to implement an evidence-based programme using a population approach?

6.2.1 How was the partnership established?

What was to become the Longford Westmeath Parenting Partnership (LWPP) was preceded by another parenting initiative, the Parenting Strategy Programme. The latter began in 2005 and its objectives were to support all parents in the task of parenting in order to prevent future problems, promote social inclusion and affirm human rights. A further objective was to develop a local strategy agreed with other agencies. A literature review was carried out first with the aim of identifying the most appropriate evidence-based universal programme. The rationale for selecting a programme was developed and meetings were held to select a programme from among those identified.

The partnership itself was established during late 2006 and early 2007. In its grant proposal to The Atlantic Philanthropies, LWPP stated that their aims were to address social inclusion, parent education and child well-being. It was also agreed that access to supports for parents would be facilitated by a partnership approach (Grant Proposal, p. 16). The initial purpose as stated in the Grant Proposal (p. 17) was both to maximise the use of the Triple P Programme and also to help those children experiencing problems:

> *'The aim of this project is to build on established partnerships to maximise the use of an evidence-based intervention, the Triple P programme ... The overall goal of this project is to improve outcomes for children with emotional and behavioural problems.'*

In interviews for this evaluation, the Project Management Team distinguished two distinct stages in the development of the partnership. First, by the end of 2006 *'we had gone through a process of agreeing a parenting strategy and agreeing a programme of delivery within the HSE sector; and at the same time we had agreed that it wouldn't just sit within the HSE sector'* (Project Management Team). Then, voluntary and community bodies were invited to attend a briefing to establish the level of interest in a community-based project, and among those who were interested agreement was reached on *'a modus operandi, a formula for training people, and which programmes we were going to deliver'* (Project Management Team).

The partners agreed a Memorandum of Understanding (MoU) after a process of consultation, facilitated by an independent External Facilitator. The main components of the MOU have already been presented in Section 3.2 and its development is discussed in Section 6.2.3.1 below. The full text of the MoU is provided in Appendix C.4. The LWPP Logic Model requires an independent facilitation process concerning how best to work together, including a review of the MOU. In 2011, the minutes record that, as part of this review, 'MoU workshops' were to be held and facilitated by the Chair and the Project Director. This review process was begun by the end of 2011. Provisional findings provided to the Research Team by the Project Management Team indicated that satisfaction was expressed by representatives with the continued relevance of LWPP's aims and principles, and with its functioning (*see Section 6.4.3*).

KEY FINDINGS: How was the partnership established?

- The partnership is composed of 17 representatives, 9 from the HSE and 8 from Statutory, Community, and Voluntary sector organisations.
- The partnership arose from a parenting strategy first agreed within the HSE and also from the commitment to adopt a partnership approach.

- Two central aims of the partnership initially were to maximise the use of Triple P and to improve outcomes for children with emotional and behavioural problems.
- Partner representatives subsequently developed an Memorandum of Understanding (MoU) and a mid-term internal review suggests satisfaction among partner representatives with it.

6.2.2 What is meant by 'partnership' from the perspective of each representative?

The majority of representatives had other experiences of partnership working before joining LWPP and brought with them an awareness of the issues involved in the process. Representatives had previous experience of a range of partnerships, from focused operational collaborations to broader strategic planning initiatives. A common thread among representatives was that, because of the MoU and the structures and processes that facilitated best use of people's time, the LWPP partnership had clarity of focus:

> *'Often I would see in other meetings that people are there because maybe they have to be there or maybe to hear what's going on, but making no real contribution. In this case [LWPP] there are always fairly good, positive contributions. That's my read of it anyway. And I'd be very much a person who would not attend 'talking shops'. When I attend LWPP meetings, I know there are outcomes, everything is set, it's timeframe, it's task, and you don't come back to the next meeting unless you've achieved the previous things set. It's a very professional set-up in that context.'* [Representative of Statutory, Community and Voluntary (SCV) sector]

Representatives also noted that participation in the partnership was seen as mutually beneficial. Partners became involved with LWPP so as to attain various objectives of their own, but also they contributed to a shared goal and objectives:

> *'Everyone has their own agenda and ours was that we needed to get a stronger parent network. So when I was invited to get involved, I could see that we could both get something out of the partnership as well as me bringing something to it.'* [Representative of SCV sector]

A number of representatives emphasised that delivering the Triple P Programme required a level of engagement and collaboration that was ambitious and as a universal and evidence-based approach was a new departure for all concerned. A common reason explaining the strong motivation to become involved with LWPP was past experiences of working with at least one of the other partners.

Where representatives were able to make comparisons, LWPP compared favourably to the experiences of participating in other partnerships. Other partnerships were described as *'often politically rather than strategically motivated'* and where *'agendas can become diluted'* [Statutory, Community and Voluntary sector]. A key difference highlighted was the processes and structures adopted by LWPP, which were based on clear and open communication.

KEY FINDINGS: What is meant by partnership from the perspective of each representative?

- The majority of representatives had other experience of partnership working and the complexities of partnership working were well understood.
- Participation in the partnership was seen as mutually beneficial.
- The Triple P Programme required a level of engagement and collaboration that was ambitious and a new departure for all concerned.
- While other partnerships were described as politically rather than strategically motivated, the structures and processes of LWPP were based on clear and open communication.

6.2.3 What factors facilitated the development of a partnership programme from the perspective of each representative?

Much of the groundwork required to set up the partnership had been put in place before LWPP was formally established and this preliminary work was initiated across Departments within the HSE. There was a need *'to sell it first internally [within the HSE]'* before approaching potential Statutory, Community and Voluntary sector partners [Project Management Team]. Most representatives came to the partnership at the invitation of one of those involved in this initial groundwork.

For some, interest in LWPP stemmed from responsibility for delivering a wide range of services to parents of children of all ages in a variety of contexts. For others, interest stemmed from a more narrow focus on a specific target group of parents with whom the partner's service was engaging for a very specific purpose. For most, there was a belief that the work they were doing in their own service could be better achieved through participation in LWPP:

> *'It was clear from the start that the way that we needed to go was two-pronged: one was evidence-based and the other one was universal. And if we wanted to achieve that, it became quite clear that it needed to be done through partnership because the HSE would not have sufficient reach, sufficient resources or sufficient acceptability to all groups of people.'* [Member of Project Management Team]

> *'I would see [involvement in LWPP] giving me extra benefit because there are barriers all the time, baggage that people will have. It's like peeling an onion – you've got to peel the layers away. And if you help people with parental children issues, you're going to get the better person … If I put someone on a course, I'm talking about at least a minimum of that costing €10,000. So I've got to look at the value for money element. I've got to be fairly sure that they want to see the course out. So that's why I commit myself to groups like this, because I see it as an extra benefit that I can offer my clients or to the community.'* [Representative of SCV sector]

There was recognition that while the HSE's involvement was significantly more than that of others, there was added value to having a wider range of partners involved:

> *'There are different things that come from the partnership and delivery is only one of them.'* [Representative from HSE]

> *'Certainly for me it has a value. And it's not that it makes my job any easier; it makes it difficult because I have to attend meetings. But what it gives back into the community and the children and parents, that has a value for me.'* [Representative of SCV sector]

Having agencies other than the HSE involved reinforced the 'universal' aspect of Triple P. Representatives from agencies who were working with parents in a range of contexts reported that seeing them getting support as parents had the potential to help them in the delivery of their own service. A number of representatives indicated a belief in the long-term impact of Triple P on the prevention of problems that their agencies often had to address.

Among representatives from within the HSE, there was a strong sense that senior management were committed to the partnership and that this commitment was across a range of Departments within the organisation. This reinforced representatives' belief in its validity. The value of the partnership as a means of delivering the programme was clear:

> *'I suppose what I feel about the partnership overall is that if we hadn't had the partnership, the thing would never have got off the ground.'* [Representative from HSE]

According to representatives from the HSE, different reasons could be identified to explain the value of the partnership for the HSE. First was the purely pragmatic reason that *'if we hadn't the partnership in the background, it might have been easier to say, well we won't bother with this'*. In addition, it was felt it was necessary to have a partnership so as to access funding and it was felt to be consistent with national policy.

Finally, at a philosophical level, there was a strong feeling of commitment to a common cause that motivated partner representatives, both in relation to Triple P but also in other areas of their work: *'We have a specific goal which we're all working [towards] so that gives us momentum.'*

KEY FINDINGS: What factors facilitated the development of a partnership programme from the perspective of each agency?

- For most, there was a belief that the work they were doing in their own service could be better achieved through participation in the partnership.
- Having the Statutory, Community, and Voluntary sector partners involved improved access to parents.
- Having the HSE involved supported a universal and preventative approach.
- Within the HSE, factors that facilitated the partnership included support from senior management of various disciplines, consistency with national policy and a shared philosophy among partners.

6.2.3.1 Memorandum of Understanding (MoU) – Development and application

While the partnership was established before the development of the MoU, there was widespread agreement among representatives that an MoU was required. The MoU proved to be a key factor that facilitated the further development of LWPP:

> *'We learnt very quickly from feedback from partners that there needed to be an architecture around this in order to drive it, in order to have it coherent and in order to bring about efficiencies.'*
> [Member of Project Management Team]

There was also agreement that the process of developing the MoU and the practice of having it in place was a key strength of the partnership. All considered the aims, objectives and principles of the MoU to be relevant and valid, and to have held over time. Where partners wanted to, or had to, make a change to an agreed commitment, it was generally done through dialogue within the context of the MoU, but *'without having to invoke the actual arrangements around the MoU'* [Member of Project Management Team].

The representatives also observed that greater openness in communication was encouraged, both by having the MoU in place but also by the process through which it was developed. This was considered important given that the partners held vastly unequal amounts of resources. Most of the Statutory, Community, and Voluntary sector representatives indicated that they felt included and listened to and that they had a genuine role in decision-making:

> *'You never get a feeling – well, you're here because it looks good.'* [Representative of SCV sector]

> *'I had worked with 60% of the people in the room before so a certain level of trust was already there. The HSE was the biggest player there, but then the HSE is not one amorphous group; they come from different disciplines and departments. They made a huge effort not to throw their weight around. Whilst our contribution was much less in terms of scale, there was a sense that it was still very much valued. The imbalance of participants in terms of organisation, etc. was handled very sensitively.'*
> [Representative of SCV sector]

Representatives indicated that trust between partners was strong. This sense of trust was based on the recognition that each partner had a particular contribution to make, but also their own agenda, and once that agenda was made clear it was easier to build trust. Representatives reported that their sense of trust came from previous relationships and experience of working with some of the 'drivers' of the project (i.e. members of the Project Management Team).

KEY FINDINGS: Memorandum of Understanding (MoU) – Development and application

- There was agreement that the process of developing the MOU and the practice of having it in place was a key strength of the partnership.
- The responses in general suggested that working relationships were good.
- The MOU encouraged openness in communication. This was considered important as the partners held vastly unequal amounts of resources in the partnership.
- There were also high levels of trust between partners.

6.2.4 How effective was the implementation within each partner agency perceived to be by all the key stakeholders?

All representatives demonstrated a significant commitment in terms of both their belief in the partnership and their prioritising attendance at meetings wherever possible. The commitment that partners made to the Triple P Programme stemmed from their area of interest and their capacity to deliver the programme. Each partner agency had an equal vote in all decisions at LWPP meetings and therefore a partner's role in decision-making was not linked to the resources or commitment they were bringing to the project. For example, although the HSE had more resources at its disposal than any other agency, it had only one vote at partner meetings. Nonetheless, the aim was to try and integrate the commitment to Triple P and LWPP with the core business of the partner agency.

While the HSE had one vote as a partner, it had a wide range of commitments to the partnership. In total, 9 HSE representatives participated in the partnership, staff were released to the Core Team and HSE staff also delivered the programme. It was intended that Panel 1 practitioners would have the greatest responsibility for delivery. Among Panel 2 practitioners, while the HSE disciplines of Family Support, Psychiatry, Disability, Speech and Language Therapy, and Occupational Therapy were all expected to be involved in programme delivery, the greatest responsibility for delivery was given to Public Health Nurses (PHNs) (*see Section 3.1 for definition of each panel and Section 7.3.2 for staff commitments to delivery of Triple P*). The data suggest that, in terms of actual contribution to the partnership, there emerged a continuum of engagement, running from those for whom LWPP activity was the main or sole focus of their work to those for whom the partnership involved attendance at various meetings and providing support for programme delivery.

The partners contributed in various ways and, according to the Project Management Team, these contributions *'cannot be equated'*. Some had little or no involvement in the delivery of the programme, but did make other contributions. In some of the Statutory, Community and Voluntary (SCV) organisations, for example, staff were trained as practitioners, but did not deliver the programme despite the expectation that they would do so. The main role of other SCV organisations was to provide venues for training or to provide ways of making contact with and recruiting parents, while other organisations provided access to pre-schools and schools, without which help, it is believed, Panel 1 practitioners could not have gained such access. One HSE discipline provided *'considerable input'* to the partnership in the form of providing a staff member (half-time equivalent) to the Core Team (although this discipline was not in a position to provide practitioners for programme delivery), while another HSE discipline coordinated delivery of the Stepping Stones version of Triple P (although the representative acknowledged they were not delivering Triple P as often as they would like).

There was evidence of some partners delivering more than they had committed to and some delivering less. Changes in commitments or in ability to deliver were generally dealt with openly and representatives felt that they could discuss issues at partnership meetings and/or with the Project Management Team as the need arose. In one instance, a representative indicated that they had not raised the issue of the pressures of their commitment at the partnership table since they felt that having made the commitment they wanted to deliver

on it; on reflection, they felt that it might have been useful to declare this and commented that it would have been a supportive environment in which to do so.

KEY FINDINGS: How effective was the implementation within each partner agency perceived to be by all the key stakeholders?

- Each partner representative had an equal vote in decisions, even though contributions varied.
- The scale and level of programme delivery by staff from partner agencies was highly variable.
- Initially, the partners believed that Public Health Nurses would make a considerable contribution to delivery. Partners contributed in various ways other than the delivery of the programme and they could not be equated, according to the Project Management Team.

6.3 Research Question 2: Delivery – Has the partnership succeeded in its objective to promote and support the delivery of evidence-based parenting knowledge and skills to the population of Longford Westmeath?

6.3.1 Has the partnership supported delivery of Triple P?

As discussed above, it was the intention that different partners were to make different contributions to LWPP and to the delivery of Triple P. In addition, some partners delivered more than they had agreed to do and some delivered less than agreed (*see Section 6.2.4*). The representatives believed that the Project Management Team was responsible for ensuring the partnership responded in a flexible way to each partner's changing capacities to deliver on their commitments:

> *'We haven't had major issues like that and I think it's because where someone is comfortable and says "Well, we can't actually deliver that anymore", it's not a low bat, it's a conversation around "Well, what can you do?"* [Member of Project Management Team]

> *'I think the door was always open to me to go back. I never felt that I hadn't an opportunity to go back at any time to re-look at the commitment.'* [Representative from HSE]

While the Project Management Team remained flexible in negotiating the commitments of partners, it also continued to support and encourage commitment:

> *'In fairness to the partnership, as well as the Project Director, I suppose they have been a little bit indulgent towards, shall we say, non-HSE partners. And rather than go at it, they've coaxed us into certain things and they've explained why we want to go where we want to go. So that has been very good.'* [Representative of SCV sector]

There is acknowledgement that while some of the changes partners made to their commitments related to funding cuts, others related to the way that staff initially were engaged in the process and that lessons have been learned in relation to delivery in that regard. The Triple P Programme was not a good 'fit' with some of those initially trained as practitioners (*see more detailed discussion in Section 7.2.7*). Having the resource of a Project Management Team that was able to respond to the changes appears to have been a key factor in representatives feeling comfortable with both their own and other partners' commitment changes.

Although representatives repeatedly stated how supportive the Project Management Team were, there was recognition that the aims of the partnership were ambitious and demanding. In general it was felt that the expectations were fair and had been agreed to, and also there was a sense that once a commitment was given it had to be delivered on. One HSE representative spoke of their Department *'not delivering [Triple P] as*

much as we would like' because they were *'severely challenged'* by a long waiting list of service users and that to meet their commitments they *'would need to deliver one or two [Group Triple P programmes] per annum'*.

The other significant factor in relation to partners delivering on their commitments appears to be their belief that the programme was making a difference to the lives of children and families. Triple P was described by one HSE representative as *'an evidence-based model that everyone can buy into'*.

KEY FINDINGS: Has the partnership supported delivery of Triple P?

- The 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.
- While the Project Management Team remained flexible in negotiating the commitments of partners, it also continued to support and encourage commitment.
- It was acknowledged that the aims of the partnership were ambitious and demanding, that expectations were fair and that partners were supported by the Project Management Team in meeting those expectations.
- It was acknowledged that some changes in commitments were due to the way potential practitioners were initially engaged.

6.3.2 Has the adoption of Triple P impacted on attitudes to evidence-based programmes?

Although the delivery of the Triple P programme was the key objective of LWPP during the evaluation period, the partnership was not restricted to delivering any one programme. A central objective of LWPP was to promote a commitment among partners to evidence-based programmes that benefit children and families more generally.

Many partners confirmed that there had been a change in attitudes towards recognising the importance of a valid evidence base for programmes:

> *'Definitely, I mean we talk about it [evidence] all the time in relation to everything that they [staff] do. Everything, all their interactions, all their health promotion education has to be evidence-based and I mean obviously parenting information should be exactly the same and we didn't have that before. It was very much "hit and miss". We had leaflets from everywhere, some you wouldn't be happy with. So in this way at the very least the common denominator now is that it's standardised and if they have to give out a leaflet, well they are given that and the resources were excellent. They really were excellent.'*
> [Representative from HSE]

In services where evidence-based working was already strong, it was felt that involvement in the partnership was viewed positively by managers and peers partly because of the evidence-based approach. There were no data on what effect, if any, the partnership had on managers of agencies where evidence-based working was not already strong.

Some representatives indicated that the experience of working in partnership on something that was supported by a strong evidence base has meant that this is something they will now be looking for in other areas of work.

In contrast, one representative from the Statutory, Community and Voluntary (SCV) sector expressed some concern that too much focus on evidence-based programmes risked giving less significance to what people in

the community say they want: *'You might use these programmes, but [there is a] fear that we are just going to get obsessed with evidence-based programmes instead of listening to people and starting from where they are at.'* The same representative spoke of the need to look at the social and economic causes of social problems rather than just responding to the needs of individual clients: *'That would be a fear as well in terms of evidence-based programmes, that you're very much focused on the individual and change as individual and not necessarily looking at the bigger picture and the causes of why the individual is where they are.'*

However, in the main, partners expressed a strong interest in the issue of evidence, its role in the work of the partners and its importance as a foundation for the Triple P Programme.

Representatives reported having received mixed feedback from staff on the ground involved in delivery, or whose peers were involved in delivery, concerning evidence-based programmes more generally. While some were positive and wanted to have more of this type of approach, others were critical of the time commitments required and also the changes of practice needed, while others doubted this type of approach would work in certain contexts. Most representatives were happy that the programme was being evaluated. Instead of relying on the reports of individual practitioners or parents, they would have access to an external assessment of the impact of the programme.

KEY FINDINGS: Has the adoption of Triple P impacted on attitudes to evidence-based programmes?

- Attitudes to working with evidence-based programmes in the main were positive, and in some organisations this positive attitude was a result of working in the partnership.
- Management support for involvement in the partnership was explained in part by the commitment to evidence-based programmes.
- Representatives reported that they will now expect to work with evidence-based programmes in the future because of their involvement in LWPP.
- Only one representative had concerns about an evidence-based approach as such.
- Representatives reported having received mixed feedback from staff involved in delivery concerning evidence-based programmes.

6.3.3 What 'added value' has been offered by partnership working?

A further question concerns whether the Triple P Programme could have been delivered as effectively without the involvement of other partners or whether instead there was 'added value' from adopting a partnership approach.

The scale of the HSE and its role in relation to children and families in the region was realistically reflected in HSE representation on LWPP. Some Statutory, Community and Voluntary (SCV) sector representatives felt that their own contribution was limited, and one HSE representative felt that the programme could possibly have been delivered without the SCV partners. Nonetheless, most representatives, both within and external to the HSE, identified added value in having SCV organisations involved in the partnership. As discussed above, representatives believed that the participation of SCV sector agencies was necessary to make contact with and recruit parents and therefore to ensure wide programme reach because such agencies were thought to have better access to parents and were seen as more acceptable to them (*see Section 6.2.3*).

Networking with other partners had helped one HSE representative develop a better understanding of what SCV sector services are available for children and families:

> *'The networking side of things, establishing links with other organisations, has benefited other pieces of my work. Basically, I'm trying to link in with parent groups, service user groups and all local*

organisations that would be out there. So through my contacts with LWPP, I'm finding I'm linking in with them to establish … a map, what organisations are out there for parents, and through them then, you know, I suppose they link me in with other key people as well. So it has helped.'
[Representative from HSE]

Some representatives reported that being a member of the LWPP partnership enhanced the value of their work in the eyes of other agencies. One representative felt that perceptions had changed and their work was valued not just as a particular type of service, but also as a service with a role in prevention and in possible collaboration with others.

Another representative spoke of the partnership creating a pool of expertise and a structured way of working that was sustainable:

'I personally feel that partnerships like this are very important in times like this because it's a huge pool of skill and expertise that you've got sitting around the table. That's probably more valuable than monetary things at this time … It allows you a forum to stand back and look at how we can do things better, neater, tighter and cleaner, and it's about maybe bringing structure back in where structure might be loose … If you don't have structure, you don't have safety, you don't have quality of service.'
[Representative of SCV sector]

KEY FINDINGS: What 'added value' has been offered by partnership working?

- Although some representatives outside of the HSE felt that their contribution was limited, most identified 'added value' in having Statutory, Community and Voluntary sector organisations involved in the partnership.
- According to the representatives, partnership working increased programme reach and acceptance, ensured population-wide coverage, improved 'networking' between agencies and enhanced the value of individual partners' work.
- Partnership also created a sustainable pool of expertise and a structured way of working.

6.4 Research Question 3: Measuring and reviewing progress – Has the partnership succeeded in its objective 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 counties?

6.4.1 Did partner contributions change since the start of involvement?

The first area where there was considerable learning concerned how best to deal with **changing levels of commitment from partners**. One area of contribution concerns programme delivery and includes the provision of staff to deliver the programme, the promotion of the programme and the recruitment of parents, and the provision of venues for programme delivery. The findings show that the capacity of organisations to contribute to the partnership changed over the course of the evaluation. Of note is that all Statutory, Community, and Voluntary (SCV) sector partners reported diminished capacity to contribute over time. Some representatives reported that they may not be able to sustain current levels of contribution because their staff numbers had been reduced, but their 'core' responsibilities had not been reduced. Some of the SCV staff trained to deliver Triple P had been made redundant and in one organisation the only staff member trained as a Triple P practitioner was currently on leave. Representatives of 4 SCV organisations noted that their

funding was tied to specific 'core' functions or activities which did not include Triple P, while another SCV agency found it difficult to remain involved in delivering on 'peripheral' objectives and could no longer be as 'proactive' as in the past.

The Project Management Team were aware of the challenges that SCV sector partners faced. It acknowledged that practitioners in SCV organisations could have been selected better and those trained could have been given better supports, including closer mentoring from Panel 1 practitioners.

Another area of contribution concerns **attendance at meetings of partner representatives**. The findings show that in 5 of the SCV organisations, either the representatives had little involvement with the partnership or the representatives were new to this role within their organisation. One organisation had not sent a representative to partnership meetings *'in a while'* and only attended meetings when they were needed. Although there was no expectation that they would deliver the programme, there *was* an expectation that they would help raise awareness about the programme, but the representative indicated a decline in activity in this area as well. In other SCV organisations, the representative's predecessor was the one who signed up to the partnership; the representative was *'not spending all my day thinking about it [LWPP]'*; there had been no *'hand over'* from the previous representative of that agency; and in two cases there had been changes in personnel and those currently in position had replaced colleagues with more experience of LWPP.

Turning to the HSE partners, when the implementation of Triple P began, there was a commitment to train all Public Health Nurses (PHNs) in the area as practitioners. Between 70% and 80% of PHNs were trained, although initially it was difficult to ensure all of these staff delivered Triple P. Subsequently, this approach was revised in two ways: (1) it was decided to no longer implement the Primary Care version of Level 3 Triple P and instead to implement Workshop Triple P (small group discussions); and (2) it was decided to target as potential practitioners only those PHNs with a *'higher child health caseload'* and not to target those with a higher adult health caseload. A related development, which occurred independently of the LWPP, was the revision of the structure of Public Health Nursing, creating 3 child health teams in urban areas (one each in Longford, Athlone and Mullingar). The partnership focused its attention on involving PHNs from these child health teams in the delivery of Triple P. Notwithstanding this, Triple P was described by a HSE representative as a *'very small part'* of the PHNs' workload and their workload pressures had increased in recent times. The Project Management Team acknowledged it was an error initially to target all PHNs as potential Triple P practitioners and it would have been more productive instead to target a small number of key PHNs:

> *'We have a smaller number of PHNs now who are much more active. We're getting many more referrals. And the remarkable thing is that the [PHN] management, despite the initial difficulties, stuck with their belief in the idea.'* [Member of Project Management Team]

The Department of Public Health supported the implementation and evaluation of the Triple P Programme as an evidence–based model that *'everyone can buy into'*. Public Health input to this programme included participation of the Director of Public Health at partnership level and the input of a senior researcher who was a member of the Project Management Team. The Director of Public Health worked closely with the Project Director on an ongoing basis to get Triple P *'on the agenda'* at a national level within the HSE. The Researcher commitment was initially 0.5 WTE (whole-time equivalent) and increased substantially in the second year. This input was a key resource for the programme: as well as providing significant input to the development of the ethical proposal and work plan for the project, the Researcher contributed to the ongoing design and management of the research and the development of related protocols.

The HSE and Tusla, Child and Family Agency

Consideration about the future roll-out of Triple P during 2013 was taking place at a time of considerable structural change within the statutory partner agency, i.e. the HSE. When the partners reviewed the MoU in late 2011, all partners re-affirmed their commitments. Although all partners have since then been affected by further financial difficulties, the HSE had made no change to its commitment. Indeed, the HSE had provided

one more member of staff for Panel 1 practitioners (Project Management Team). The new Child and Family Agency was subsequently established, in January 2014, which involved the transferring of child and family services from the HSE to the new agency, including family support and child welfare, child protection, foster care, residential care, aftercare and adoption. The HSE has retained responsibility for public health, health promotion, child and adolescent mental health, and psychology.

At the time of completing this evaluation, both the Area Manager for Child and Family Services in the Midlands Area and the HSE Local Area Manager expressed their continuing support for the LWPP partnership. However, the HSE Local Area Manager expressed concern that the creation of the new Child and Family Agency had led to uncertainty over which statutory body would have responsibility for LWPP and the delivery of Triple P. Although no decision had been made at this time, he believed it likely that the Child and Family Agency would be given responsibility for this role and that the HSE *'will not be asked to have a remit for this'*. More specifically, the concern expressed was that a partnership approach and the Triple P programme requires a *'holistic approach'* (i.e. a universal or population approach), where many different disciplines and organisations are involved, and if many relevant HSE Departments were left without a responsibility for the partnership, the statutory sector would no longer be in a position to take the universal/ population approach necessary for its contribution to the partnership.

Other partners expressed uncertainty about how responsibilities and budgets would be divided and who within the new Child and Family Agency and the HSE would be willing to drive forward the partnership and the delivery of Triple P. Genuine concern was expressed about this by senior managers within the HSE. The Project Director also acknowledged uncertainty about this issue and about how the partnership will be driven forward in the future through 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.

KEY FINDINGS: Did partner contributions change since the start of their involvement?

- The partner agencies contributed to the partnership in various ways, including the provision of staff to deliver the programme, the promotion of the programme, the recruitment of parents, the provision of venues for programme delivery and attendance at meetings of partner representatives.
- The capacity of agencies to contribute to the partnership changed over time. All Statutory, Community and Voluntary sector organisations reported that they had less capacity to contribute, and 4 of them reported that their funding was tied to specific 'core' activities, which did not include Triple P.
- In 5 of the Statutory, Community and Voluntary sector agencies, either the representatives had little involvement with the partnership or were new to this role within their organisation.
- There was a radical revision of the role of Public Health Nurses (PHNs) in the partnership. The Project Management Team believed it was an error initially to target all PHNs as potential Triple P practitioners and it would have been more productive instead to target a small number of key PHNs.
- With one exception, other HSE partners continued to make contributions to the partnership.
- The creation of the new Child and Family Agency has led to uncertainty among the HSE and Project Management Team over which statutory body will have responsibility for the LWPP partnership and the delivery of Triple P.

6.4.2 Did the initial reasons for joining the partnership still hold?

A further area of considerable learning concerned the motivations of partners and how those motivations did or did not change over the course of time. The Chair of LWPP stressed it was important *'not to assume that all partners have the same motivations'*. The crucial issue is whether the variety of motivations present can help sustain a partnership.

For the HSE representatives, many of the original reasons for joining LWPP were still valid. Some of the HSE representatives were in favour of a partnership approach because, they believed, Statutory, Community and Voluntary (SCV) sector groups would be able to help gain access to parents in cases where it was believed the HSE would not be successful. The partnership model itself was *'crucial'*, according to the HSE's Public Health representative, in particular because it adds capacity to attract a wider audience. As another HSE representative put it, the HSE itself was seen as being *'too prescriptive'* by many families and the SCV sector organisations were generally not perceived in this way.

HSE partners also wanted to reduce the perceived inefficiency of having many overlapping parenting programmes and also a lack of collaboration between HSE Departments. Within the HSE, a motivation for starting the partnership was to ensure consistency in parenting programmes, according to the Project Management Team. In the past, staff had been trained in *'17 different parenting programmes'* and it was important to avoid this type of replication: *'Those of us who have chosen to work together have that kind of efficiency of resources'* (Project Management Team). Within the HSE, a further motivation for starting the partnership was to *'get rid of the silos'* that Departments would have. Triple P was not discipline-specific: *'You don't need to be a psychologist to deliver Triple P'* (Project Management Team). For that reason, different Departments were working together in LWPP and in the delivery of Triple P, and this also contributed to efficiency.

Initially Public Health Nurses (PHNs) joined the partnership so as to play a significant role in the delivery of Triple P. But, as outlined above, these expectations were revised downwards to fit the changing work environment of PHNs and greater emphasis was placed on their playing a role in recruitment of parents to the programme. The Director of PHN believed that the partnership had initially been *'naïve'* about the role PHNs could play. She believed a main role of PHNs should be to refer parents to Triple P and therefore to act as *'a conduit point'*. She also believed that small-group discussions (i.e. Level 3 Workshops) were better suited to PHNs since the methodology was similar to that used by PHNs in the past. In contrast, she believed that PHNs would find one-to-one work (i.e. Level 3 Primary Care) more challenging and less of a good fit with their training and experiences. It is important to ensure *'a fit'* between people and the levels at which they are delivering, she argued. This question of the role of PHNs and their 'fit' with Triple P is discussed in more depth in Section 7.3.7.1 and Section 7.3.7.2: two issues are addressed – the views of PHNs on the Primary Care version of Level 3 and their views on the compatibility between the principles of Triple P and PHN training and experience.

Some Statutory, Community, and Voluntary (SCV) sector representatives joined the partnership because of the promise shown by Triple P as an effective programme and this continued to be a motivating factor at the end of the evaluation. The original reasons why SCV agencies chose to become partners included the following: seeing the evidence of what the Triple P Programme could achieve; being impressed by a presentation delivered by Professor Matt Sanders, the developer of Triple P; ensuring that all pre-school service providers were *'on the same page'* when it came to good parenting; and being supported by key funders in joining the partnership. Two representatives from SCV agencies who were not involved in delivery had joined the partnership because they believed it would be good for all parents, although they did not have direct experience of or evidence that the programme had worked. Others were motivated to become partners because of the leadership, expertise and helpfulness shown by the members of the Project Management Team within LWPP, who were considered to be *'on the ball'*.

Some SCV sector agencies joined the partnership so as to contribute to the related goal of tackling social exclusion. This was the case for those working in areas of community and local development. However, those representatives reported that this became increasingly problematic in a period of funding cuts and they subsequently came under pressure from funders not to see LWPP as part of their 'core' business.

KEY FINDINGS: Did the initial reasons for joining the partnership still hold?

- Initial reasons for joining the partnership still held for many. Some HSE representatives were in favour of a partnership to help gain access to parents and to reduce the 'inefficiency' of having many overlapping programmes, while also increasing collaboration between HSE Departments.
- While originally Public Health Nurses (PHNs) were to deliver a large proportion of Level 3 Primary Care, it was subsequently decided to revise downwards PHN commitments to delivery, to focus on Workshops rather than Primary Care Level 3 and to place greater emphasis on recruitment of parents to the programme.
- Statutory, Community and Voluntary sector partners are still committed to the Triple P Programme. They continue to be motivated by a belief in the effectiveness of the programme, the excellence and leadership of the Project Management Team, and the need for consistency in parenting support.
- Some Statutory, Community and Voluntary sector representatives joined LWPP so as to contribute to the related goal of tackling social exclusion, but experienced pressure from funders not to see LWPP as part of this 'core' activity.

6.4.3 Did the MoU help in running the partnership?

As already discussed, the LWPP partner representatives had generally positive views of the Memorandum of Understanding (MoU). In particular, they believed that the process of developing the MOU and the practice of having it in place was a key strength of the partnership, that the MOU encouraged openness in communication and trust, and that this was important in particular given the unequal power of partners (*see Section 6.2.3.1*). The following section explores the role of the MoU in running the partnership, paying particular attention to how the partnership dealt with changing levels of partner commitment.

Representatives were asked whether LWPP was operating in accordance with its MOU and also what difficult issues had arisen and whether they were addressed in accordance with the MOU. According to one member of the Project Management Team, the value of the MOU was in *'the process of developing it'*: the process of *'building relationships and sharing perspectives'* and in that way developing the MoU *'engrained'* in the partners *'what it [LWPP] is all about'*. While the text of the document itself may be of value to new members who wish to become informed about the workings of the partnership (*for full MoU text, see Appendix C.4*), other than that the *'document itself is … a bit lost at this stage'* and instead what is important is that it is *'a living document'*.

The findings suggest that the representatives, working together, came to agreements about changes to the commitments of partner organisations, changes that were required because of increasing resource constraints. The Project Management Team accepted that the *'optics'* of all partners *'pulling their weight'* was important. However, the Project Management Team was aware that partner agencies had lost some staff due to funding cuts. It was then necessary to *'tweak'* the partners' commitments: either for Panel 1 practitioners to provide more help in delivering the programme or for the partners to find means of contributing to the partnership other than by direct delivery. An HSE representative observed that the MOU was used to help identify potential areas of conflict and was *'process driven'* for each issue, and therefore seen as an *'objective'* way to proceed. According to one member of the Project Management Team, the MoU helped bind partners together, keeping partners *'on board'* when they were in danger of *'slipping off the radar'*.

One key consideration was how the LWPP Chair and/or the Project Director should work through issues relating to programme delivery with their colleagues from the HSE. The Chair noted that the same agencies can have many different connections and only one of them is as a partner in LWPP; it was reckoned that the important thing was to put on the 'right hat' for the right context and to see beyond other relationships. The Director of Public Health Nursing noted that changes to the involvement of PHNs were not addressed at the wider partnership meetings; instead, because of the good working relationship with the Project Director, these changes could be agreed outside the meetings, but other partners were kept informed of such changes. The Project Director viewed this issue as a matter pertaining to the internal running of a HSE department and therefore not appropriate for the partnership forum. The Area Manager for Child and Family Services also spoke of the nature of her contact with the Project Director: while the Project Director would contact her with *'emergent issues'* relating specifically to her HSE role, she in turn could make progress on these issues by contacting those disciplines that report to her in the HSE. According to the Project Director, this is an example of partner members being active in progressing partnership issues between meetings.

The role of the Project Management Team in *'steering'* these changes was mentioned. HSE representatives referred to the Project Director and Chair as the *'key players'* and described them as *'good steerers'* because of their enthusiasm, personality and ability to lead. A Statutory, Community and Voluntary (SCV) sector partner believed that all partners were equal, but *'some were more equal than others'* in the sense that HSE personnel took a lead role in LWPP and had more experience in both the organisation and the delivery of such a programme. They also commented that the lead role of the HSE was important since *'somebody has to hold responsibility'* and it was important to have a strong organisation. It was acknowledged by HSE representatives that the Project Director had to make day-to-day decisions, the *'nitty gritty'* of running the programme, in a timely fashion and therefore without waiting for partnership meetings to do so; however, although the Project Director and the Chair have *'a huge role', 'decisions are made by the partnership'*. Even small contributions by other partners were necessary for the *'credibility'* of the partnership, as observed by representatives from the SCV sector. At the same time, given the strength of the HSE, it was important that representatives of SCV organisations had sufficient seniority and confidence to raise issues that may prove contentious. In addition, as one HSE representative commented, it was important that the Chair did not act as a representative of the HSE, although the current Chair was a HSE staff member. For this reason, according to the same participant, the role of Chair should rotate between the different partner agencies. The role of Chair was open to nominations twice since the start of the partnership, according to the Project Management Team.

KEY FINDINGS: Did the MoU help in running the partnership?

- The MoU had value not as a text that was referred to, but rather as 'a living document'. The example offered was the way in which partners 'worked together' to agree changes to the commitments of other partners, changes that were required because of increasing resource constraints.
- The MOU was used to help identify potential areas of conflict and was 'process driven' for each issue and therefore was seen as an 'objective' way to proceed.
- Some important changes to the partnership were agreed informally, outside of partnership meetings, notably the changes to one HSE partner's commitments. This issue was seen as a matter pertaining to the internal running of a HSE department and therefore not appropriate for the partnership forum.
- All the major strategic decisions were made by the partnership. However, the operational decision-making was made by the Project Management Team and/or the Core Team.
- The role of Chair was open to nominations twice since the start of the partnership.

6.4.4 What were the strengths and weaknesses of a partnership approach?

Representatives were asked what they thought were the strengths and weakness of the partnership approach. Specifically they were asked whether a partnership approach was required for the delivery of Triple P.

Strengths of partnership working

Commitment to partnership working

According to HSE representatives, their experience of LWPP had confirmed their commitment to working in partnership. One HSE representative described herself as a *'firm believer'* in such an approach and that this belief had been *'cemented'* by the experience of LWPP. She went on to say a partnership approach was *'very beneficial'* for parents, the HSE, and the Statutory, Community and Voluntary (SCV) sector organisations. Better value for money was ensured by the pooling of resources and so a partnership approach was *'more productive'* and *'the only way forward'* in a time of financial crisis. The involvement of *'different groups'* was the explanation given by another HSE representative for why a partnership approach can *'make it work'* since it utilises the strengths of different resources and also strengthens relationships between different organisations. Another way to maximise the use of resources, according to the same HSE representative, is to have a parent representative as a member of the partnership in the future.

SCV sector representatives also reported that their already existing commitment to a partnership approach had been reinforced by their experiences of LWPP. The findings suggest that a partnership approach was an important consideration in the decision of SCV groups to become involved. One SCV representative was *'sceptical'* about involvement with the HSE to begin with, but conceded that not only had the HSE delivered, but also that this was possible because of the partnership approach. At the same time, the HSE brings with it *'kudos'* as a health and social care provider that other organisations lack. Other SCV representatives reported that their agencies are partnerships – it is *'the way we do things'* – and that linkages should be retained, in particular with the HSE. There was a similar view expressed by one HSE representative, who noted that many of those who came together in the LWPP were already working in partnership in areas such as disability, primary care and family services, and therefore *'working relationships'* were already in place between HSE and SCV sector agencies.

Population effect

According to 2 separate HSE representatives, a partnership is necessary for *'a population effect'*. A population effect requires that parents from all social backgrounds participate and there must be a *'mix of parents'* if the programme is to be *'non-stigmatising'*. A population effect is possible only when parents can be effectively recruited and the benefit of a partnership approach is that it can facilitate recruitment of parents. The most important issue was 'getting people [parents] in front of the speaker [practitioner]' and this was made difficult by the fact that marginalised groups are more difficult to recruit.

One member of the Project Management Team acknowledged that the partnership had not been as successful as hoped in the recruitment of those parents with the greatest levels of need. However, the partners in the more recently established Laois and Offaly Parenting Partnership were enjoying success in remedying this perceived shortcoming by continuing to pursue a partnership approach: it had been made a priority in the new parenting partnership, which in turn was being *'contacted by organisations working with high risk families'* who want to contribute to Triple P.

A SCV sector representative believed that when programmes are targeted at marginalised parents they can, in turn, *'feel targeted'*. Both HSE and SCV representatives reported that a stigma can attach to some dealings with the HSE. Although the HSE provides significant levels of services to parents, nonetheless it was believed that parents perceive *'a stigma in relation to having to come to a health centre'* (Project Management Team) and therefore the HSE on its own would not have sufficient access to parents (SCV representative). As members of the Project Management Team and SCV representatives also acknowledged, *'sometimes people communicate better with community groups'* and for that reason, *'better information'* about people's *'real needs'* can be garnered through a partnership approach (HSE representative).

Relationships

Representatives indicated that participation in the LWPP improved relationships both between partner agencies and between staff within their own disciplines/organisations. There was also evidence of an impact on partnership working external to the LWPP. However, this was more at the level of improving existing relationships, with little evidence of new collaborative initiatives outside of the LWPP that could be attributed to the experience of being involved in the partnership. Representatives reported high levels of trust in those who were centrally involved in the initial drive to adopt Triple P. This was linked to the development of both pre-existing and new relationships. The style of working of key personnel was important, including their honesty and openness. There was also a perception that power issues between the HSE and other agencies with far less of a role in the delivery of Triple P had been acknowledged openly. Significant investment had been made in building relationships and an important role in this had been played by the MoU and its development.

The Triple P Programme

Generally, there was strong confidence in the Triple P Programme, which means there was commitment to delivering it successfully and working together to do so. Representatives thought the current evaluation was important in this respect. They would no longer be relying on the existing evidence base in relation to Triple P, but instead could have access to evidence on how it was implemented in the Irish and local context. There were reports of positive feedback about and interest in the programme generally. Many of the representatives indicated that they had received feedback about the programme in their personal lives, for example at a party, at the hairdresser, at their child's school.. Feedback reported by participants at this level was always positive.

Flexibility

The representatives were in agreement that the LWPP responded and adapted to the needs of partner agencies. Some of this flexibility was needed due to changes in individual partners' capacity to deliver and some was needed when lessons were learned from the experience of delivery. The MoU is significant here both in terms of helping people be clear about what they were signing up to and in giving people a framework within which to negotiate when conditions changed. The presence of a Project Management Team that was responsive to issues as they arose was also considered important.

Challenges to partnership working

Economic environment

Each of the partner agencies had made progress in the process of embedding the partnership as a 'core activity' or part of their 'core business'. However, this process had been adversely affected by a worsening economic climate and the funding cuts that all partners were experiencing. Some representatives were optimistic that this environment would facilitate decisions that ensure approaches such as that of LWPP are supported as a cost-effective and efficient way of working. The real impact of job losses and staff shortages meant that the ability of some partners to deliver on their commitments to date had been compromised. Most were fearful of the impact of further cuts, particularly those representatives for whom the partnership was not considered a 'core' activity by funders.

Scale of commitment

Another key challenge related to each partner agency's level of commitment and the number of staff for which they had responsibility. This issue arose for those within the HSE who had significant delivery responsibility at primary care level, in particular PHNs. The relevant factors included staffing, change management, professional

practice and caseload management (*see Section 6.4.1*). SCV partners also faced this challenge, largely because their organisations were coming under pressure to focus solely on 'core' activities.

Future of the partnership

A common concern for representatives was what the partnership would look like once this current funding phase had ended. There were also concerns expressed about the future of the HSE, its priorities in a new structure, possible changes in geographical remit and changes in job roles of those perceived to be central to driving the partnership in the future. The individuals involved in the partnership and the relationships that had been established were identified as key strengths. Concerns about changes to membership were expressed in terms of the impact on *'the harmony of the group'*.

Within the HSE, the setting up of the new Tusla, Child and Family Agency was mentioned as a potential challenge in terms of the future of child health services and the integrated approach of the implementation of Triple P. There was concern that in the changeover, the partnership could *'get lost along the way'*. Maintaining the balance between partners who had very different levels of involvement came across as an ongoing challenge, requiring careful management. The ability of the partnership to respond to this and to a changing economic environment was a concern of many representatives.

KEY FINDINGS: What were the strengths and weaknesses of a partnership approach?

Strengths of partnership working

- The findings suggest that a partnership approach was an important consideration in the decision of Statutory, Community and Voluntary (SCV) sector groups to become involved because they operated as partnerships already and because of the 'kudos' of working with the HSE.
- HSE representatives believed a partnership approach was necessary so as to recruit parents, overcome the stigma of parenting programmes and ensure a population effect.
- One member of the Project Management Team acknowledged that the partnership had not been as successful as hoped in the recruitment of those parents with the greatest levels of need. However, the newly established Laois and Offaly Parenting Partnership had made this a priority and therefore aimed to address this issue within a partnership approach.
- Relationships: The issue of disparities or perceived imbalances in power was well managed by the LWPP. Representatives reported high levels of trust in those who were centrally involved in the initial drive to adopt Triple P.
- The Triple P Programme: There was strong commitment to the programme and significant interest in the evaluation as a source of evidence for the Irish context.
- Partnership: There was a strong commitment to the principal of partnership working among representatives.
- Flexibility: The LWPP responded and adapted to the needs of partners flexibly, thanks to the MoU and the efforts of the Project Management Team.

Challenges to partnership working

- The main concerns of representatives related to the impact of increased funding cuts and recruitment embargos on the capacity to deliver the programme.
- A common concern for representatives was what the partnership would look like once this current funding phase had ended and the Child and Family Agency had been established.

6.4.5 In what way could the partnership be improved?

Representatives were asked about how the partnership could be improved. As the partners had endeavoured to apply what had been learned in the Longford Westmeath partnership in planning for and implementing the Laois Offaly partnership, the comments of the representatives often referred to both partnerships. However, it should be noted in interpreting these findings that the two partnerships are separate entities and, other than the Project Director and some of the HSE representatives, there is no overlap in representatives.

The LWPP representatives reflected on the following issues as being of considerable importance for the roll-out of the partnership:

1. Should the partnership be replicated?
2. What agencies should or should not be in the partnership?
3. What individuals should be targeted as practitioners?
4. Must partners provide staff to deliver the Triple P Programme?

Should the partnership be replicated?

All the representatives in the study were in favour of expanding the delivery of Triple P to the two neighbouring counties of Laois and Offaly. One HSE representative was *'very excited'* about the prospect of creating a new partnership because there is a benefit of *'having one programme we can all sign up to'*. One SCV representative described the plan to expand programme delivery as 'a brilliant idea' since parents face *'the same problems everywhere'* and there is a need to *'get people to buy in'* to the programme. Another SCV representative argued that it would be wise to *'replicate'* the partnership approach adopted in Longford Westmeath. While the LWPP will continue as *'an entity on its own'*, the question posed by the Project Management Team was what sort of relationship will there be between the LWPP and the new partnership in Laois and Offaly. At the time of completing this evaluation, the 2 partnerships were continuing as separate entities, although they shared the same Project Director and the same Panel 1 practitioners. Moreover, HSE staff in all four counties reported to the same Area Manager for Child and Family Services, who had a remit for HSE involvement in both partnerships.

What agencies should or should not be in the partnership?

The second issue concerned what agencies should or should not be in the partnership. Some of the representatives believed that there was no need for new partners as such, but rather better involvement by existing partners. HSE representatives commented that what was needed was to get partners to attend meetings and to get people to release staff to fulfil their commitments to the partnership. The new partnership in Laois and Offaly, based partly on what was learned from the experience of the LWPP in Longford and Westmeath, had established new approaches intended to increase the involvement of partner representatives. Sub-committees focusing on specific implementation issues (e.g. finance, external relations, recruitment) were used from the start of 2013 in Laois and Offaly, with members drawn from both the Project Management Team and other partner organisations. The intention is to make the partnership *'stronger'* and *'more active'* in day-to-day implementation issues (Project Management Team).

Some representatives believed that new partners could be recruited to the LWPP. There was still *'an open door'* and other organisations could join (HSE representative). Although the LWPP has two education centres as partners and very significant support from national school principals, it was argued that in addition the Department of Education and Skills should be a partner so that the partnership will have more *'credibility'* with schools (SCV representative) and the partnership would benefit hugely from having the Department of Education and Skills on board (Project Management Team). The Area Manager for Child and Family Services was explicit in her view that not only would Triple P be beneficial to teachers and special needs assistants, but also at the national level the Department of Education and Skills and the Department of Children and Youth Affairs should support the partnership and the programme.

Another change that has been implemented in Laois and Offaly, partly on the basis of learning from the LWPP, concerns the targeting of family support. According to the Project Director, in order to recruit organisations for whom 'family support' was a key part of their work and values, the new partnership has expanded the definition of relevant organisations from 'child and family' to 'child, family and community', which would include crèches and crèche workers. The Chair also pointed out that the LWPP has aims other than those focused on by Triple P and is actively involved with other evidence-based parenting programmes, including those focusing on child protection, child welfare, Vocational Education Committees (VEC), adult education and teenagers. Therefore, in moving forward beyond the current project, there is a natural opportunity for other relevant organisations to become involved. The Chair also noted that more could have been done in Longford and Westmeath to engage the Department of Social Work, in particular in the delivery of Level 5. As the Department of Social Work is very closely involved with the new partnership in Laois and Offaly, once again, this is an example of learning from the LWPP and how it has been enacted.

What individuals should be targeted as practitioners?

The third issue concerned what individuals should be targeted as practitioners. The partners had decided that in the future only selected individuals should be trained. If they are trained, they must be *'the right people'*, meaning they should have the right attributes, including the ability to deliver a programme to a large group, to engage with an audience and to be seen as *'an authority'*, confident and enthusiastic. Crucially, as pointed out by a HSE representative, practitioners need not be from any one profession or background. In hindsight, it was agreed by representatives from both the HSE and SCV sector that the programme was not a good fit for some individuals trained initially as practitioners; some agencies had shrunk in size and resources and could not sustain their commitments to programme delivery. While, originally, agencies themselves decided which individuals to put forward for training, in the new partnership in Laois and Offaly since 2013, the emphasis has been placed on *'picking the right people'* (Project Management Team) and a *'Person Specification document'* was developed for the recruitment of practitioners (*see Appendix C.3*). In the new partnership, there was a selection process for practitioners that included an interview and an examination of background, skills, interests and capacity to delivery Triple P in the practitioner's current post.

Must partners provide staff to deliver the Triple P programme?

The final issue was whether each partner agency must provide staff to deliver the Triple P Programme. There were different views on how much contribution each partner must make to remain a partner in a meaningful sense. What was referred to as a *'realist'* view was that all partners were dealing with serious funding problems. Some SCV representatives said that at this time and in the future, they would find it difficult to meet their commitments to the LWPP because there was uncertainty over whether they would still receive enough financial support to conduct their 'core' activities, which did not include Triple P. Members of the Project Management Team stressed that although it may look like an organisation has *'pulled back, even to themselves'*, they still want to be a partner, and although some HSE disciplines *'are not really playing much of a role'* what matters is that it is the HSE itself which is the partner. These members were of the view that *'partnership isn't just about facilitation'* and that delivery was *'not an essential element of partnership*'.

The alternative view *was* that programme delivery was a necessary part of partnership. According to one member of the Project Management Team, it is *'disempowering'* for a partner to *'pull back from full engagement'* and so re-commitment is needed. A HSE representative commented that although Panel 2 practitioners will continue to come under pressure in attempting to deliver Triple P due to their other core work commitments, nonetheless *'it would not be good for the ethos of the programme'*, as a multi-discipline programme, if only Panel 1 practitioners were to deliver Triple P. The individual representatives in the partner agencies should also deliver Triple P, even if only once, since this will support the enthusiasm they need to promote the programme in their own agency (HSE). Although it is less important that each partner agency delivers to a large number of parents, *'it's very important that you do have staff delivering the programme, have an in-depth knowledge of what the programme is about and have an in-depth knowledge of the importance of fidelity to the programme'* (Project Management Team).

The view held by some in the Project Management Team had evolved by the end of the evaluation period. The Project Director acknowledged that some partners had become *'less than fully involved as time went on'*. This was put down to two related factors. While many Panel 2 practitioners were less than fully engaged, the small group of Panel 1 practitioners were able to deal with much of the resulting deficit in the delivery of the programme, which is borne out by data on programme delivery (*see Section 7.2.6.2*). In the first three rounds of data collection for this study, members of the Project Management Team stressed that even partners who did not provide staff for programme delivery were considered full and equal partners, in particular as partners could contribute in various other ways, including by promoting the programme, recruiting parents or providing venues for delivery. However, in the final round of interviews, at which time the partnership had been rolled out in the two neighbouring counties, the Project Management Team had amended its view of the issue. According to the Project Director, one possible structure proposed for the new partnership, although not yet implemented, is a 'two-tier' partnership. In the proposed new structure, the first tier of 'core' partners will be expected to provide practitioners for the delivery of Triple P, while the second tier of 'associative' or 'supporting' partners will be expected to make other contributions instead, including the provision of venues for delivery and help with recruitment and raising awareness. This proposed development reflects an acknowledgement that although partnership is not just about delivery, delivery is necessary for full partnership.

KEY FINDINGS: In what way could the partnership be improved?

- All the representatives were in favour of the creation of a new, independent partnership and the expansion of Triple P delivery to two neighbouring counties (Laois and Offaly).
- Participants disagreed over whether new partner agencies were needed in the LWPP, with some arguing for better involvement by existing partners, as done in Laois and Offaly with the establishment of partnership sub-committees.
- Some representatives believed the Department of Education and Skills and the Social Work discipline should be more closely involved in the partnership.
- Partners acknowledged that the programme was not a good fit for many of those trained initially as practitioners and based on what was learnt from this process, a Person Specification document was developed for the recruitment of practitioners by the new partnership established in Laois and Offaly.
- There were different views on how much contribution each partner must make to remain a partner in a meaningful sense. While some believed partnership was not simply a matter of delivery, for others delivery was a necessary part of partnership and all partners should deliver Triple P, even though not all should have the same responsibilities in this area.
- The view held by some in the Project Management Team had evolved by the end of the evaluation period. Initially, members of the Project Management Team stressed that even partners who did not provide staff for programme delivery were considered full and equal partners. By the end of the evaluation, one possible structure proposed for Laois and Offaly was a two-tier partnership, with the 'core' tier providing practitioners for the delivery of Triple P while the 'associative' partners provide support for delivery (e.g. venues, recruitment, publicity).

7. Findings from Implementation Study

The aim of the Implementation study was to analyse the extent and nature of programme take-up, how well the programme was organised and run, and the extent to which the programme was implemented as planned.

7.1 Research questions and methodology

7.1.1 Research questions

The Implementation Study was structured around two research questions. In addition, under each research question, the pertinent issues for implementation of the programme were also investigated.

- **Research Question 1:** What was the extent and nature of programme take-up (i.e. programme utilisation)?
  - What were the different Triple P Levels that were planned and delivered?
  - How were delivery targets set?
  - How were parents recruited?
  - What progress was made towards achieving targets in delivering the programme?
  - What was learned about programme delivery?
  - What progress was made towards achieving targets in training practitioners and supporting programme delivery by practitioners?
  - What was learned about training practitioners and supporting programme delivery?
- **Research Question 2:** How well was the programme planned, organised and delivered, and to what extent was the programme implemented as planned (i.e. programme organisation and programme fidelity)?
  - How was Triple P selected and implemented?
  - What were the funding and staffing commitments of the partners?
  - What structures were created for programme coordination?
  - What were parents' views on the quality of programme content and delivery?
  - What were practitioners' views on the quality of programme content and delivery?
  - What practitioner training and supports were planned and delivered?
  - What were practitioners' views on the supports needed and received, their own confidence and the helpfulness of the programme?
  - What measures were put in place to ensure programme fidelity?
  - Did parents receive the recommended programme dosage?

7.1.2 Data collection

Documentary data were sourced from the following:

- Minutes of Core Team meetings (x 21) 2010 – 2012.
- Minutes of LWPP meetings (x 37) 2010 – 2012.
- Agendas of LWPP meetings (x 23) 2010 – 2012.
- Progress Reports for The Atlantic Philanthropies (x 4) 2010 – 2012.
- Grant applications (x 3) 2009 and 2012.
- Minutes of Practitioner Support Forums and Area Team Meetings (x 16) 2010 – 2011.
- Minutes and Communications for 'Parenting Strategy' (x 20) 2005 – 2006.

- Communications concerning establishment of LWPP (x 19) 2005 – 2010.

The following **LWPP documents** were analysed as part of the Implementation Study:

- LWPP Memorandum of Understanding (MoU).
- Grant Proposal to The Atlantic Philanthropies.
- LWPP Triple P – Positive Parenting Programme Logic Model.

Qualitative data were sourced from the following:

- Interviews with the LWPP Project Management Team (December 2011 and May 3013).
- Interviews with The Atlantic Philanthropies and HSE (December 2011 and July 2013).
- 5 focus groups with parents (n=33) – 2 for Workshop Triple P participants, 3 for Group Triple P participants.
- 5 one-to-one telephone interviews with Triple P Seminar participants.
- 3 focus groups (n=21) with practitioners.

Quantitative data were collected through a **survey** completed by practitioners:

- The T1 survey (November 2011) included 8 practitioners from Panel 1 and 13 from Panel 2.
- The T2 survey (November 2012) included 7 practitioners from Panel 1 and 6 Public Health Nurses from Panel 2.

Data on delivery were sourced from the following:

- Programme records were analysed in calculating figures for programme delivery.

7.1.3 Selection and recruitment of participants (Practitioners)

Practitioners

Participants were selected from the population of Panel 1 and Panel 2 practitioners. All Panel 1 practitioners were invited to participate in 2 focus groups and 2 surveys. Panel 2 practitioners were selected in two ways. For the first focus group and the first survey, all Panel 2 practitioners were invited to participate; for the second focus group and the second survey, all Public Health Nurses identified as Panel 2 practitioners were invited to participate. In addition, a one-to-one telephone interview was conducted with the Director of Public Health Nursing. For additional information, *see Section 7.2.3.2* for a profile of participants in the focus groups with practitioners and *see Section 7.2.6.2* for a profile of participants in the questionnaires completed by practitioners.

Contact details for practitioners were sourced from the Project Management Team. Practitioners were then contacted by the Research Team and invited to participate in the evaluation. Practitioners were provided with written information about the study, covering issues of the voluntary nature of participation, confidentiality and anonymity, and also a consent form for participation in focus groups. Participants in focus groups were also asked to complete a background questionnaire. All interviews were recorded and audio files were subsequently transcribed. Practitioners were also invited to complete a survey, which was returned by post without any identifiers to ensure anonymity of participants.

Parents

Parents were selected from the participants in the Triple P Programme who consented to take part in the evaluation and also who had consented to follow-up contact in connection with focus groups. Parents were also selected based on location, the Triple P Level in which they participated and whether their session was scheduled in the morning or evening. The following 5 focus groups were held:

- Mullingar Group Triple P day;
- Mullingar Group Triple P evening;
- Athlone Group Triple P day;
- Athlone Workshop Triple P day;
- Mullingar Workshop Triple P day.

Two further focus groups were scheduled (Athlone Group Triple P day and Kinnegad Workshop Triple P day), but in both instances parents did not attend and as a result the focus groups did not occur.

In addition, 5 telephone interviews were conducted with participants in the Triple P Seminars.

See Section 7.2.3 for a profile of participants in the focus groups and telephone interviews with parents.

A representative sample of potential participants was randomly selected from the target group for each focus group. As the Research Team did not have access to parents' contact details, information sheets were sent from the Research Team to the Project Management Team, who then forwarded them to parents and followed this up with a telephone call to explain the focus group. Parents' information sheets covered issues of voluntariness, confidentiality and anonymity. Parents were asked to sign consent forms on the day of the focus group and also to complete a background questionnaire. All interviews were recorded and audio files were subsequently transcribed.

7.1.4 Analysis of qualitative data

The overall research questions for the evaluation shaped the questions asked in interviews with participants. Therefore, the interview questions addressed the evaluation concerns of programme take-up, programme organisation and fidelity to the programme. **Parents** were asked how they heard about the programme and their motivations for taking part, their experiences of the programme, whether there were changes (in child behaviour, parenting and family) that could be ascribed to the programme, whether they would recommend the programme to others, and what changes or additions to the programme they would suggest. **Practitioners** were asked about their motivations for using Triple P, their perspectives on training, the materials used and supports given, their views on what did and did not work well in delivery, their perspectives on the impact of Triple P on families, and their views on recruitment, the Triple P model and public awareness of Triple P.

In addition, the question format in the interviews was open-ended and as a result participants were encouraged to be expansive and in focus groups to respond to the comments of others. This facilitated the emergence of new themes that were not dictated by the researchers' prior aims.

Analysis of the qualitative data was structured by two overarching objectives:

- First, the Research Team wanted to know whether the programme had been applied successfully in the context of Longford and Westmeath. Therefore, it was important to come to an understanding of the programme within its social context.
- The second objective was to give a voice to participants. While the parents and the practitioners in the evaluation provided quantitative data on the various programme outcomes, the qualitative data

collection methods provided an opportunity for parents and practitioners to represent the setting from their own point of view and in their own terms. Therefore, in interpreting the data, the Research Team sought to discover the emerging themes in relation to the contextual setting for the programme and also to interpret the meaning of the participants' experiences of the programme.

The Research Team also employed a number of methods to validate findings. Alternative explanations of findings were considered and negative cases were also identified. In discussing the findings, careful consideration was given to the data and the methods used. For example, when a view or statement was attributable to only one participant, it was important to clarify the context for the view or statement and its significance for the overall findings. In this way, the researchers sought to provide corroboration for the findings.

7.2 Research Question 1: What was the extent and nature of programme take-up (i.e. programme utilisation)?

7.2.1 What were the different Triple P Levels that were planned and delivered?

This sub-section examines the Triple P Programme that LWPP planned to implement and deliver. As discussed in Section 3.4, Triple P is a population approach to parenting. As part of a population approach, the *principle of programme 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 The various components or levels of Triple P that the partners planned and delivered are described below.

Level 1: Media strategy

In the media strategy, the target sample was the total population of parents in Longford and Westmeath. The strategy included a LWPP website, a Triple P newspaper (called the Tippaper), and publication of articles on the Triple P parenting strategy in local newspapers. In addition, the media campaign included the posting of podcasts on the LWPP website, the circulation of fliers and posters, as well as the launch event in 2010.

One element of support from Triple P International was the 'Stay Positive!' media strategy. This is described in LWPP's Grant Proposal (p. 73) as 'an integrated communications strategy designed to reach a broad cross-section of the population and to encourage and galvanise community support/participation in positive parenting'. The three phases to the media strategy were:

- use of posters, flyers, print advertising and advertorial to raise awareness of the importance of positive parenting;
- development and launch of a Triple P LWPP website to provide details on programme components and supply parents/carers with information and tips on common parenting issues;
- further use of brochures, flyers, posters and radio, in additional to the circulation of Triple P newspapers, to further heighten the awareness and understanding of the Triple P Programme.

Level 2: Triple P Seminars

This level involved the delivery of 3 individual topic-based seminars by trained Triple P practitioners throughout Longford and Westmeath. The seminars explored the following topics:

- Seminar 1: Power of positive parenting.
- Seminar 2: Raising confident competent children.

- Seminar 3: Raising resilient children.

Tip sheets on the topic were provided to parents who attended. The target for delivery was 4,777 seminar participants over 2 years.

Level 3: Primary Care Triple P

This was planned as a 3- to 4-session intervention, targeting parents who had identified a specific behaviour problem in their children. The final number of sessions was to be determined by progress on the target behaviour. There was to be 2 delivery strands:

- Strand 1: Participants receive training from their Public Health Nurse, generally in the family home or health centre.
- Strand 2: Participants receive training delivered by a Triple P practitioner in a general practice or community setting.

The delivery target was 2,628 participants over 2 years.

Level 3: Workshop Triple P

Having experienced difficulties delivering Triple P Primary Care (*see above*), it was discontinued and in its place LWPP implemented a Workshop version of Level 3 which had just become available from Triple P International. This level involved delivery of individual topic-based workshops by trained Triple P practitioners throughout Longford and Westmeath. Parents could select from 4 different topics and there were up to 15 participants per workshop. The delivery target was 2,628 participants over 2 years. This target included the participants in Strands 1 and 2 described above. The individual workshops explored the following topics:

- Workshop 1: Dealing with disobedience.
- Workshop 2: Managing fighting and aggression.
- Workshop 3: Hassle-free shopping with children.
- Workshop 4: Developing good bedtime routines.

Level 4: Group Triple P

This was an 8-session intervention that targeted parents who wanted help with children with behaviour difficulties, although the programme was open to all parents without any screening. The intervention comprised 5 face-to-face group sessions and 3 individual sessions by telephone. An additional phone call was included, the purpose of which was to give feedback on pre-intervention and post-intervention questionnaires, to help anchor positive changes in parents' own efforts and to identify any outstanding concerns (Project Management Team). The delivery target was 717 participants over 2 years.

Level 5: Enhanced and Pathways

Level 5 is particularly focused on supporting parents who are struggling to cope with child behaviour concerns in addition to relationship and/or personal difficulties. It is a 4-session strategy and is an adjunctive intervention used in combination with Group Triple P. Specific training was to be provided for practitioners. The target number of parents was 160. However, this component of Triple P was not delivered during the evaluation timeframe.

7.2.2 How were delivery targets set?

In its Grant Proposal (p. 62) to The Atlantic Philanthropies, LWPP provided 'the agreed delivery targets regarding all Triple P Programme components over the lifetime of this project'. Table 7.1 presents the total number of parents projected to receive support in each Triple P Programme component during the 2-year period of the evaluation. Targets for the delivery of Triple P were arrived at based on calculations provided to the LWPP by Triple P International.

Table 7.1: Programme delivery targets – Year 1 and Year 2

Triple P Level	Year 1 Target	Year 2 Target	Total Target
Level 2: Seminars	2,000	2,777	4,777
Level 3: Primary Care	1,000	1,628	2,628
Level 4: Group	300	417	717
Level 5: Enhanced and Pathways	60	100	160

Table 7.2 shows the potential take-up of the programme. Triple P International's *Training Outcome Report, March 2010 to September 2011* recorded the number of practitioners trained during the 2010-2011 period and the Levels at which they were trained. Table 7.2 also includes estimates of the number of families per facilitator per year that the programme could be delivered to.

Table 7.2: Programme take-up assumptions

Course type	No. of practitioners trained	Approx. no. of families per year per facilitator	Potential families reached
Level 2: Seminar	14	300 seminar places	4,200 seminar places
Level 3: Discussion Groups	16	50 families	1,600 families
Level 3: Primary Care	76	50 families	3,800 families
Level 4: Group	37	30 families	1,110 families
Level 5: Enhanced	21	25 families	252 families
Level 5 Pathways	21	25 families	252 families

Source: Triple P International *Training Outcome Report March 2010 to September 2011*

Based on the projections in Triple P International's *Training Outcome* report, approximately 10 practitioners would be required to meet LWPP's targets at Group Triple P over 2 years; approximately 26 practitioners would be required to meet LWPP's targets at Workshop Triple P; and 7-10 practitioners would be required to meet targets for Triple P Seminars. However, the projections do not state whether it is expected that practitioners delivering one component would not also deliver another component. If practitioners were to be playing more than one role (e.g. delivering Seminars, Workshops and Groups) and this is not accounted for in the projections, then the number of practitioners required to meet targets may have been underestimated.

KEY FINDINGS: How were targets set?

- Based on estimates received from Triple P International, LWPP projected delivery of Group Triple P to 717 parents with approximately 10 practitioners; the delivery of Workshop Triple P to 2,628 parents with approximately 26 practitioners; and the delivery of Triple P Seminars to 4,777 parents with approximately 7-10 practitioners.
- The accuracy of the projections may be questioned as they did not factor in whether practitioners were spending time delivering more than one component of Triple P.

7.2.3 How were parents recruited?

This section, on how parents were recruited, first analyses what informed the decision of parents to participate in Triple P. Focus groups with parents as well as questionnaires completed by parents provide data on how parents first heard of the programme. Focus groups with parents then provide data on the reasons why parents chose to attend the Triple P Programme. The discussion then moves on to present data collected from practitioners during focus groups concerning their role in the recruitment of parents.

7.2.3.1 What informed the decision of parents to participate?

How parents first heard of the Triple P Programme

Data were gathered on how parents first heard about the Triple P Programme. Parents who completed the questionnaires were asked about how they first heard of the programme. The profile of parents who completed questionnaires is presented in Sections 4.2.2, 4.4.2, 4.5.2, 4.6.2 and 4.8.2. Also, qualitative data were collected from parents during focus groups. The profile of participants in the focus groups is presented in Table 7.3.

Table 7.3: Profile of participants in focus groups (FG) and one-to-one interviews with parents

	Level 4 (Day) Nov 2011 (FG x 2; n=16)	Level 3 May 2012 (FG x 2; n=10)	Level 2 Nov 2012 (Interviews; n=5)	Level 4 (Evening) June 2013 (FG x 1; n=7)
Gender of parent				
Female/Male	11/5	8/2	5/0	6/1
Age of parent				
Mean	41	34	-	38
Marital status				
Married/Other	11/5	8/2	-	6/1
Country of birth				
Born in Ireland/Other	11/5	8/2	-	5/2
Number of children				
Mean	2.4	1.9	2.8	2.1

Group Triple P

In the focus groups conducted with Group Triple P participants, the parents discussed the different ways in which they had become aware of the programme. Parents heard about the programme from friends who had themselves taken part, from a flyer picked up at the PHN office or from crèches; one parent had attended the Matt Sanders public talk and as a result was inspired to participate. In questionnaires completed by participants in Group Triple P (n=521), the most common way that people heard about the Triple P Programme was through informal sources of support, i.e. friends, relatives, neighbours (29%) (*see Table A.9 in Appendix A.2*). In addition, almost 19% heard about the programme through childcare or pre-school, and 18% heard through Primary Care sources. However, 22% of parents completing the questionnaires found out about the programme through schools, an avenue of information not mentioned in focus groups.

In addition, according to the data collected in questionnaires, 14% of individuals heard about the programme through the Triple P Tippaper. In the June 2013 focus group with parents, special consideration was given to the Tippaper. The Tippaper had been distributed by LWPP to all parents of children in Junior Infants, Senior Infants and 1st Class, as well as to parents of children in many crèches in the area. First, parents were asked if they were aware of the Tippaper. Before copies of the Tippaper were produced, only one parent recognised

it by name. When copies were then distributed, 4 of the 7 parents stated that they had come across it before, both through school and crèche. The Tippaper was also accessed online by one of the 4 parents above. Those who had come across the Tippaper reported that it was something they read, although in one case a mother reported that she rather than her husband would read it. The Tippaper was also well regarded as a source of parenting tips as well as parents' stories that they could relate to and identify with. One parent noted that, as her child did not attend crèche and was too young for school, for that reason she had not come across the Tippaper.

Workshop Triple P

In the 2 focus groups with Workshop participants, parents spoke about how they first became aware of the programme. In these focus groups, parents were prompted to say what they thought of the media strategy. (They were not prompted in this way in the first 2 focus groups for Group Triple P participants.) One consistent finding from all who commented on the issue in the 2 focus groups was that the 'Stay Positive!' posters used in advertising the programme were not popular with parents. The series of posters each show a picture of a child whose expression suggests that he/she is upset and/or engaged in challenging behaviour, and the caption encourages the parent with the words 'Stay positive'. However, participating parents said they were not aware that the caption was intended for the parent, as opposed to the child, and that this was confusing since in many cases the gender of the child did not match the gender of the person addressed by the caption. (For example, a picture of a boy would have the following caption: 'Stay positive, Isabel'.) Parents also found the poster 'negative' in terms of the situation or behaviour presented.

Parents also did not recognise the name of the 'Level' they had attended. Participants in the Workshops did not know that this was 'Level 3' or that this was different from 'Seminars.' Nonetheless, parents showed a high level of awareness concerning the structure of the programme and in particular that there was an 8-session version of the programme available.

Data on how parents first heard about Workshop Triple P were also collected from the questionnaires completed by participants. In the first workshop ('Dealing with disobedience') (n=408), the most common way that people heard about the Triple P Programme was through teachers and school staff (34%), childcare or pre-school (26%), friends, relatives or neighbours (17%), and GPs or nurses (16%) (*see Table A.31 in Appendix A.3*).

The same pattern of results were observed in the second workshop ('Managing fighting and aggression') (n=122). The most common way that people heard about the Triple P Programme was through teachers and school staff (29%), childcare or pre-school (29%), friends, relatives or neighbours (28%), and GPs or nurses (17%) (*see Table A.33 in Appendix A.3*).

The pattern changed for the fourth workshop ('Developing good bedtime routines') (n=44). Parents were equally likely to have heard of the Triple P Programme from any of the following sources: friends, relatives or neighbours (26%), teachers and school staff (26%), GPs or nurses (26%), and childcare or pre-school (26%) (*see Table A.35 in Appendix A.3*).

Triple P Seminars

In data collected from questionnaires (n=1,867), the most common way that people heard about the seminars was through schools (30%, 48%, 66% in the 3 seminars). From May 2011, the seminars were run primarily through schools and this would have been the main source of information for the vast majority of the seminars. The second most common source of information on the seminars was informal support networks such as friends, relatives or neighbours, with 15%, 18%, and 26% respectively of participants in the 3 seminars finding out about the programme in this manner.

Very few participants heard about Triple P Seminars through Primary Care sources (including GPs and PHNs) and it should be noted the programme was not advertised through any of these sources. In addition, specific Triple P modes of communication, such as the website and the Triple P paper (Tippaper), were identified infrequently as sources of information for the seminars. One exception was that 15% of participants from Seminar 3 ('Raising resilient children') found out about the seminar through the Tippaper. However, it is important to bear in mind that Seminar 3 had a small pool of participants in comparison to the other two seminars.

Reasons why parents chose to attend Triple P

Parents attending the Group Triple P focus groups also discussed their reasons for attending Triple P. A number of participants felt they ***'didn't have any issues really'***, but yet that they would *'do courses for a lot less'*, such as golfing, driving or work-related training. As the profile of participants in Group Triple P shows, many parents scored their children in the 'normal' range for behavioural and emotional problems and also many parents scored themselves highly for parenting opinions, experiences and strategies (*see Section 4.2.1*). Others mentioned the need for education and skills as parents and hoped the Triple P Programme would provide this. Parents mentioned that there were not many other parenting courses available. Some chose the programme because of a change in their family's circumstances, including redundancy and bereavement.

In contrast, some parents began the programme due to specific concerns or worries about their ***'children's behaviour'*** and again this is reflected in the data on the profile of participants (*see Section 4.2.1*). One parent thought that her child was autistic, *'but it turns out he's not; he just had violent tantrums and he was very, very difficult, but that was him then, not anymore'*. Another parent's child was diagnosed with autism and she was *'looking for a rescue plan'*; she felt Triple P helped her deal with that. Other parents were having difficulty with discipline and conflict, eating and meal times, and hyperactivity.

Participants in focus groups for parents who had attended the Workshops were also asked about their initial reasons for choosing the programme. The reasons parents chose to attend the Workshops varied, but were similar to those motivating participants in the Groups. One Workshop participant spoke about *'not enjoying parenting and I knew I should; everyone is saying it's fun'* and this was because she felt her children were *'getting bolder'* while she was becoming ***'more tired and more angry'***. Others spoke of wanting to regain some *'control'*, of having to deal with *'cheekiness and tantrums'* and the *'terrible twos'*.

The same topic was covered in one-to-one interviews with Seminar participants. 'Raising confident competent children' was one of the topics covered in the seminars. Parents who attended this seminar and who were interviewed as part of this evaluation spoke of the importance of ***'self-esteem'*** for their children. One parent noted the reason she attended was because her youngest child was *'feeling frustrated'* at school and was *'low in confidence'* in school, while another parent referred to the problems of *'low confidence in new situations'* and yet another spoke of *'the importance of self-esteem for kids'*. One parent said she and her husband had been in denial about needing help and that attendance at the Triple P Seminar encouraged them to *'let down their guard'* and to accept that *'support was needed'*.

KEY FINDINGS

Sample size

- Qualitative: Parents in focus groups (n=33) and in one-to-one interviews (n=5).
- Quantitative: Participants in Seminars (n=1,867); Workshops: Dealing with disobedience (n=408), Managing fighting and aggression (n=122), Developing good bedtime routines (n=44); and Group Triple P (n=521).

How did parents hear about the programme?

- In focus groups, the most common way that people heard about the Triple P Programme was through schools, friends and relatives, followed by contacts in pre-school and primary care.
- Name recognition for the Triple P newspaper, the Tippaper, was low, although parents did recognise copies of it and reported positively on its content.
- Many parents had a negative view of the 'Stay Positive!' recruitment posters.
- Group: Parents heard about the programme through friends, relatives or neighbours (29%), schools (22%), childcare or pre-school (19%), primary care sources (18%) and the Tippaper (14%).
- Workshop 1: Parents heard about the programme through teachers (34%), childcare or pre-school (26%), friends, relatives or neighbours (17%) and primary care (16%).
- Workshop 2: Parents heard about the programme through teachers and school staff (29%), childcare or pre-school (29%), friends, relatives or neighbours (28%) and primary care (17%).
- Workshop 4: Parents heard about the programme through teachers and school staff (26%), friends, relatives or neighbours (26%), childcare or pre-school settings (26%) and primary care (GPs or nurses) (26%).
- Seminars: Parents heard about the programme through schools (30%, 48% and 66% in the 3 seminars), and through pre-school and informal sources of support such as friends, relatives or neighbours (15%, 18% and 26% in the 3 seminars).

Reasons why parents chose to attend Triple P?

- In focus groups, parents reported selecting Triple P for a variety of reasons, including a general desire for education, recent changes in family life, perceived child behaviour or emotional problems, and the child's self-esteem.

7.2.3.2 What role did practitioners play in the recruitment of parents?

Three focus groups were held with practitioners (*see Table 7.4*). The first focus group in May 2011 was attended by 7 practitioners (5 from Panel 1 and 2 from Panel 2). A second focus group was held with 10 Public Health Nurses (PHNs) in February 2013 (all Panel 2 practitioners) and a final focus group was held with 4 Panel 1 practitioners in March 2013.

Table 7.4: Profile of participants in practitioner focus groups

	May 2011 n=7 Panel 1, n=5 Panel 2, n=2	February 2013 n=10 Panel 2, n=10 [PHNs]	March 2013 n=4 Panel 1, n=4
Number of Seminars delivered	M = 4.3	M = 0.5	M = 21
(Mean and Range)	Range = 0-10	Range = 0-5	Range = 0-30
Number of parents seen in Level 3 Primary Care	--	M = 7.1	M = 2.75
(Mean and Range)		Range = 0-30	Range = 0-6
Number of Workshops delivered	M = 47	--	M = 29.5
(Mean and Range)	Range = 0-150		Range = 1-40
Number of Groups delivered	M = 9.6	M = 2	M = 20.5
(Mean and Range)	Range = 1-20	Range = 0-9	Range = 0-40
Supervise other practitioners using Triple P	Yes, n=5	Yes, n=1	Yes, n=3
	No, n=2	No, n=9	No, n=1
Percentage of time spent using Triple P	M = 71%	M = 15%	M = 100%
	Range = 10%-100%	Range = 2%-20%	Range = 100%-100%
Received Triple P supervision peer support in previous 3 months	Yes, n=7	--	Yes, n=3
	--	No, n=8	No, n=1

The recruitment of parents as participants in the programme was not listed explicitly as one of the responsibilities of the Panel 1 practitioners in the operational model for LWPP (*see Section 3.1*). However, recruitment was covered in the Triple P training for practitioners and is covered in the programme manuals. Panel 1 practitioners were expected to contribute to the promotion of Triple P throughout Longford Westmeath; according to the LWPP Grant Proposal (p. 74), Panel 1 practitioners were to do so 'through the delivery of presentations and other actions as per the agreed communications strategy'. In addition, the responsibilities of Panel 1 practitioners included many tasks related to the coordination of delivery, such as taking referrals from other professionals, booking venues and advertising sessions, all of which overlap with the role of recruiting parents.

One of the most significant challenges in recruiting parents, according to one member of the Project Management Team, was *'the de-stigmatisation of parenting programmes, getting parents to actually say … "It's for every parent" '*. This challenge was addressed through the media strategy in general, and perhaps most important of all in terms of this objective was the Tippaper. Initially, parents were reluctant to let their stories be used in the paper, but this was the case only with the first edition. From that point on, parents who have taken part in Triple P have been willing also to engage with the paper and, according to the Project Management Team, this may be because they see that parenting issues are dealt with *'positively'*.

Panel 1 practitioners also contributed to the Tippaper. They spoke about their own experiences of delivering the programme and the benefits for parents and children they have observed. This was part of their role in promoting Triple P.

Panel 1 practitioners also gave their views on the recruitment process. In the first focus group with Panel 1 and Panel 2 practitioners, some reported that the recruitment methods used in the past had not always been successful: *'You can put a lot of work into promoting a workshop and three people turn up.'* The most effective methods to raise awareness, according to Panel 1 practitioners, were parent-to-parent word-of-mouth, along with professional referrals. There were also perceived problems with the initial public awareness strategy, specifically with the 'Stay Positive!' posters: *'A lot of people just did not get the message.'* The same judgement about the posters was reported in the focus group with PHNs (although not in the final focus group with only Panel 1 practitioners as participants). As already discussed (*see Section 7.2.3*), participating parents expressed a similar view.

In the first focus group with Panel 1 and Panel 2 practitioners in May 2011, participants also gave their views on the preferred recruitment process. Many participants did not believe in the approach of first setting up groups and then trying to recruit parents, which was the established practice at that point. Instead, the practitioners would prefer to ask PHNs in particular to provide referrals first and for Panel 1 practitioners to set up programmes in response to the demand. In this way, the recruitment of parents would be *'more structured … as opposed to us going round, you know, not even knowing the area that we're in maybe'*. Since then, a focus group was held with PHNs from the Panel 2 of practitioners in February 2013. The PHNs in this focus group reported that they were happy to refer parents to Triple P courses and that they were now doing that.

In the first focus group with Panel 1 and Panel 2 practitioners in May 2011, the practitioners were, in general, critical of the initial decision to give PHNs a significant role in the delivery of Triple P: *'I think if they had initially looked at who has the time, resources and the ability and the interest to deliver Triple P, I think it might have been different.'*

It was also reported that practitioners themselves did not have the influence needed to recruit parents through contacts with PHNs, schools, crèches and other organisations. Instead, managerial support in those institutions was needed: *'I think it does have to come from a higher level.'* Greater support was also required from the partner organisations within LWPP: *'If it was coming from the partners, and there was a certain sense of once a month they had a group, that it made it their business to be, you know, delivering something.'* Nonetheless, both the Director of PHN and the Project Director for LWPP have reported that there was managerial support for the role that PHNs were to play in the implementation of Triple P and that the problems experienced in engaging PHNs was not due to lack of managerial support within the discipline.

The practitioners also had an opportunity to reflect on what had been learned about recruitment over the 2 years of the evaluation. One participant in the focus group for Panel 1 practitioners in 2013 spoke about being *'flabbergasted'* that parents still had never heard of the programme and of the *'constant battle'* in certain areas to raise awareness of and interest in the programme. Practitioners also noted that they had not been as successful as earlier hoped in the recruitment of parents with low levels of education and poor social skills. It was important to get the right contact person, namely the professionals working directly with the parents. However, the Panel 1 practitioners were also confident that they had learned a great deal about how best to recruit parents. One important issue was when to run the programme. Because of the pressures and routines of family life, the programme should only be scheduled between Tuesday and Thursday, and either in the mid-morning or the early evening. Also, different times of year suited different Levels of the programme: the provision of Seminars in schools in May-June and September-October, not running Groups at Easter or during Summer or Christmas, and running Workshops in the Summer.

KEY FINDINGS: How were parents recruited?

Sample size

- Participants in focus groups (n=21).

Recruitment of parents

- Panel 1 practitioners suggested parents should be recruited by other service providers (e.g. PHNs).
- Practitioners believed the Tippaper was more successful for those parents who had already attended the programme.
- Practitioners did not believe the 'Stay Positive!' posters were effective.
- Panel 1 practitioners believed that a lot had been learned about how better scheduling of the programme could improve recruitment of parents.

7.2.4 What progress was made towards achieving targets in delivering the programme to parents?

Level 1: Media strategy

As part of Triple P Level 1, an extensive media strategy was conducted in the Longford and Westmeath area. Articles were published in local newspapers, along with an extended article in a national newspaper. In total, 36 articles were published in 4 local newspapers. In addition, 14 notices advertising scheduled delivery of Triple P were published in local newspapers. Triple P material was shown on television screens in Credit Unions and programme information was also carried in community and local newssheets and newsletters.

Many of the articles published in local media were part of the 'Stay Positive!' media strategy. The articles had a number of related purposes: to raise awareness about parenting issues; to raise awareness about the Triple P approach to parenting; and to de-stigmatise parenting programmes. The headlines below, taken from a selection of articles published in local newspapers, illustrate this range of purpose:

'Five simple tips to parenting'
'The best ways of telling kids what to do'
'How much TV does your child watch?'
'Are boys harder to raise than girls?'
'Discipline is not a dirty word'
'How parents can deal with rudeness and disrespect'
'How to avoid that meal-time madness'
'Dealing with the night-time terrors'
'Dealing with those fearful feelings'
'Dealing with interruptions from your child'
'Dealing with disobedience'
'How to get out the door on time'
'How to avoid parenting traps'

In addition to the media strategy, 5 issues of the Tippaper were published over 2 years and 4 months. The paper carried stories from and about parents who had taken part in the Triple P Programme, together with positive parenting messages, information and parenting tips. The paper was circulated in a targeted and planned approach, including through children's schools, with support received from schools for this purpose.

A website for the Triple P Programme was also launched and maintained by LWPP. Visits to the website peaked in June and September 2011 (*see Figure 7.2*). The percentage of new visitors peaked in May-June 2011 (50%-51%), August-September 2011 (47%-48%), May 2012 (59%) and September-December 2012 (65%, 63%, 53.5%, 65%) (*see Figure 7.1*). However, these high numbers of new visitors occurred at the same time as high bounce rates (i.e. the percentage of visitors who move on to another website straight away). In December 2011, the number of pages visited (25) and the time spent on the website (18 minutes) were also at their highest (*see Figure 7.1*).

Figure 7.1: Website usage: Average time, bounce rate, number of pages, percentage new visits

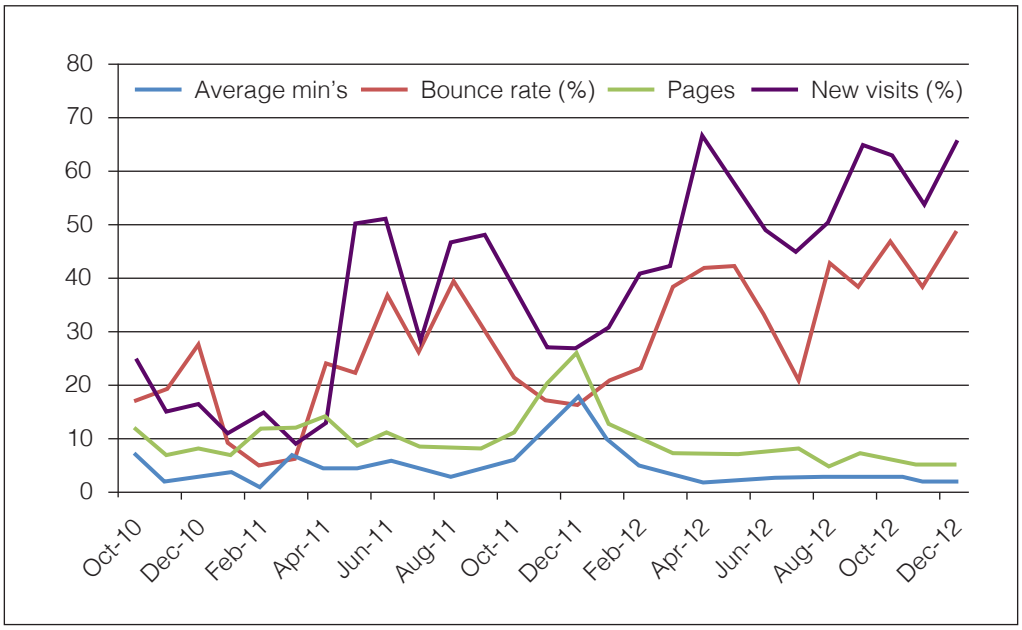
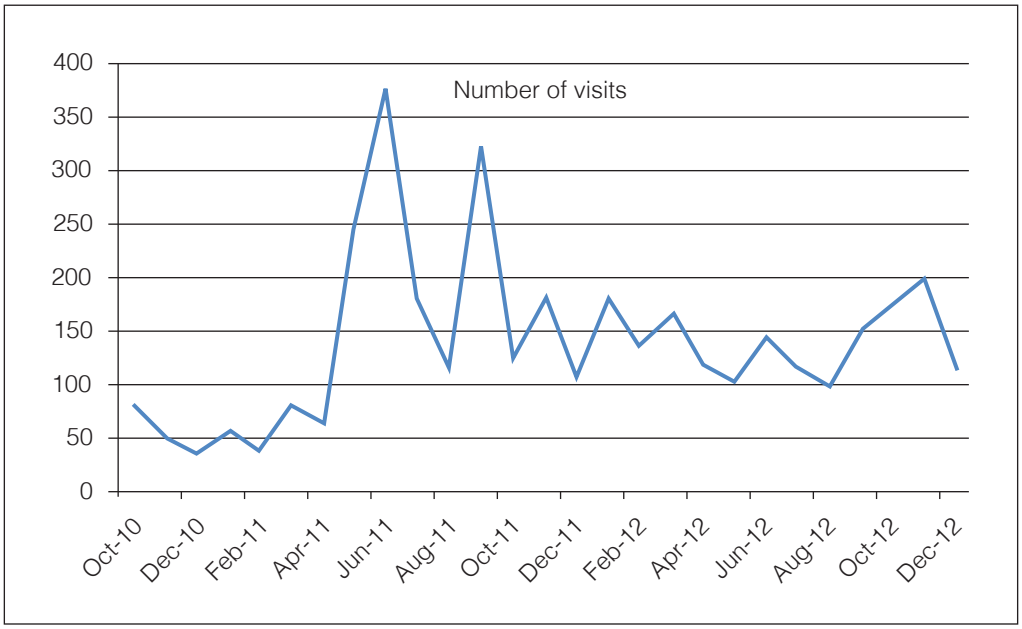


Figure 7.2: Website usage: Number of visits



Delivery of Levels 2 Seminars, Level 3 Workshop/Primary Care, Level 4 Group

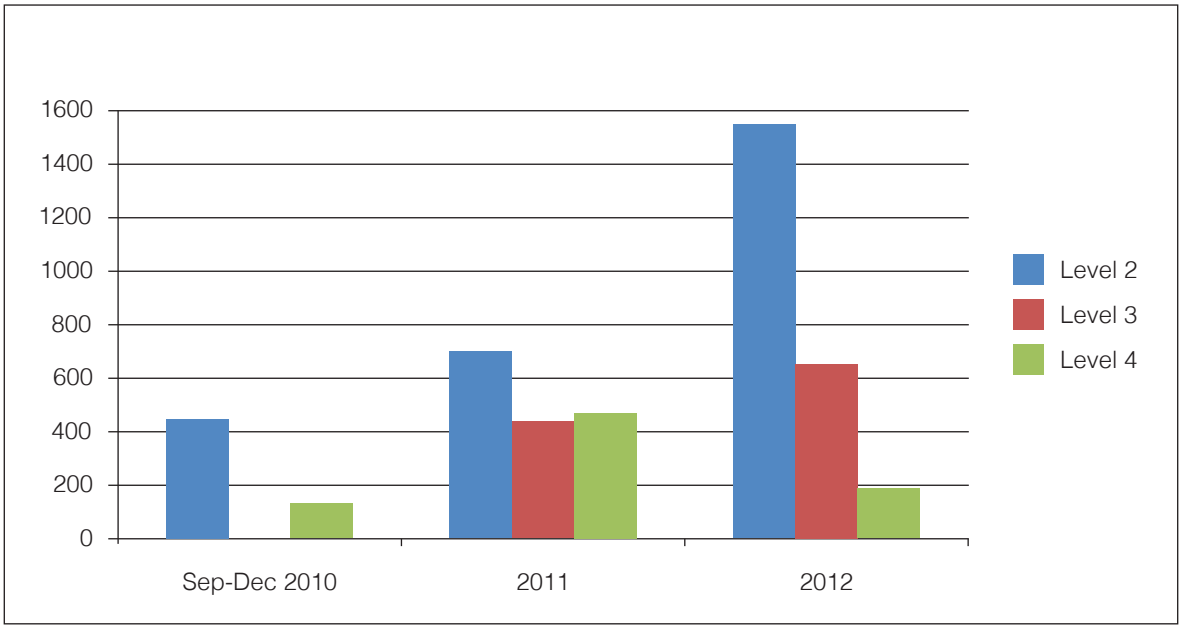
The number of participants in Triple P over the period of the evaluation is presented in Table 7.5. Data are presented on the number of participants at each programme level (*see Appendix D.1 for the calculation of delivery figures*). While the target for Group Triple P was met, targets were not met for Level 2, Level 3 or Level 5. Figure 7.3 shows that the delivery of the programme at the different levels varied between the 4 months at the end of 2010, 2011 and 2012. While at the end of 2010 and throughout 2011, there were a greater number of participants in Level 4 than in Level 3, in 2012 the number of participants in Level 4 was lower than in either Level 2 or Level 3.

Table 7.5: Programme delivery for Year 1 and Year 2

Triple P Level	No. of participants attending		
	Sept 2010 – Dec 2011 delivery (16 months)	2012 delivery (12 months)	Sept 2010 – Dec 2012 delivery (28 months)
Level 2: Seminars	1,149	1,550	2,699
Level 3: Workshop/Primary Care	443	657	1,100
Level 4: Group	611	192	803
Level 5: Enhanced and Pathways	0	0	0
Total	**2,203**	**2,399**	**4,602**

Where workshops were delivered to crèche workers who did not report that they were parents of children in the relevant age group (n=135), these were not included in the calculations of numbers attending.

Figure 7.3: Delivery of each programme Level in 2010 (Sept-Dec), 2011 and 2012



Note: Level 3 2011 includes Workshop (n=390) and Primary Care (n=53).

Level 4: Group Triple P

Group Triple P was delivered to 803 parents over the evaluation period. Of the total number of participants, 720 gave their consent to take part in the evaluation of Triple P, but 189 did not have a child in the target age range for the programme (36-95 months). Of the 531 study participants, 393 completed both the pre-intervention and post-intervention questionnaires (*see Section 4.2*), representing a response rate of 74%. Finally, 691 participants completed the programme, i.e. the number who attended the first 4 face-to-face group sessions (*see Section 7.3.9*).

As there were 7,317 families in Longford and Westmeath with children aged 3-7 (*see Table 4.1*), after removing the 189 parents who did not have a child in the target age range for the programme (36-95 months), this component of the programme was received by 8% of the target population (n=614).

When asked if they had attended some other Triple P component, participants in Group Triple P were most likely to have attended a seminar (27%, n=139), while a small minority had attended some 'other' Triple P event (7%, n=35) or Primary Care Triple P (1%, n=7).

Level 2: Triple P Seminars

The target for Level 2 was to deliver the programme to 4,777 parents over the 2 years. The data on the delivery of Level 2 Seminars show that 2,699 parents participated (*see Table 7.5*). Data available on Level 2 Seminars from September 2010 to December 2012 show that in total 194 seminar groups were held. The number attending Seminar 1 was 1,303; the number attending Seminar 2 was 1,283; and the number attending Seminar 3 was 113. From the total number of participants, the numbers who agreed to participate in the evaluation of Triple P was 1,981: 1,086 in Seminar 1; 677 in Seminar 2; and 121 in Seminar 3. It is possible to calculate that parents took up 2,699 places in the programme. As details of each participant were not recorded, it was not possible to calculate the total number of unique participants at Level 2.

When asked if they had attended some other Triple P Seminar, participants in Triple P Seminars were most likely to have attended Seminar 1 (n=456, 23%), while a small minority had attended Seminar 2 (n=183, 9%) or Seminar 3 (n=111, 6%).

Level 3: Workshop Triple P

In total, 796 gave their consent to participate in the evaluation of Triple P and of this figure 562 had a child in the target age range for the programme (36-95 months). The response rate, measured as a percentage of those who consented to participate and had a child in the target age range and who completed both questionnaires, was 47% for the 'Dealing with disobedience' workshop, 52% for the 'Managing fighting and aggression' workshop and 57% for the 'Developing good bedtime routines' workshop.

Some of the workshops were delivered as part of continuing professional development, in particular, but not exclusively to crèche workers (n=233). The data from these workshops are included in the calculations above, except for those participants who did not report having children of their own. A number of other participants took part in lunchtime workshops run at the parents' place of work (n=88).

A further 53 parents took part in the Primary Care version of Level 3 between January 2011 and August 2011. Primary Care delivery ran from January to August 2011 and the workshops were begun in May 2011.

The target for Level 3 was to deliver the programme to 2,628 parents over the 2 years. The data on the delivery of Level 3 Primary Care and Workshops show that 1,100 parents participated. They took part in 4 workshops as well as Primary Care (*see Table 7.6*). As there were 7,317 families in Longford and Westmeath with children aged 3-7 (*see Table 4.1*), after removing the 234 parents who did not have a child in the target age range for the programme (36-95 months), this component of the programme was received by 12% of the target population (n=876).

Table 7.6: Level 3 delivery 2011 and 2012

Workshop	2011	2012	Total
Dealing with disobedience	252	474	726
Good bedtime routines	63	46	109
Hassle free shopping	7	3	10
Managing fighting and aggression	68	113	181
No workshop identified		21	21
Total	**390**	**657**	**1,047**
Primary Care	53	–	53
Level 3 Total			**1,100**

When asked if they had attended some other Triple P component, participants in Workshop Triple P were most likely to have attended a seminar (n=124, 21%), while a small minority had attended some 'other' Triple P event (n=69, 12%) or Primary Care Triple P (n=19, 3%).

KEY FINDINGS: What progress was made towards achieving targets in delivering the programme to parents?

- Level 1 (Media) delivery included the publication of newspaper articles, the circulation of a free Triple P paper (the Tippaper) and the maintenance of a website.
- Level 2 Seminars were delivered to 2,699 parents (below the target of 4,777).
- Level 3 was delivered to 1,100 parents (below the target of 2,628).
- Level 4 was delivered to 803 parents (above the target of 717).
- In Year 2, delivery of Level 2 increased significantly, while delivery of Level 4 decreased.

7.2.5 What was learned about programme delivery and what changes were made?

This section explores what was learned about programme delivery by the Project Management Team and what changes were made. It outlines the key decisions taken by LWPP in the delivery of Triple P and the rationale for those decisions. The impact of these key decisions for the delivery of Triple P is then explored with reference to data on programme delivery over the evaluation period, which is presented in Figure 7.4.

Level 2: Triple P Seminars

Total number of places taken up by parents: n=2,699

The strategy in relation to the delivery of Level 2 Seminars was revised in March 2012. The minutes of a team meeting record that the new strategy was to run seminars in schools for parents attending Induction Day for children about to enter Junior Infants (May-June) and at the start of the school year for children in Junior Infants, Senior Infants, First Class and Second Class (September-October). The former were offered Seminar 1 on 'Power of positive parenting – Preparing your child for school', while the latter were offered Seminar 2 on 'Raising confident competent children'. In interviews for this evaluation, members of the Project Management Team explained that, without changing programme content, the illustrative examples employed were all related to school. The Project Management Team also emphasised the effort required to build up trust with schools before it was agreed to include these seminars as part of the induction meeting.

The rationale for the decision to run seminars in schools for parents attending Induction Day was two-fold, according to the Project Management Team. First, the revised strategy promised to attract a larger number of participants as the delivery of seminars was to be linked with schools, both the pre-summer Induction Day and the start of the school year in September. Second, the Project Management Team had become aware of new findings showing the effectiveness of Level 2 Seminars. In interviews for this evaluation, members of the Project Management Team indicated that while originally the seminars were seen primarily as an awareness-raising mechanism, subsequently they were recognised as having the potential to bring about improvements for parents and children. Finally, the Project Management Team believed that the seminars would still play a role in recruiting parents to other Triple P Levels and they expected to see increases in the number of participants in other components of the programme following the Seminars.

Figure 7.4 illustrates how the change in strategy affected delivery of Level 2 Seminars. Although there were large numbers attending Level 2 Seminars in March 2012, there were dramatic increases in Level 2 participation in May-June and September-October 2012, when Level 2 was run in conjunction with schools.

The large numbers attending in September 2010 and June 2011 can be explained by the two seminars delivered by Professor Matt Sanders. During the periods of May-June and September-October 2012, the numbers attending other levels of Triple P declined. This was to be expected, in part because of the resources dedicated to the delivery of Level 2 during these periods (Project Management Team). Also, numbers attending Level 3 increased in the months after the school-linked seminars and this may be explained in part by the success of the school-linked seminars as a recruitment strategy for other levels of the programme (Project Management Team). At the seminars, an undertaking was given to promptly telephone parents who requested more information and to book them into courses where requested. However, other factors can be identified as affecting delivery rates of Level 3 and Level 4 (*see below*).

Level 3: Workshop Triple P and Primary Care

Total number of parents participating: n=1,100

The original strategy for Level 3 was to deliver Level 3 Primary Care and one approach chosen was to do so within GP practices (Strand 2). Panel 1 practitioners were to co-deliver the one-to-one sessions to parents presenting with specific parenting difficulties and who were referred by the GP. However, due to the large numbers who did not show up for the booked sessions, by the end of 2010 it was decided that this was not an efficient use of Panel 1 practitioners' time (Project Management Team).

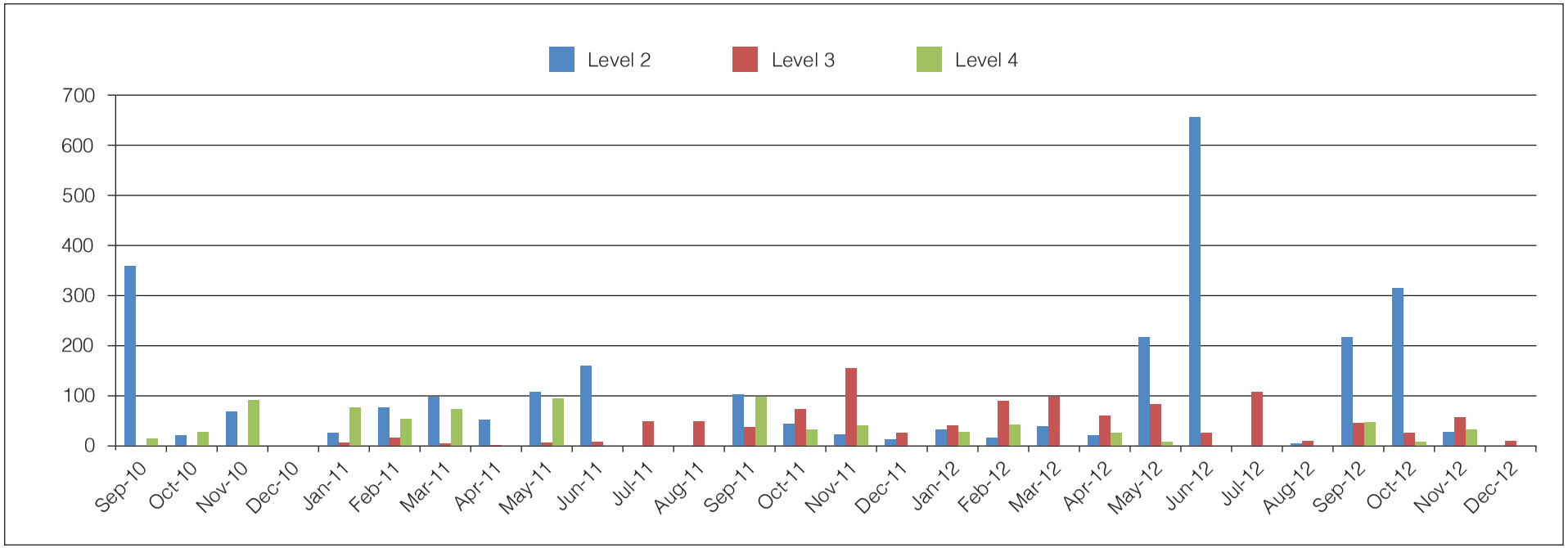
The other approach chosen for Level 3 Primary Care was for Public Health Nurses (PHNs) to play a substantial role in delivery (Strand 1). With that in mind, LWPP were committed to training 40 PHNs as Triple P practitioners. According to Murphy and Owens (2010):

> *'The accreditation of all Longford Westmeath PHNs in Triple P [had been facilitated by late 2010, because] their role in the national child health surveillance and screening programme and their base with communities means that they are ideally placed to identify and offer interventions to families of young children experiencing difficulties or who want to learn how to prevent some problems from arising.'*

However, the delivery of Level 3 Primary Care by PHNs was lower than targeted and for that reason, in May 2011, a revised strategy was decided upon, namely to implement a Workshop version of Level 3. While Primary Care Level 3 was delivered on a one-to-one basis with parents over 4 sessions, Workshops were once-off small group discussions, each lasting 2 hours. The LWPP minutes show that, by October 2011, the key delivery priority for the partners were the Workshops in an effort to ensure the target number for Level 3 would be met. It is important to note that the 'workshops' had only just become available (i.e. they were not an option previously).

Nonetheless, by the end of Year 1 (December 2011), as the Project Management Team emphasised, the PHNs continued to play a role in the following ways: they recruited parents into Triple P; the PHN Department included the Triple P clinics in their work timetables; recommendations for attendance at Triple P had been inserted into the PHN clinic letters sent to parents; and PHNs were giving out flyers for and talking about Triple P with parents. According to a member of the Project Management Team, *'What it has evolved into is extremely useful for the branding and delivery of Triple P, just in a different way to what we initially envisaged'*. It was also suggested that resource commitment is an issue for all organisations and this is *'a fluid and changing situation'*. It was noted that *'overall commitments from the HSE have actually been in excess of what was originally signed up to by them'*.

Figure 7.4: 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

During 2012, one significant development was the establishment of Child Health Teams within Public Health Nursing, i.e. PHNs with a higher child health caseload. This was an innovation within the PHN Department and therefore it occurred independently of LWPP. However, it was decided by the partners to make the most of this development and that priority should be given to the engagement with PHNs in Child Health Teams in three urban areas (interview with Director of PHN). As PHNs in Child Health Teams have children as their core client group, the partners believed that the Triple P Programme would be of more interest to this group of PHNs and that this group would be more likely to deliver the programme and/or refer parents to it.

A further development in the delivery of Level 3 was to target crèche staff as workshop participants and the Triple P Workshops were developed as part of the continuing professional development of crèche staff. The rationale for this decision was threefold: many crèche staff would be mothers, the importance of the wider environment for children (as children spend time in crèches) and crèche staff could promote the programme to parents.

Another development was to run the Triple P Workshops in the workplace, organised in 2 separate 1-hour sessions at lunchtime.

Figure 7.4 shows the delivery of Level 3, including data on Primary Care and Workshops. The increase in numbers attending Level 3 in July 2011 is explained by the rolling out of the Workshops at this time and the number of participants increased dramatically to a high point in November 2011. As the workshops are once-off events, they do not require a commitment from parents over a number of weeks. For that reason, the scheduling of workshops was not greatly affected by seasonal factors such as summer, Easter, and Christmas holidays, when many parents will not have availability for long-term commitments. Nonetheless, Figure 7.4 shows peaks and troughs in the delivery of Level 3. This may be explained by resource restrictions, in particular when the Panel 1 practitioners were delivering Level 2 Seminars during the months of June and October 2012.

Level 4: Group Triple P

Total number of parents participating: n=803

In the final 4 months of 2010, LWPP were delivering Seminars, the Primary Care version of Level 3, and Level 4 Group Triple P. When LWPP began to deliver Triple P in late 2010, the priority was given to Level 4 Groups. In interviews for this evaluation, members of the Project Management Team explained their rationale as follows. They believed that practitioners required experience in delivering Level 4, which is the most demanding component of Triple P, before they could have the experience and skills needed to deliver Level 2 Seminars and Level 3 Primary Care/Workshops. The Project Management Team offered two explanations for why the numbers attending Level 4 in 2012 were lower than in 2011. The first was that, as the programme component is intended for a minority of parents with more significant needs, the longer Group Triple P is available, the smaller the pool of parents it is drawing from. Therefore, there would have been fewer parents selecting Group Triple P in 2012. The second explanation relates to the idea of minimal sufficiency and a population approach. While Triple P is a universal programme, and therefore intended for all families, nonetheless Level 4 is intended for a higher level of need than Levels 2 or 3. Therefore, it was correct to offer Group Triple P to fewer and fewer parents over time since it was important that greater priority be given to the larger population of parents with lower levels of need who are targeted with Levels 2 and 3.

As Figure 7.4 shows, there was considerable success in delivering Level 4 at the end of 2010 and right throughout 2011. Because the programme is run over 8 consecutive weeks, it could not be planned when parents are more likely to be unavailable and therefore programmes were timed to finish just prior to Christmas and Easter (April) and were not run across the summer months.

The Project Management Team found that while there was a very good retention of participants among those who attended the first session (*see Section 7.3.9*), many parents who booked a place on the programme failed to turn up to that first session. In the original strategy, Groups were scheduled to run once 10 parents were booked to attend. However, with some parents failing to attend the first session, many Groups were run without the full complement of participants. This was not an efficient use of practitioners' resources and also the smaller Groups were considered less effective for parents. In March 2012, it was decided that each Group must have 15 parents booked in before it would be run. The Project Management Team believed that while this would reduce the number of Groups run, it would not necessarily reduce the number of parents participating.

Originally, contact with parents in Group Triple P ended in Week 8, when parents completed the post-programme questionnaire. In late 2010, it was decided to contact parents after Week 8 to provide feedback on changes between pre- and post-programme questionnaires. This was an optional element of Triple P that LWPP elected to use. The Project Management Team reported that parents respond well to the follow-up telephone call and also it allows the Facilitator to follow up with any outstanding issues or questions.

Level 5: Enhanced and Pathways

It was decided by LWPP not to proceed with Level 5: Enhanced and Pathways components of the Triple P Programme. The delivery of this level requires collaboration with Social Work departments in the HSE and this process has yet to result in programme delivery.

KEY FINDINGS: What was learned about programme delivery and what was changed?

- In Year 2 (2012), a decision was made to offer Triple P Seminars to parents in primary schools. While originally the seminars were seen primarily as an awareness-raising mechanism, subsequently they were recognised as having the potential to bring about improvements for parents and children.
- Three iterations of Level 3 were implemented: Primary Care delivered in GP surgeries, Primary Care delivered by PHNs, and Workshops. Workshops were delivered to a greater number of parents than Primary Care and (unlike Level 4) delivery of Workshops was not restricted by seasonal factors.
- The Project Management Team gave the following reasons to explain why Level 4 delivery was greatest in Year 1: it was necessary to give practitioners experience first in delivering the most demanding programme level; the pool of families with higher levels of need suited for Level 4 would have declined after Year 1; and it was necessary in Year 2 to prioritise the larger pool of families with lower levels of need suited to Levels 2 and 3.
- Delivery of Level 4 was also restricted by seasonal factors (because Level 4 Groups lasted 8 weeks, they were not scheduled for periods when family holidays were likely, i.e. December, Easter and Summer).

7.2.6 What progress was made towards achieving targets in training practitioners and supporting programme delivery by practitioners?

This section explores the extent to which those who were trained as practitioners also delivered the programme. First, analyses of documentary data on programme delivery are presented to explore the profile of practitioners involved in programme delivery. Second, based on data collected from questionnaires completed by practitioners, the views of practitioners on their own level of involvement in programme delivery are presented.

7.2.6.1 Profile of practitioners trained to deliver Triple P and delivering Triple P

This sub-section presents data on the number of practitioners trained to deliver Triple P and on the total number of sessions delivered to parents by all Triple P practitioners.

Table 7.7 presents data on the number of practitioners trained and accredited to deliver different Levels of Triple P in the period 2010-2012. The table shows the significant progress made in training practitioners in Level 2 Seminars, Level 3 Primary Care and Level 3 Workshop, Level 4 Group and Level 5 Enhanced. The figures suggest that the LWPP was not experiencing difficulties pursuing its targets in training practitioners. The figures also provide an indication of the profile of practitioners at each level of the programme. While the majority of practitioners trained to deliver Group Triple P were from Panel 2, the majority of those trained to deliver Workshop Triple P and Triple P Seminars were from Panel 1 or the broader Core Team.

However, the figures do not provide precise information on the capacity of the LWPP to meet its targets in programme delivery. As an indeterminate number of those counted as being trained in one programme level were also trained in another programme level, the total number of trained practitioners is somewhat fewer than the total calculated by summing the numbers recorded as being trained in each level. While targets for programme delivery were set based on estimates of the number of parents that could receive the programme from a set number of trained practitioners, any estimate of capacity to deliver the programme must factor in whether the same practitioners were being expected to deliver more than one level.

Table 7.7: Practitioners trained between March 2010 and June 2011

Triple P Level	Numbers trained	Numbers accredited	Profile of practitioners (where information available)
Level 2: Seminars	12	12	PHN x 2 Panel 1 x 7 Other Core Team x 3
Level 3: Primary Care (standalone training)	42	35	PHNs x 35
Level 3: Workshops	14	14	PHN x 6 Panel 1 x 7 Other Core Team x 1
Level 4: Group and Primary Care (combined training)	38	35	PHN x 5 Other Panel 2 x 20 Panel 1 x 7 Other Core Team x 3
Level 5: Enhanced	21	21	
Level 5: Pathways	21	21	

Source: Triple P International *Training Outcome Report March 2010 to September 2011*.

Figures amended based on information from Project Management Team.

Files containing data on all instances of programme delivery from September 2010 to December 2012 were analysed. The aim was to explore the profile of practitioners delivering Triple P.

Table 7.8 includes the numbers who delivered Triple P from September 2010 to December 2012, as recorded in LWPP data files. There were 46 individual practitioners involved in the delivery of Triple P to parents. The figures show fewer delivering Triple P than were trained to do so at Level 3 Primary Care and Level 3 Workshop, while in contrast the figures show the large number of practitioners involved in delivery of Level 4 Groups. In addition, Panel 1 practitioners delivered the programme to a greater number of parents and also the average number of parents seen by Panel 1 practitioners was higher than for Panel 2 practitioners. The project plan for the implementation of Triple P required that each Panel 1 practitioner take on more responsibility for delivery than each Panel 2 practitioner, and this is borne out in the figures for the delivery

of the programme by practitioners. However, it was also planned that 60+ Panel 2 practitioners would be involved in programme delivery and this objective was not attained (*see Section 7.3.2*).

The majority of Level 4 Group Triple P were delivered by Panel 1 practitioners: 8 Panel 1 practitioners delivered or co-delivered to 1,160 parents (an average of 145 parents) and 33 Panel 2 practitioners delivered or co-delivered to 558 parents (an average of 17 parents). (Due to the 'pairing' of practitioners at many groups, the figures above are greater than the total parent figure recorded for participation in Level 4 Group.).[8]

The majority of Workshops were delivered by Panel 1 practitioners: 8 Panel 1 practitioners delivered or co-delivered to 1,817 parents (an average of 227 parents) and 3 Panel 2 practitioners delivered or co-delivered to 23 parents (an average of 8 parents).

Table 7.8: Delivery of Triple P by Panel 1 and Panel 2

	Panel 1		Panel 2	
	Practitioners	**Parents (mean)**	**Practitioners**	**Parents (mean)**
Level 4: Group	8	145	33	17
Level 3: Workshop	8	227	3	8
Level 3: Primary Care Strand 1	2	2	5	1
Level 3: Primary Care Strand 2	3	6	3	1
Practitioners	**Practitioners**	**Seminars (mean)**	**Practitioners**	**Seminars (mean)**
Level 2: Seminars	8	23	4	11

Note: Excluded are Prof. Matt Sanders and members of the Project Management Team (i.e. Project Director and Chair). As practitioners delivered many sessions in 'pairs', the totals in the above table are greater than the total number of sessions delivered to parents.

Level 3 Primary Care Strand 1: Data were available on Primary Care Strand 1 from February 2011 to August 2011. A total of 17 parents participated. Four of the one-to-one sessions were delivered by 2 Panel 1 practitioners and 5 Panel 2 practitioners delivered 7 of the sessions.

Level 3 Primary Care Strand 2: Data were available on Primary Care Strand 2 from January to August 2011. 33 parents participated. Three Panel 1 practitioners delivered 18 one-to-one sessions to parents and 3 Panel 2 practitioners delivered one session each to parents in the 8-month period.

The Triple P Seminars were delivered by practitioners from Panels 1 and 2. Eight Panel 1 practitioners delivered (or co-delivered) a total of 186 seminars, or 23 seminars each on average. Four Panel 2 practitioners delivered (or co-delivered) a total of 44 seminars, or 11 seminars each on average. These figures exclude the two seminars delivered by Professor Matt Sanders and 12 seminars delivered by members of the Project Management Team (Project Director and Chair).

7.2.6.2 What were practitioners' views of their own involvement in programme delivery?

Practitioners participated in two surveys as part of this evaluation. The T1 survey (November 2011) included 8 practitioners from Panel 1 and 13 from Panel 2. The T2 survey (November 2012) included 7 practitioners from Panel 1 and 6 Public Health Nurses from Panel 2. Data collected on their involvement in programme delivery are presented below. It should be noted that while programme delivery was a core professional responsibility for Panel 1 practitioners, this was not the case for Panel 2 practitioners. Also, while Panel 1 practitioners were expected to deliver all levels of the programme, again this was not the case for Panel 2

8. The Interim Report presented figures on the number of practitioners delivering Triple P from each HSE Department and each Statutory, Community, and Voluntary sector partner organisation and the number of parents that Triple P was delivered to by these practitioners. For the current document, the Final Report, no data were available on the breakdown of delivery by Panel 2 practitioners.

practitioners. The data show that, although programme delivery varied, Panel 1 practitioners delivered the different levels of the programme to more parents than Panel 2 practitioners.

Number of sessions delivered by practitioners

Many participants had not delivered any Level 2 Seminars (T1, 66%; T2, 77%) or Level 3 Primary Care/ Workshops (T1, 47%; T2, 69%), a minority had not delivered any Level 4 Groups at T1 (14%) and a majority had not delivered Level 4 at T2 (62%). At T1, the majority had some experience delivering Level 4 Groups: over half had delivered 1-9 groups (62%) and some had delivered 10-19 groups (19%). Those who had delivered 10-19 groups had also delivered the greatest number of Level 2 Seminars (10-20). Only one other participant had delivered Level 3 Workshops to more parents than any of these 4 practitioners. All 4 were Panel 1 practitioners.

At T2, the 8 participants who had not delivered any Level 4 Groups were PHNs from Panel 2, and of this group only 4 had delivered the Triple P Programme, and in all instances they delivered Level 3 Workshops. However, one further PHN participant noted that she used Triple P materials in one-to-one sessions with her clients. Findings from the focus group with PHNs suggest this may not have been an isolated incident since many participants reported using the materials in this way. The participants described how they used the Triple P Tip Sheets with their clients and that this was one source of information they provided, along with, for example, speech and language therapy material. This approach was described as *'opportunistic'*, as Triple P information and/or skills were introduced as part of routine developmental checks with young children. This type of engagement with parents would therefore fall outside the recognised approach for delivering Triple P Level 3.

Using data collected from the facilitator surveys, a 'total sessions' score was calculated based on the number of Triple P sessions the practitioners had delivered since they were trained. The total sessions score was calculated by summing the data for Level 2 Seminars, Level 3 Primary Care parents (delivered on a one-to-one basis), Level 3 Workshops and Level 4 Groups. The total sessions scores ranged from 0-115, with a median of 5.50. At T1 and T2, those from Panel 1 delivered more training sessions to parents than those from Panel 2. At T1, 7 Panel 1 practitioners delivered 6 training sessions or more (i.e. above the median), while only one delivered fewer than the median number. At T2, 6 Panel 1 practitioners delivered more than the median number and only one delivered fewer than the median number. In contrast, at T1 only one Panel 2 practitioner delivered more than the median number and at T2 most Panel 2 practitioners delivered fewer than the median number (n=4) and 3 delivered more than the median number of sessions.

Percentage of time spent using Triple P

Respondents were asked how many hours per month they spent in parent consultations (*see Table 7.9*). While practitioners from Panel 2 spent a small percentage of their time in parent consultations using Triple P (less than 50% at T1 and less than 10% at T2), all bar one facilitator from Panel 1 spent the majority of their time using Triple P (60% or more at T1 and 50% or more at T2).

Practitioners were also asked what percentage of time in parent consultations ideally they would spend using Triple P (*see Table 7.10*). At T1, the majority of Panel 2 practitioners wanted to spend more time using Triple P (n=7). At T2, Panel 2 practitioners either wanted to spend more time using Triple P (n=3) or were happy with the amount of time spent using Triple P (n=2). In contrast, only one Panel 1 facilitator reported wanting to spend more time using Triple P at T1, and only 2 did so at T2. It should be noted in interpreting these findings that the majority of Panel 1 practitioners used Triple P 90% or more of the time and therefore could not have increased the time spent using the programme.

Table 7.9: Percentage of parent consultation time spent using Triple P

Time 1			Time 1		
Percentage of time using Triple P	**Panel 1 (n)**	**Panel 2 (n)**	**Percentage of time using Triple P**	**Panel 1 (n)**	**Panel 2 (n)**
0.00	–	–	0.00	–	4
5.00	–	2	5.00	–	–
10.00	1	3	10.00	–	1
20.00	–	2	20.00	1	–
30.00	–	1	30.00	–	–
50.00	–	1	50.00	1	–
60.00	1	–	60.00	–	–
80.00	–	–	80.00	1	–
90.00	2	–	90.00	–	–
100.00	4	–	100.00	4	–
Total	**8**	**9**	**Total**	**7**	**5**

Table 7.10: Desired change in percentage of time using Triple P

Time 1			Time 1		
Desired change (%)	**Panel 1 (n)**	**Panel 2 (n)**	**Desired change (%)**	**Panel 1 (n)**	**Panel 2 (n)**
-50.00	-	-	-50.00	1	-
-40.00	–	–	-40.00	1	–
-30.00	1	–	-30.00	–	–
-20.00	–	–	-20.00	1	–
-10.00	1	–	-10.00	–	–
-5.00	–	–	-5.00	–	–
0.00	3	1	0.00	1	2
5.00	–	–	5.00	-	2
10.00	1	–	10.00	–	1
15.00	–	1	15.00	–	–
20.00	–	1	20.00	1	–
30.00	–	1	30.00	–	–
40.00	–	3	40.00	–	–
50.00	–	–	50.00	1	–
80.00	–	1	80.00	–	–
Total	**7**	**8**	**Total**	**6**	**5**

KEY FINDINGS: What progress was made towards achieving targets in training practitioners and supporting programme delivery?

- Data from surveys completed by practitioners (T1: n=21; T2: n=13) show that programme delivery varied and Panel 1 practitioners delivered the different levels of the programme to more parents than Panel 2 practitioners. However, only Panel 1 practitioners reported wanting to spend less time using Triple P.
- At each level, Panel 1 practitioners were responsible for the majority of programme delivery.
- Panel 2 practitioners were more likely to deliver Level 4 (n=33) and only small numbers delivered Level 3 (n=3) and Level 2 (n=4).

7.2.7 What was learned about training practitioners and supporting delivery

The Project Management Team's experience of the implementation process in Longford and Westmeath has led to considerable learning concerning training practitioners and supporting delivery. One initiative can be mentioned to illustrate this, although it was not implemented in the study counties during the study timeframe. The Project Management Team has introduced a new process for the selection of Panel 2 practitioners in Laois and Offaly. Practitioners will be interviewed before training is offered and a 'Person Specification' document has been drawn up for that purpose (*see Appendix C.3*). The key learning from the implementation of Triple P in Longford and Westmeath was that many of those trained as practitioners did not deliver. This was the case for a number of reasons, including that Triple P would not be considered relevant or central to their work, and that the professionals in question did not have sufficient experience of working with parents/families or did not have access to parents in their role or were not fully committed to deliver Triple P on a regular basis. In Laois and Offaly, to implement what had been learned, the partners will target those for whom the programme will be a better fit.

7.3 Research Question 2: How well was the programme organised and delivered and what was the extent to which the programme was implemented as planned (i.e. programme organisation and programme fidelity)?

7.3.1 How was Triple P selected and implemented?

The key stages in the creation of LWPP are described below and the implementation of the Triple P Programme. The future sustainability of the partnership and the delivery of the programme is also examined.

Why was the Triple P – Positive Parenting Programme selected?

Two members of the current Project Management Team were central to the initiatives taken to establish the Longford Westmeath Parenting Partnership (LWPP). The Project Management Team were asked why initially the Triple P Programme was selected for delivery by LWPP. At the outset, there was agreement among the prospective partners both that there was a *'demand for parenting programmes'* and that *'quite a bit of money had been invested in training people in various programmes'*, but that actual delivery did not reflect this investment. According to the Chair of LWPP, there was also growing interest in and awareness of both Triple P and the Incredible Years Programme among the partners, thanks largely to the efforts of the prospective Project Director. Shortly after this process had begun, the National Institute of Clinical Excellence also identified both Incredible Years and Triple P as evidence-based programmes.

As discussed in Section 3.4, Triple P adopts a public health or population approach. The *principle of programme 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. According to the Project Management Team, Triple P was chosen because it adopts a public health approach and for that reason it does not *'over-service'* a particular need. In contrast, it was argued, if the Incredible Years Programme was to be delivered across the whole population, the cost would have been *'exorbitant'* and it would have placed *'everyone in the same type of programme'*. In other words, there is a danger of an over-servicing of need in any approach that is not multi-level. In addition, Triple P is for *'every family … It was imperative that we wanted to get to children with behavioural problems and if we wanted to [improve] access to skills for all parents in that area then it had to be a general population approach'* (Project Management Team). A further perceived advantage of Triple P was that, as a multi-disciplinary programme,

practitioners could be drawn from a wide range of disciplines; in particular, it was noted, practitioners did not require training in psychology (Project Management Team).

How was funding secured for the partnership and programme delivery?

This sub-section explores the financial support provided for programme implementation and the reasons given for this initial support. The minutes of LWPP meetings record that by the end of 2009 the following funding had been secured for the 2 years of implementation (originally to be 2010 and 2011):

- The Atlantic Philanthropies: €799,000
- HSE: €120,000
- Aontacht Phobail Teoranta (APT): €120,000
- Department of Children and Youth Affairs/DCYA
  (then the Office of the Minister for Children and Youth Affairs/OMCYA): €250,000

The considerable support of the HSE for programme implementation included agreement to the re-orientation of HSE staff to LWPP roles. By December 2009, the HSE staffing commitments for Panel 1 and Panel 2 were agreed, and by January 2010 the LWPP were to move to new offices in Athlone.

The Atlantic Philanthropies agreed to fund LWPP for a number of reasons. According to its representative for this study, the partnership was in agreement with The Atlantic Philanthropies' objectives of prevention and early intervention and of evidence-based programmes. A further important consideration included the interest shown by the DCYA (then the OMCYA) in the partnership aspects of the LWPP and also that the HSE was prepared to *'buy in'* to the partnership and to back that up with *'significant'* resources.

Archways, due to its own experience in implementing the Incredible Years Programme, was to support the implementation of Triple P and specifically it was to provide technical support around *'basic project management'* and *'financial administration'* issues. An important aspect of the funding of the project is that The Atlantic Philanthropies was not to fund State institutions directly. For that reason, the grant was held with Archways rather than with the LWPP.

The HSE Local Area Manager also strongly supported the funding of LWPP by the HSE. The reason for this support was the conviction that the HSE on its own could not deliver the required services and achieve the desired outcomes for parents and children. Alternative models were needed and a partnership approach was preferred. The Local Area Manager believed that without partnership, the project of implementing the programme would have failed. Also, the partnership approach was a key consideration in agreeing to fund the project:

> *'Basically the rationale for giving it [funding] at the time, and for my continued support, is the realisation that resources were reducing in the community, that if we kept doing what we were doing, we simply wouldn't have enough resources. And we were looking at alternative models as to how we could deliver. And we identified the partnership approach with LWPP as the preferred way because we felt we could get additional capacity that the HSE alone couldn't do by itself.'* [HSE Local Area Manager]

KEY FINDINGS: How was the Triple P programme selected and implemented?

- The initial reason for choosing to implement the Triple P Programme was that, because it adopts a population approach and because of its multi-level structure, it would be a more efficient use of resources and practitioners could be attracted from a wide range of disciplines.

- The LWPP experienced success in attracting funding for the project, in particular from The Atlantic Philanthropies, the HSE and the Department of Children and Youth Affairs.
- The reasons given by funders for their initial support included its adoption of a partnership approach and its commitment to early intervention.

How will sustainability be ensured?

The Research Team spoke with representatives from The Atlantic Philanthropies and the HSE, both in 2011 and again in 2013, concerning the future sustainability of LWPP and the Triple P Programme.[9] Both participants were involved in initial decisions within their organisations to fund LWPP and therefore were considered key informants on the sustainability of LWPP.

When asked what would count as 'success' for the partnership, the representative of The Atlantic Philanthropies listed the following criteria:

1. In the population study, *'effectiveness'* must be demonstrated in differences between the comparison and intervention counties.
2. The study must show that the programme is *'transferable'* outside of Australia, where it was developed, and that there would be grounds then to replicate the programme elsewhere in Ireland.
3. The programme should be *'cost-effective'* in that it should lead to reduced usage of, and savings to, the health services.
4. Finally, the relevant statutory authority – 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 – must *'continue to engage'* with the programme:

> *'I think that what would count as success for us is that the model … demonstrates effectiveness and the Triple P programme becomes one the HSE, or whoever it may be, the Child and Family Agency, that that's a programme that gets replicated, that other areas would take it on'.*
> *[Representative of The Atlantic Philanthropies]*

Beginning in 2013, funding was secured from The Atlantic Philanthropies (and other sources) for the implementation of Triple P in the original two counties (Longford and Westmeath), along with two new counties (Laois and Offaly) known as the Midlands Area Parenting Partnership. This grant was made on the basis that The Atlantic Philanthropies were *'reasonably confident that LWPP had developed a model of delivery that worked'* and therefore that LWPP had shown that Triple P could be transferred to the Irish context and that there was a *'potential for replication'* of this model. Although in the process of winding down its operations in Ireland, The Atlantic Philanthropies had been engaged in a dialogue with the statutory sector about what had been learned from the evaluation of Triple P. The representative believed the findings from the *Interim Report* for this evaluation strongly suggested, on the one hand, that the final findings would show that Triple P did work for Irish parents. On the other hand, the way in which Triple P was implemented by LWPP provided considerable learning for the statutory sector about a *'way of working'* and of *'deploying resources'*. According to The Atlantic Philanthropies, the key issue for Triple P, notwithstanding that it involves a partnership approach, is whether and how the delivery of the programme can be made *'sustainable within the statutory system'*.

Interviews were carried out with two representatives from the HSE: the HSE Local Area Manager and the HSE Area Manager for Children and Families in the Midlands Area. For the HSE Local Area Manager, the partnership would be considered a success if it led to *'a reduction in referrals to other services'*. It should also lead to *'better support for families than before'*. The HSE Local Area Manager was committed to the concept of rolling out the programme nationally. As he commented: *'[Triple P is] one of the things that I am most proud of in my time as Local Area Manager … because I sincerely believe it's the way the public service should be doing its business in terms of partnerships with other organisations.'*

9. Representatives from the DCYA were invited to take part in the evaluation, but were unable to do so.

The HSE Local Area Manager also drew attention to implications for the future of the LWPP of the establishment of the new Child and Family Agency. He expressed concern that the creation of the new agency had led to uncertainty over which of the statutory bodies – 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 – would have responsibility for LWPP and the delivery of Triple P. These concerns have been addressed in detail in Chapter 6 as part of the findings from the Partnership Study.

The HSE Area Manager for Children and Families in the Midlands Area was also committed to supporting the roll-out of Triple P in the original two counties (Longford and Westmeath) and in the two neighbouring counties (Laois and Offaly). The implementation of the programme represented the use of public money for a good objective, namely to support children and ensure they can have a better life and as such is *'much needed support'*. She emphasised that Triple P would be beneficial for teachers, pre-school workers and special needs assistants, and that both foster carers and residential child carers should be required to take the programme. She also emphasised the importance of obtaining support and buy-in from both the Department of Education and Skills and the Department of Children and Youth Affairs.

KEY FINDINGS: How will sustainability be ensured?

- In looking at sustainability, the partnership will be considered successful by funders based on study findings and also the continued commitment from other funders and partners.
- The Atlantic Philanthropies agreed to fund the roll-out of the programme to two neighbouring counties (Laois and Offaly) on the basis that LWPP had shown that Triple P could be transferred to the Irish context and that there was a 'potential for replication' of this model. A key issue was whether and how the delivery of the programme can be made sustainable within the statutory system while retaining a partnership approach.
- The HSE Local Area Manager and the HSE Area Manager for Children and Families in the Midlands Area both fully supported programme roll-out in Laois and Offaly. However, the former expressed concern that the creation of the new Child and Family Agency had led to uncertainty over which of the statutory bodies – 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 – would have responsibility for LWPP and the delivery of Triple P.

7.3.2 What were the funding and staffing commitments of the partners?

Both the funding and staffing commitments for the project are important components of programme organisation and the Triple P Logic Model (*see Section 3.1*) lists the following as two 'inputs' necessary for programme implementation: (1) partnership organisation, expertise and staff; and (2) external partners – sources of expertise and funding. Table 7.11 provides projections for both expenditure and income for the 2 years of the project. In particular, it shows significant contributions from the HSE, The Atlantic Philanthropies, OMCYA and LWPP.

The project was to begin in January 2010. However, due to a number of factors, including industrial action within the HSE, implementation began only in September 2010. While the figures presented in Table 7.11 were projections of expenditure and income for a 2-year project (2010 and 2011), with the delays in starting the programme the implementation period was 2 years and 4 months (September 2010 – December 2012).

Table 7.11: Projected high-level budget*

Expenditure	Year 1	Year 2
Management and Support Staff	211,116	236,116
Operations	116,000	107,500
Training, Delivery and Technical Support	838,376	700,447
Research and Evaluation	219,125	219,126
Promotion and Networking	41,100	46,100
Total Project Expenditure	**1,425,717**	**1,309,289**
Income		
HSE contribution (staff)	643,921	598,952
LWPP contribution (staff)	134,342	124,342
Conference	5,000	-
Special Lottery Grant	20,000	20,000
LWPP Partnership: financial contribution	20,000	-
HSE Triple P materials	20,000	-
HSE: Financial contribution	60,000	60,000
Office of the Minister for Children and Youth Affairs (OMCYA)	125,000	125,000
The Atlantic Philanthropies	397,454	380,995
Total Project Income	**1,425,717**	**1,309,289**

* Figures for actual expenditure over the course of the evaluation were not available.

Source: LWPP Grant Proposal

The project's Operational Model (*see Section 3.1*) identified two separate panels of practitioners: Panel 1, the Principal Programme Delivery Team, was to be comprised of 8 practitioners (representing 5.6 whole-time equivalents). The profile of the 8 practitioners recruited to Panel 1 is presented in Table 7.12. All but one of the Panel 1 practitioners were *in situ* by Year 2.

Table 7.12: Profile of Panel 1 practitioners

ID Number	Status within LWPP	Profession	Was staff member *in situ* for Year 1?
1	Full-time LWPP	Child leader	Yes
2	Full-time LWPP	Child leader	Yes
3	Full-time LWPP	Nurse	Yes
4	Full-time LWPP	Child care worker	Yes
5	Three days per week	Health promotion	Yes
6	Three days per week	Health promotion	Yes
7	Two days per week	Health promotion	No (*in situ* Year 2)
8	Full-time community sector	Youth worker	No

Note: There were two maternity leaves during this time.

It was proposed that Panel 2 would comprise 60+ practitioners from a range of different partner organisations. Tables 7.13 and 7.14 present the staff numbers and their occupations committed to Triple P by HSE Longford Westmeath and other partners (Grant Proposal, pp. 84-85). The HSE committed 5 whole-time equivalents and 3 half-time equivalents. It also committed a further 48 staff to deliver Triple P – 40 from Public Health Nursing alone. The other partners committed 12 staff to deliver Triple P (Panel 2 practitioners) and one half-time equivalent to Panel 1.

It is important to note that these staffing commitments for Panel 2 practitioners changed over the course of the 2 years. In this chapter, we have already explored the rationale for key decisions made by the Project Management Team concerning programme delivery (*see Section 7.2.5*) and the progress made towards achieving targets in supporting practitioners to deliver (*see Section 5.3.3*); below, we will look at how changes in commitments were coordinated (*see Section 7.3.3*) and practitioners' views on the challenges of delivering Triple P (*see Section 7.3.6*).

Table 7.13: Staff committed by HSE Longford Westmeath*

Discipline	Commitment prior to Year 1
Public Health Nursing	35 members of staff (108 hours per annum) 4 members of staff (70 hours per annum) 1 staff member (95 hours per annum)
Child Minding Advisory Officer	1 staff member (110 hours per annum)
Family Support Worker	1 staff member (110 hours per annum)
Social Care Leader	1 staff member (110 hours per annum)
Family Welfare Conference Coordinator	1 staff member (110 hours per annum)
Occupational Therapist	2 staff members (110 hours per annum)
Child and Adolescent Mental Health Service	2 staff members (110 hours per annum)
Project Manager	1 WTE x 2 years
Social Care Leader	2 WTE x 2 years
Social Care Worker	2 WTE x 2 years
Pre-school Training Officer	0.5 WTE x 2 years
Health Promotion Worker	3 or 4 x WTE x 2 years
Senior Researcher (Public Health)	0.75 WTE x 2 years

* These figures relate to commitments given before implementation began. Figures for the number of staff provided for programme delivery during implementation were not available.

WTE = whole-time equivalent

Table 7.14: Staff committed by the other partner organisations*

Organisation	Commitment prior to Year 1
Athlone Community Services Council Ltd.	Allocation of 1 worker to Panel 1 at a 0.5 WTE for project delivery. Provision of free facilities and access to community groups also included.
Westmeath County Childcare Committee	Commitment to allocate 1 worker to Panel 2.
Longford Community Resources Ltd.	Allocation of 4 workers to Panel 2. Provision of free facilities. Access to community groups and LCRL website.
Westmeath Community Development Ltd.	Allocation of 3 staff members to Panel 2. Free access to training rooms.
Longford Vocational Education Committee	Allocation of 2 trainers to Panel 2. Access to training rooms.
Longford County Childcare Committee	Allocation of 2 workers to Panel 2.

* Figures for the number of Panel 2 practitioners who delivered the programme were not available.

WTE = whole-time equivalent

KEY FINDINGS: What were the funding and staffing commitments of the partners?

- Partner organisations gave commitments to provide staff and other resources to support the delivery of Triple P.

7.3.3 What structures were created for programme coordination?

This section explores the structures put in place for the coordination of programme delivery. It focuses on the developments that preceded the evaluation timeframe, between 2007 and late 2010, and the lessons learned from that period.

Training and delivery prior to establishment of Core Team

The training of practitioners began in 2007, before the establishment of the Core Team. No grant was available initially for this objective, but because of their commitment to the programme and good working relations between representatives, the partners agreed to fund training themselves. The Project Management Team believes that the positive experience of partners in this initial round of training created a strong commitment to the programme and its delivery, which was important for the further development of the partnership.

Although an increasing number of practitioners were trained to deliver Triple P during 2007 and 2008, and a *'contract for delivery'* was signed by service heads for the release of trained staff to deliver Triple P programmes as necessary, the partners still faced challenges around agreeing a calendar for programme delivery and these challenges were dealt with through engagement with partners (Project Management Team). For example, in June 2008, representatives from each partner organisation were asked by the Chair of LWPP to go back to the trained personnel in their organisation and request they make contact with the Project Director to indicate whether or not they would be delivering Triple P in the future (documentary analysis).

Centralisation of coordination and Programme Coordinator's role

Delivery of Triple P and the efficient use of all resources were required by a *'strong partnership'*, according to the LWPP Logic Model. Initially, before the establishment of the Project Management Team, the coordination of programme delivery was not centralised. The partners agreed that their trained personnel *'would deliver a number of programmes, maybe two per annum, and that it would be delivered from within their own organisations and the organisations would take responsibility for that'* [Member of Project Management Team].

At this time, prior to 2010, programme delivery was coordinated by a member of staff based in one of the partner organisations and funded by LWPP. Subsequently, the coordination role was taken within the Project Management Team and a *'coordination'* or *'central hub'* was created (Project Management Team). Programme implementation was coordinated by LWPP staff, including the Project Director, the Programme Coordinator, the Senior Researcher and administrative staff. The Project Management Team stressed that this process of centralisation was undertaken with the full agreement of all partners and that this was a *'new architecture'* put in place to address some difficulties that partners themselves had identified. The issue also illustrates that partners were learning just how important coordination itself was: *'Coordination was not just having somebody who was prepared to add-on to their job of taking in names and processing them'* (Project Management Team). Rather, programme coordination included management functions and coordination functions, and therefore it was more than an administrative support role.

The project had a Programme Coordinator in place from 2010 with the following responsibilities:

- supporting the facilitation of Core Team meetings;
- planning as part of LWPP Management Team;
- coordinating and planning in conjunction with the Core Team of local delivery across the two counties;
- co-delivery of Triple P to support fidelity and promote practices;
- attendance at Practitioner Support Meetings where implementation and delivery issues were discussed and responses developed;
- facilitating and organising Practitioner Area Team meetings in Longford, Athlone and Mullingar;
- networking with local agencies and partner organisations;
- promotion of programme and recruitment of parents;
- development of communication and recruitment strategies.

Panel 1 Practitioners

One of the principal structures created for programme coordination was the group of Panel 1 practitioners. This Principal Programme Delivery Team was to be comprised of 8 practitioners (representing 5.6 whole-time equivalents). Their functions were to:

- deliver the Triple P Programme to parents in Longford and Westmeath;
- support the Core Team to deliver Triple P fidelity training to all members of Panel 2;
- ensure that the fidelity requirements of the programme were maintained at all times;
- contribute to the promotion of Triple P throughout Longford Westmeath;
- interact with key stakeholder groups at local and regional level;
- provide peer-to-peer support to members of Panel 2.

Core Team

Another innovation was the creation of a Core Team to manage the implementation of Triple P by LWPP. It involved 6 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. **Practitioners** (Panel 1) 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.

The Core Team played an important ongoing role in implementation. According to the Project Director, the discussion and consideration of implementation issues by the Core Team was considerable and it contributed positively to decision-making throughout the implementation period. 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.

KEY FINDINGS: What structures were created for programme coordination?

- Challenges arose in ensuring agreed levels of programme delivery before the establishment of the Core Team and these were dealt with through engagement between the partners.
- The partners created a single, centralised coordination 'hub', having found that an implementation structure was important.
- A Programme Coordinator has been in place since 2010 to provide support in relation to planning, delivery and development of related protocols.
- The Core Team, including Panel 1 practitioners, made a positive ongoing contribution to programme implementation and were a source of support for the Project Management Team.

7.3.4 What were parents' views on the quality of programme content and delivery?

Data were gathered on the quality of programme delivery from parents through focus groups and through questionnaires.

Parents who completed the questionnaires were asked about their satisfaction with Triple P. Participants in Group Triple P and Workshop Triple P were invited to complete the 13-item Satisfaction Questionnaire (SQ) and participants in Triple P Seminars were invited to complete the 9-item Client Satisfaction Questionnaire (CSQ) (*see Sections 4.2.1 and 4.4.1*). Parents also had the option of providing additional qualitative comments in the questionnaires.

Also qualitative data were collected in focus groups from parents on their experiences of and satisfaction with the following levels of the Triple P Programme:

- Level 2: Triple P Seminar
- Level 3: Workshop Triple P
- Level 4: Group Triple P (Day and Evening)

The profile of participants in the focus groups is presented in Table 7.3 above.

Level 2: Triple P Seminars

Interview data

Parents who attended Level 2 Triple P Seminars also took part in one-to-one telephone calls with the Research Team as part of the evaluation. The aim of the interviews was to explore the impact of the programme on parenting and child behaviour. There were 5 participants and interviews were carried out in November 2012.

In the interviews, only one parent reported that attendance at the seminar had ***'no positive impact'***. As we have seen (*see Section 7.2.1*), the Level 2 Seminars are only one level implemented by LWPP and are targeted at parents with low levels of need. This participant believed the seminar was *'only an introduction'*, that she *'would have to do the course [Level 4 Group Triple P] to get any good out of it'* and that because of the time required to care for a very young baby she did *'not have the time to do the 8 weeks [the Level 4 Group Triple P]'*. Other parents spoke of some aspects of their ***'children's behaviour that remained***

a cause for concern', such as low confidence in regard to homework. However, in the main, the parents interviewed said that **attendance at the seminar had a positive impact on their parenting and on the behaviour of their children.**

Parents learned *'not to beat yourself up as a parent'*, but rather *'to be **more confident** as a parent'*. One parent mentioned the need to be ***'more realistic'*** about what she can do as a parent and about the improvements she can expect from her child. Other parents commented that the seminar had an affirmative impact because it *'reminds you that everything is pretty much OK'* or it reminded parents of '*things you don't think of everyday'*, including to **encourage independence** by not doing too much for the child and to not expect the same things from children of different ages. One parent emphasised the importance of communication: before attending the seminar, she was *'getting caught up'* in daily jobs and *'rushing about'*. One positive outcome of attendance at the seminar was spending **more time talking** with her child, making time for one-to-one communication, and to be *'a friend'*. One parent reported her children making more effort at home, for example in making their beds. Another parent believed that since introducing better routines, she can see her children's **behaviour improving** generally.

Participants in the seminars reported wanting more time to ask questions and also to be provided with more information and books. At the same time, the information and hand-outs were valued for their detailed information, which were seen as *'building blocks'* for their own parenting. The practitioner was also praised as *'a lady who knows her stuff'* and *'very refreshing'*, and the co-practitioners *'were marvellous'*. The practitioner was also described as a 'role model' by one of the parents. Participants also reported they were interested in taking part in another seminar or in another, more intensive level of Triple P.

Questionnaires: Quantitative data

The questionnaires completed by participants in the seminars (n=1,862) support the positive comments reported by most of the interviewees above. Overall satisfaction was uniformly high for the individual seminars. Average scores for all individual items were in the upper end of the scale and average satisfaction levels for the overall Client Satisfaction Questionnaire were very positive (*see Table 7.15*).

Table 7.15: Satisfaction ratings for individual seminars (n=1,862)

	Seminar 1 *Power of positive thinking* n=1,070	Seminar 2 *Raising confident competent children* n=669	Seminar 3 *Raising resilient children* n=123
Quality of the seminar presentation	6.17 (0.91)	6.21 (0.87)	6.25 (0.84)
Opportunities for questions	5.98 (1.25)	6.26 (1.00)	6.41 (0.89)
Was the seminar interesting?	6.29 (0.94)	6.38 (0.84)	6.46 (0.76)
Use of clear examples to illustrate parenting issues	6.37 (0.87)	6.41 (0.80)	6.39 (0.85)
Clear explanations provided by the presenter	6.38 (0.85)	6.43 (0.77)	6.40 (0.85)
Gain sufficient knowledge/information to implement advice?	6.10 (0.98)	6.30 (0.86)	6.34 (0.75)
Overall rating of content	6.25 (0.90)	6.35 (0.81)	6.41 (0.76)
Helpful in understanding what you can do to help child learn new skills and behaviour?	6.20 (0.90)	6.33 (0.85)	6.35 (0.78)
Intention to implement parenting advice received	6.43 (0.83)	6.56 (0.71)	6.59 (0.68)
Total*	**56.19 (6.65)**	**57.27 (6.03)**	**57.59 (5.75)**

Figures represent mean scores followed by standard deviations in parentheses.

For the individual items: Minimum score = 1, Maximum score = 7

* Total score: Minimum score = 9; Maximum score = 63

Satisfaction scores for different socio-economic groups were compared (*see Tables A.48, A.49 and A.50 in Appendix A.4*). Although the results of the analysis was outside the accepted parameters for statistical significance, $F(2, 1{,}072) = 2.587$, $p = .076$, the data show that for each seminar, the highest satisfaction scores were reported by the highest socio-economic group (Class 1: Professional and Managerial/Technical), followed by the middle socio-economic group (Class 2: Non-manual and Skilled manual) and finally the lowest socio-economic group (Class 3: Semi-skilled and Unskilled).

Questionnaires: Qualitative data

When parents were given an opportunity to provide further comments, as part of the Client Satisfaction Questionnaire, only a minority chose to do so. Within each seminar, between 3%-6% of parents responded to the open-ended question of *'Do you have any other comments?'* Many of the comments consisted of global positive evaluations of the seminars, with participants expressing that they found the seminars *'enjoyable'*, *'interesting'* and *'informative'*. The second most common category of responses referred to delivery-related issues, with a small number of participants suggesting the content was too rushed and insufficient time was allowed for the session. A small number of participants suggested that the material covered was common-sense and they were already familiar with the content. In some cases, parents felt they required more specific information or further workshops.

Level 3: Workshop Triple P

Focus Group data

Focus groups were carried out with participants of the Level 3 Workshops. In May 2012, two focus groups were held, one in Athlone and one in Mullingar, with 10 parents attending in total.

Workshops are run as a once-off session and therefore the interaction between practitioners and parents is less intensive than in Groups. Nonetheless, parents attending the focus group spoke about how *'excellent'* their Facilitator was. There was an *'informal start'*, discussions were possible after each section, no one was singled out and there was no judgement passed. With the **Facilitator sharing** her own experiences as a parent, the participants were made to feel they were *'not a bad parent'* and encouraged to think positively.

As with those who attended the Groups (*see below*), Workshop participants spoke of a *'light going on'*. There was a moment of **self-awareness** about both the simplicity of what was required and that being *'positive'* was central. On the one hand, parents should be optimistic about how achievable good parenting is. They knew they did not have to go home from the Workshop and *'try to change everything'* and so they felt there was *'less pressure'*, with one parent noting *'Do not expect your child to be good all of the time'*. Also what was required was to focus on the positive, for example, by encouraging, praising and rewarding good behaviour rather than focusing on bad behaviour. Parents spoke of the following **good outcomes** for their parenting and their children's behaviour: the parents were calmer and had more patience; they learned to avoid confusion for the child regarding expectations; the areas where change was needed decreased over time; and the work required to encourage the better behaviour was needed only initially.

Parents suggested a number of possible **changes or improvements** to the workshops. Parents would appreciate more time to speak informally with other parents, to share experiences and learn from each other. Follow-up support from the Facilitator was also suggested: parents would appreciate that support and encouragement *'if you let it slip'*. Parents also mentioned the idea of a drop-in centre as a source of support. Greater awareness-raising is needed to remove the stigma around seeking help and to encourage parents to participate. For example, one parent noted that when a workshop was offered to parents of children in a primary school, *'only 6 out of 400 [total number of parents in school] did Triple P in the school'*. One parent said she would be glad to help recruit parents and to tell others how *'my family life has improved so much. We have fun'*.

Questionnaires: Quantitative data

The questionnaires completed by participants in the Workshops (n=279) support the positive comments reported by participants in the focus groups (*see above*). Overall satisfaction was uniformly high for the individual workshops as well.

Participants who completed the post-workshop assessment for the 'Dealing with disobedience' workshop and who consented to be part of the evaluation also completed a Client Satisfaction Questionnaire (n=191). The results are presented in Table 7.16. Overall satisfaction levels for this workshop were lower than those reported for the other two workshops, with an average total score of 69.68 (out of a maximum score of 91). Higher overall scores were reported for the 'Managing fighting and aggression' workshop (72 out of a maximum score of 91) and the 'Developing good bedtime routines' workshop (77 out of a maximum score of 91) (*see Tables 7.17 and 7.18*).

For the 'Dealing with disobedience' workshop, on individual items satisfaction levels ranged from 4.18-5.99 (maximum possible item score = 7). The lowest satisfaction rating was on *'Do you think your relationship with your partner has been improved by the programme?'* (4.18). For the 'Managing fighting and aggression' workshop, individual items indicate high satisfaction levels ranging from 4.60-6.19 (maximum possible item score = 7). The lowest satisfaction rating was on *'Do you think your relationship with your partner has been improved by the programme?'* (4.6); this, however, was nonetheless a moderate score. For the 'Developing good bedtime routines' workshop, individual items also indicate high satisfaction levels ranging from 5.11-6.5 (maximum possible item score = 7). Once again, the lowest satisfaction rating was on *'Do you think your relationship with your partner has been improved by the programme?'* (5.11); this, however, was nonetheless a moderate score and considerably higher than the score for the same item among participants in the' Dealing with disobedience' workshop.

Table 7.16: Satisfaction scores for 'Dealing with disobedience' workshop (Client Satisfaction Questionnaire/CSQ)

	N	M	SD
How would you rate the quality of the service you and your child received?	191	5.68	.99
Did you receive the type of help you wanted from the programme?	191	5.46	1.04
To what extend has the programme met your child's needs?	191	5.01	1.21
To what extent has the programme met your needs?	190	5.10	1.19
How satisfied were you with the amount of help you and your child received?	191	5.53	1.05
Has the programme helped you to deal more effectively with your child's behaviour?	191	5.68	.99
Has the programme helped you to deal more effectively with problems that arise in your family?	190	5.53	.99
Do you think your relationship with your partner has been improved by the programme?	170	4.18	1.42
In an overall sense, how satisfied are you with the programme you and your child received?	190	5.63	.96
If you were to seek help again, would you come back to Triple P?	189	5.99	1.16
Has the programme helped you to develop skills that can be applied to other family members?	186	5.53	1.11
In your opinion, how is your child's behaviour at this point?	189	5.53	.89
How would you describe your feelings at this point about your child's progress?	189	5.71	.91
Total score for CSQ	**191**	**69.68**	**10.48**

Figures represent number of participants (N), mean score (M) and standard deviation (SD).

Table 7.17: Satisfaction scores for 'Managing fighting and aggression' workshop (Client Satisfaction Questionnaire/CSQ)

	N	M	SD
How would you rate the quality of the service you and your child received?	64	5.75	.71
Did you receive the type of help you wanted from the programme?	64	5.62	.92
To what extend has the programme met your child's needs?	64	5.00	1.04
To what extent has the programme met your needs?	64	5.06	1.10
How satisfied were you with the amount of help you and your child received?	64	5.53	1.07
Has the programme helped you to deal more effectively with your child's behaviour?	64	5.83	.95
Has the programme helped you to deal more effectively with problems that arise in your family?	64	5.77	.92
Do you think your relationship with your partner has been improved by the programme?	58	4.60	1.35
In an overall sense, how satisfied are you with the programme you received?	64	5.77	.92
If you were to seek help again, would you come back to Triple P?	64	6.19	.97
Has the programme helped you to develop skills that can be applied to other family members?	63	5.79	1.02
In your opinion, how is your child's behaviour at this point?	64	5.69	.64
How would you describe your feelings at this point about your child's progress?	64	5.83	.88
Total score for CSQ	**64**	**71.91**	**9.24**

Figures represent number of participants (N), mean score (M) and standard deviation (SD).

Table 7.18: Satisfaction scores for 'Developing good bedtime routines' workshop (Client Satisfaction Questionnaire/CSQ)

	N	M	SD
How would you rate the quality of the service you and your child received?	23	6.26	.86
Did you receive the type of help you wanted from the programme?	24	6.04	1.00
To what extend has the programme met your child's needs?	24	5.58	1.28
To what extent has the programme met your needs?	24	5.67	1.40
How satisfied were you with the amount of help you and your child received?	24	6.21	.88
Has the programme helped you to deal more effectively with your child's behaviour?	24	6.13	1.04
Has the programme helped you to deal more effectively with problems that arise in your family?	24	5.96	1.04
Do you think your relationship with your partner has been improved by the programme?	19	5.11	1.56
In an overall sense, how satisfied are you with the programme you and your child received?	24	6.42	.78
If you were to seek help again, would you come back to Triple P?	24	6.50	.78
Has the programme helped you to develop skills that can be applied to other family members?	24	6.08	.97
In your opinion, how is your child's behaviour at this point?	24	5.96	.86
How would you describe your feelings at this point about your child's progress?	24	6.04	1.04
Total score for CSQ	**24**	**76.63**	**10.64**

Figures represent number of participants (N), mean score (M) and standard deviation (SD).

Questionnaires: Qualitative data

Parents also had the option to 'add any other comments' when completing the questionnaire.

Level 3 Workshop 1: Dealing with disobedience

Approximately 18% of the parents responded to the final question, which allowed them to provide any other additional information. The majority of comments were positive endorsements of the programme, which was variously described as *'helpful'*, *'informative'*, *'fantastic'* and *'worthwhile'*. Some parents referred to the tips and practical strategies as particularly beneficial, while others referred to the increased confidence they gained from participating in the programme. A small number of parents also stated that they found it very helpful to meet with other parents who are experiencing similar issues. Very few parents identified problems with the programme. While a small number of parents felt the material was common knowledge, it was perceived as helpful nonetheless.

Level 3 Workshop 2: Managing fighting and aggression

When parents were invited to provide any other information, only 15% chose to do so, resulting in approximately 10 comments in total. Positive comments were expressed on the benefits of the programme and the changes that parents were able to implement as a result of the programme. Some limitations were expressed, including the timing of the sessions not being suitable for working parents and the difficulties a parent experienced accessing special needs services. But in general, of the small number of comments provided, most were positive in nature.

Level 3 Workshop 4: Developing good bedtime routines

Only 4 parents chose to make additional comments at the end of this workshop. Two individuals highlighted special family circumstances that created more challenging care-giving environments. A further two individuals commented on the programme, with one describing it as *'beneficial and supportive'*, while the other suggested it would be helpful if programme *'participants were introduced to each other'* since she was not familiar with the other people present.

Level 4: Group Triple P

Focus Group data

In the two focus groups held with parents who attended Level 4 Groups run during the day, all participants reported positive experiences of the Triple P Programme. One positive experience was getting the **opportunity to meet with and talk to other parents**. Parents believed that, as a result, they felt better supported, they no longer felt *'on their own'* or *'isolated'*, and this also encouraged greater openness in the training sessions.

The **content of the programme** was described as being *'practical'* and based on *'common sense'*. The way in which the material was covered and delivered also encouraged parents to participate fully and helped develop trust within the group. As one parent commented, *'It brought everybody in in a gentle way. The subjects were put across in a nice sort of a gentle manner and nobody was made to feel like they couldn't speak or were afraid to speak'.*

Parents also were thankful that they were not asked to cover a great deal in each session: *'You didn't get all these skills and have to go home and a week later nearly be like supernanny! Seven days and your life is changed!'*

Parents emphasised that beliefs or **values were not forced on them**. Some said they had been helped to develop skills, but they were free to apply those skills in the way they felt best. There was *'no credo behind it [Triple P]'*. Parents also liked the fact that they **set their own targets** at the beginning and then checked their progress against those targets: *'You kind of forget what the behaviour was like sometimes if it's improved so much.'* Parents also learnt the benefit of **consistency** in parenting: *'You set out your markers and you stick with them and that's it.'* Parents also spoke of learning to avoid the **escalation trap**, whereby bad behaviour is unintentionally rewarded and encouraged. They also spoke of using praise when interacting with their children and the benefits they have seen as a result.

When parents were asked what worked and why, **the practitioners themselves and their own personal experience of parenting** were raised. It was generally agreed that if a practitioner was also a parent, he or she would be able to speak from personal experience. In one of the focus groups, four parents agreed that because their practitioner was not a parent, the effectiveness of the programme was for that reason limited: *'If something arose that wasn't in the book, then we weren't going there!'* One parent felt that this was an issue of empathy and understanding: *'I think you tend to talk more to the person who understands better what you're saying … It's about feeling understood, you know. Perhaps it doesn't have to be per se that a person [practitioner] has children.'*

Another element of the programme that worked was the **homework** tasks, which acted as *'ice breakers'*, encouraging parents to be open and forthcoming and trusting. The homework also gave parents specific things to focus on over the week, including goals, behaviours and strategies.

Many parents also felt that a crucial component of the programme was **the telephone calls from practitioners** (Weeks 5, 6 and 7). It was felt that someone was taking an individual interest in them and that they had a mentor: *'No more than with the child, when you've got your individual interest from the course giver, I thought that was very, very good. It put me in a situation where I kind of said, "Well, God, if she's this interested in me, I really have to make this work".'*

One positive outcome was greater **self-awareness** as a parent and in particular the realisation that they, the parents, had to change: *'And you'd realise mostly it was mine, me, not the child and that was a big realisation for me because I was the one putting pressure on them.'*

Parents also spoke of **the need to take better care of themselves as parents:** 'One thing it said is to look after yourself because if you don't look after yourself, you're not going to be any good for them, to look after your children.' Parents who had previously felt unable to **cope with stressful situations** also now felt that they had developed the skills needed to do so: *'So I haven't lost my temper or really shouted at the kids in the last 6 months. [Before this] I had a few times really shouted at them, loud, and swore at them, so I don't do that anymore. That doesn't happen.'*

Many of the parents believed that if there are **two parents** in a household, then both parents should attend the course: *'The only difficulty I had is what you learn on the course and then you go home, but your partner hasn't been at the course. So you're, "Well, I heard this today at the course. This is the way we should do it".'*

Some said that after starting the course, they encouraged their partner to attend as well, but other parents spoke of not being in a position to *'force'* anyone else to attend a course and also the difficulty of two parents taking time to go to such courses.

Parents did **criticise the support material** on the Triple P DVD, which was made in Australia. Some noted that it was looked dated; others thought that the situations seemed contrived and yet others believed that the children in the DVD did not behave like the children they were used to: *'I know that my kids, most of my friends' kids, didn't go on the same way as kids on the TV did.'*

Finally, there was a lengthy discussion in one focus group about some **parenting strategies that it was felt Triple P had no room for**, but that nonetheless were needed or valuable. One parent spoke of the problem she had getting her child in the morning to leave the house to be taken to school: *'I have actually got into the car and the moment I get into the car, then when she sees that I'm going to pull away, she actually does get in … Positive parenting doesn't work at five to eight in the morning when you're in a hurry!'* In response, however, another parent believed that the Triple P approach to the issue was to use *'consequences'*, namely, telling the child what the consequences of their misbehaviour would be (e.g. missing playtime later in the day) and following through on that every day that the misbehaviour occurred. It was believed that within a few days the misbehaviour would have disappeared and that this was simply by following the Triple P approach.

All participants said they would **recommend the programme** to other parents.

> *'It's just a great course and everybody should do it! It'd probably end up saving the State an awful lot of money in the long term with loads of different issues.'*
>
> *'Even if you don't have problems, it's good to chat with other parents and [hear about] their different experiences.'*

A further focus group was run with parents who for the most part attended a Level 4 Group programme run in the evening. The focus group was run in Mullingar in June 2013, with 7 parents in attendance. This focus group concentrated on topics where, it was believed by the researchers, more qualitative data were required (*see findings below*). First, special attention was given to **the time at which the Groups were run**. Five of the 7 participants attended the programme in the evening (starting at 7.30pm or 8pm). The parents reported that they did so because this was **the only time** they could attend since they were either minding the children or working during the day, and therefore this flexibility in programme delivery was appreciated. Parents also spoke of the **social dimension** to their participation in the programme: it was a break from routine, an opportunity to be out of the house, a chance to meet other adults and a chance to share experiences with and learn from others. Similar views were expressed by participants attending the programme during the day. This finding suggests that the social dimension of participation is important regardless of time of day.

A further particular issue addressed in this focus group was **the follow-up telephone call**. Standard practice in Level 4 Group Triple P requires 3 or 4 one-to-one telephone sessions after parents have completed the 4 face-to-face Group sessions. LWPP offered and evaluated a further telephone call, where practitioners provided feedback to parents on the results from both their pre- and post-programme questionnaires. This allows practitioners to draw attention to important changes occurring in the parents' lives in regard to their parenting and their children's behaviour. In this focus group, parents were asked about their experience of this follow-up telephone call. However, none of the parents attending were aware of it. Therefore, either the practice had not been followed with this small sample, or practitioners did not succeed in contacting the parents directly, or they had been offered it and no longer recalled this happening.

Questionnaires: Quantitative data

The questionnaires completed by participants in Group Triple P (n=391) support the positive comments reported by the focus group participants (*see above*). Overall satisfaction levels were very high (*see Table 7.19*), with an average total score of 80.10 (out of a maximum score of 91). Individual items also indicate high satisfaction levels ranging from to 5.17-6.54 (maximum possible item score = 7). As was the case with Workshop participants, the lowest satisfaction rating was on *'Do you think your relationship with your partner has been improved by the programme?'* (5.17); this, however, was nonetheless a high score.

Table 7.19: Satisfaction ratings for Group Triple P (Client Satisfaction Questionnaire/CSQ)

	N	M	SD
How would you rate the quality of the service you and your child receive?	390	6.47	.77
Did you receive the type of help you wanted from the programme?	391	6.40	.85
To what extent has this programme met your child's needs?	391	5.89	1.08
To what extent has this programme met your needs?	391	6.02	1.03
How satisfied were you with the amount of help you and your child received?	389	6.31	1.04
Has the programme helped you to deal more effectively with your child's behaviour?	391	6.54	.74
Has the programme helped you to deal more effectively with problems that arise in your family?	391	6.36	.86
Do you think your relationship with your partner has been improved by the programme?	356	5.17	1.60
In an overall sense, how satisfied are you with the programme you and your child received?	389	6.44	.87
If you were to seek help again, would you come to Triple P?	389	6.51	.89
Has the programme helped you to develop skills that can be applied to other family members?	389	6.25	.997
In your opinion, how is your child's behaviour at this point?	390	6.16	.72
How would you describe your feelings at this point about your child's progress?	390	6.21	.86
Total score for CSQ	**391**	**80.10**	**8.795**

Figures represent number of participants (N), mean score (M) and standard deviation (SD).

Questionnaires: Qualitative data

Approximately 40% of parents in Group Triple P chose to 'add any other comments' at the end of the Client Satisfaction Questionnaire. Most individuals described their experience in positive terms. Some of the words that parents used to describe the programme included *'excellent'*, *'informative'*, *'enjoyable'*, *'helpful'* and *'worthwhile'*. Examples of comments provided by parents included: *'[This programme] would give every parent hope that they can change things and be the parent they want to be'* and *'Very informative and an education to me and my husband'.*

In addition to such positive endorsements of the programme, parents identified a variety of changes within their family, their approach to parenting and their children, following participation in the programme. The most common type of response identified was **changes in parental behaviour** and the **strategies and practices that parents use** within their families. Of those who responded to this question, a number of parents reported acquiring new tools and strategies that helped to change their own behaviour and that of their child. Some parents suggested that the tools they acquired helped them *'to manage problems'*, *'to overcome a lot of things without getting angry'* and to change the way they reacted to problems. A number of parents also reported increased confidence in their parenting skills as a result of programme participation. Some parents also reported that having completed the programme, they gained a **new understanding and awareness of their own behaviour** and that of their children. For example, parents reported that the programme *'made me aware that it's not the child's fault; it's my mood'* and Triple P *'made me realise children are more intelligent than I gave them credit for'.*

Some parents also reported **improvements in family life**. Examples of quotes reflecting changes within the family include: *'[This programme] helped me get my family back on track'; 'I found it really helpful, and the whole family is more positive and functions much better'*; and '*wonderful programme, most satisfying, wonderful results at home'*. A small number of parents also reported **improved relationships** with their children following programme participation.

However, only a very small number of comments referred specifically to changes in children's behaviour following programme participation. Much of the evaluative comments were more global in nature, outlining positive changes in general and the more specific comments when they arose were more likely to refer to changes in parenting approaches or changes at a family level.

In line with the frequent positive experiences that were reported, a small group of parents argued that this programme was **applicable to all parents** and was something everyone would benefit from. Examples of such quotes include: *'Very good, all parents should go to it, especially fathers'; and 'The very best programme for every family'.*

A small number of parents also highlighted the benefit of **discussing issues with other parents** in a group setting. The support provided by others helped parents in knowing they were not alone in dealing with such issues.

While some limitations in programme delivery were identified, they were relatively infrequent. The most common issue identified was the additional time would be beneficial, but the frequency with which this issue was identified was nonetheless very low.

KEY FINDINGS: What were parents' views on the quality of programme content and delivery?

Note: Parents' views on Level 1: Media strategy were presented above in Section 7.2.3.1.

Sample size

- Qualitative: Parents in focus groups (n=33) and in one-to-one interviews (n=5).
- Quantitative: Participants in Seminars (n=1,867); Workshops: Dealing with disobedience (n=408), Managing fighting and aggression (n=122), Developing good bedtime routines (n=44); and Group Triple P (n=521).

Triple P Seminars

- In interviews, only one parent reported that attendance at the Level 2 Seminars had no positive impact. According to the remaining parents, attending the seminars had made them more confident and realistic as a parent, they were more likely to encourage their children to be independent and to spend time talking with their children, and their children's behaviour had improved. The parents attending Level 2 also reported that the facilitation was of a very high quality.
- In questionnaires completed by participants, overall satisfaction was uniformly high for the individual seminars. Average scores for all individual items were in the upper end of the scale and average scores for the overall satisfaction questionnaire were very positive.
- Satisfaction scores differed by socio-economic group, with higher levels of satisfaction reported by higher socio-economic groups.

Workshop Triple P

- In focus groups for this evaluation, parents attending the Level 3 Workshops valued the quality of the facilitation. The benefits of programme participation included greater self-awareness of one's parenting and improved parenting strategies.
- Parents spoke of the following good outcomes for their parenting and their children's behaviour: the parents were calmer and had more patience; they learned to avoid confusion for the child regarding expectations; the areas where change was needed decreased over time; and the work required to encourage the better behaviour was needed only initially.
- In questionnaires completed by participants, overall satisfaction was uniformly high for the individual workshops.
- Overall satisfaction levels for the 'Dealing with disobedience' workshop (M = 69.68 out of a maximum score of 91) were lower than for the other two workshops and for Level 4. Individual item scores ranged from 4.18-5.99 (maximum possible item score = 7).
- Overall satisfaction levels for the 'Managing fighting and aggression' workshop were high, with an average total score of 72 (out of a maximum score of 91). Individual items also indicate high satisfaction levels ranging from 4.6-6.19 (maximum possible item score = 7).
- Overall satisfaction levels were high for the 'Developing good bedtime routines' workshop, with an average total score of 77 (out of a maximum score of 91). Individual items also indicate high satisfaction levels ranging from 5.11-6.5 (maximum possible item score = 7).
- In all workshops, the lowest scores were reported for the impact of the programme on the parents' relationship.

Group Triple P

- In focus groups for this evaluation, parents attending the Level 4 Groups reported positive experiences of the programme, including the opportunity to meet other parents, programme content, the strategies and tips learnt, the practitioners themselves and 3 one-to-one telephone sessions.
- Good outcomes included greater self-awareness of one's parenting, the capacity to cope with stressful situations and realising the importance of taking care of oneself.
- Parents also valued the various ways they were encouraged to self-regulate: to set their own targets at the beginning and then check their progress against those targets; to be consistent; and to avoid the escalation trap whereby bad behaviour is unintentionally rewarded and encouraged.
- All parents would recommend the programme to others.
- Parents reported that practitioners who were also parents were more understanding and more able to respond to their questions and concerns.
- Parents also reported that they attended the Level 4 Groups run in the evenings because it was the only time that suited them and they appreciated having this option. The benefits of programme participation included socialising with other parents.
- In questionnaires completed by participants, overall satisfaction levels for Level 4 Group were very high, with an average total score of 80.10 (out of a maximum score of 91). Individual items also indicate high satisfaction levels ranging from 5.17-6.54 (maximum possible item score = 7).
- Most of the evaluative comments in the questionnaires outlined positive changes in general and the more specific comments when they arose were more likely to refer to changes in parenting approaches or changes at a family level.

7.3.5 What were practitioners' views on the quality of programme content and delivery?

Data were gathered from practitioners attending focus groups and also from practitioners who completed surveys at two time points. *See Section 7.2.3* for the profile of practitioners in focus groups and *see Section 7.2.6.2* for a profile of practitioners who completed the surveys.

In the first focus group with practitioners, there was a consensus that the Group Triple P sessions worked well for parents. The first reason for their success was ***'keeping it very simple** and very down to earth'*. The second reason was the effort made to **de-stigmatise** the parenting programme itself: *'It's acknowledging that they are problems that everybody faces, that they're not on their own.'* Practitioners reported seeing parents *'come in with a lot of guilt and a lot of baggage even if their child is behaving well'* or else the parents seemed to feel *'I've really got a big issue'* or *'I'm doing everything wrong'* or *'I suppose you've noticed why I'm here'*. Attending the programme allowed parents to deal with those feelings constructively, in particular since they would soon realise that they were not the only parents with concerns or problems.

There was broad agreement that Triple P was **adaptable** to the individual circumstances of every family. It was noted that even though Triple P is based on a manual, *'there's a huge element of choice for the parent in the programme'*. Parents are asked to select their own goals, target behaviours, parenting strategies and parenting routines: *'The core thing about Triple P is that it's not right or wrong, good or bad.'* The programme requires that parents take a *'positive'* approach to their children, and also that practitioners remain positive with parents. In this way, it was argued, the programme is adaptable because it encourages parents to **self-regulate** and children to become **problem-solvers**:

> *'Even if they say, "Oh, I'm doing everything wrong", you try and pick out what they're doing well and base it on that: "Well look, how have you coped with that before? What have you done that's worked? Can you try this? Do you think this will work? Tell me how you could put that into practice tomorrow".'* [Practitioner attending focus group]

Although it was believed Triple P was adaptable to every family, it was also noted that parents from some cultures have to make an even greater effort to accept the principles of positive parenting. One assumption expressed in the focus group was that some parents from other cultures *'would have quite a low tolerance for misbehaviour and they would say, back in their countries children didn't behave like this.'*

In Level 4, parents are given feedback from their first questionnaire at Week 5 and then after Week 8 they are given feedback on their second questionnaire. It was argued that the data collected through the questionnaires were integral to Triple P as a parenting programme:

> *'Sometimes there's a lot in the questionnaire, but it really gives parents the chance to kind of reflect on what's going on: how is my child behaving, how confident am I dealing with the situation, am I getting support at home …'* [Parent attending focus group]

It was found that during the 3 one-to-one telephone calls with practitioners, parents would say things in these conversations that they would not say in front of the whole group of parents. Filling out the questionnaires is itself important since it may be the parent's first time *'taking an honest look'* at their relationship, and also the first time *'taking care of yourself'*.

In the focus group with **Public Health Nurses** (PHNs), participants agreed that Triple P was of value to them in their everyday work with clients. They described how they provided the Triple P **tip sheets** to parents as a source of information and it was believed that the parents liked and appreciated the material. Triple P also provides support to PHNs, in particular the strategies for dealing with parenting problems. Since PHNs are the front-line practitioners who meet parents at their children's developmental checks, this was an ideal opportunity to introduce Triple P material. PHNs referred to Triple P as a **preventative measure**: parents may not be aware that their child's behaviour is problematic or that there is help available, and this is where

Triple P is beneficial. The PHNs also spoke of the social dimension to Triple P: the programme requires and allows relationships to be built between practitioner and parent since it is a *'two way'* interaction requiring *'openness'* on both sides.

Findings from the focus groups are supported by data collected in surveys from practitioners at two time points: T1 (November 2011) and T2 (November 2012) (*see Section 7.2.6.1 for a profile of survey participants*). In one focus group, a practitioner said it was *'great that parents could attend a parenting course without having to wait a long time'* or be required to have 'a very serious presenting problem'. When asked about the availability of services for parents in their area,. the majority of respondents viewed the availability of services for parents in their community as *'very poor'*, *'poor'* or *'adequate'* (T1: 67%; T2: 69%) and a minority viewed services as 'quite good' or 'very good' (T1: 24%; T2: 31%). Respondents also believed that the LWPP initiative of Triple P had **improved the availability of parenting support** and advice in their community. The majority believed that support was *'extremely improved'* as a result of the programme (T1: 76%; T2: 77%).

Finally, the majority of participants in the focus groups and also the majority of respondents in the surveys said that they would **recommend Triple P** to others. In the survey, at T1 all respondents said they would recommend Triple P to their colleagues and to a family member. However, at T2, one PHN reported she would not recommend Triple P to colleagues or a family member, and two further PHNs reported that they would not recommend it to their colleagues: one commented that the duration of the programme was too long to expect working mothers to attend.

KEY FINDINGS: What were practitioners' views on the quality of programme content and delivery?

Sample size

- Participants in focus groups (n=21)
- Data from surveys completed by practitioners (T1: n=21; T2: n=13)

Practitioners' views on Triple P content and delivery

- According to practitioners, the programme was successful for a number of reasons: it kept things simple, it de-stigmatised seeking help, and it encouraged parents to self-regulate and children to be problem-solvers. These findings correspond with data from the Parenting Study on improvements made by parents between pre- and post-intervention.
- Practitioners believed that data collected through the questionnaires were integral to Triple P as a parenting programme since they were used to provide feedback to parents on their progress over the course of the programme and on areas where continued effort would be required.
- Public Health Nurses valued Triple P as a preventative measure and used some of the Triple P material in their everyday work with parents.
- The majority of practitioners surveyed viewed services to parents as 'very poor', 'poor' or 'adequate,' but they also believed that the LWPP initiative had 'extremely improved' the availability of services to parents.

7.3.6 What practitioner training and supports were planned and delivered?

This section looks at the training and accreditation made available to Triple P practitioners and also what supports were put in place for them. It was the intention that supports for practitioners would play a role in ensuring programme fidelity (*see Section 7.3.8*).

Training of practitioners

In the LWPP Logic Model, one of the programme inputs was 'high quality training programmes for practitioners' and one of the programme activities was to 'develop, train and accredit the workforce.' The partnership delivered all four levels of the Triple P Programme: Level 1 Media, Level 2 Seminars, Level 3 Workshop (plus Primary Care) and Level 4 Group. Triple P practitioners were to be trained by Triple P International and all practitioners were to complete the Triple P accreditation process. Appendix D.2 provides a profile of practitioners who typically attend training courses at different levels and the training and accreditation involved for each level of Triple P, as well as the resources provided to each facilitator by Triple P International. In 2010 and 2011, Triple P International also completed a follow-up evaluation to obtain feedback on practitioners' levels of satisfaction with the training received and the accreditation process.

Attendance at Triple P Provider Training Courses was part of a 5-step training and accreditation process, which consisted of:

- completion of set readings;
- attendance at a dedicated training course (Part 1);
- implementation of Triple P in the workplace, including development of peer support networks;
- access to Triple P Provider Network (web-based);
- completion of accreditation requirements (Part 2).

In its Grant Proposal (p. 38), LWPP stated that 'Completion of each of these steps is essential for the successful implementation of Triple P'. Triple P International itself states that the accreditation process must be completed for official recognition of proficiency in programme delivery (Triple P International, 2006). Appendix D.3 contains the proposed training courses for Triple P practitioners as set out in the LWPP Grant Proposal.

What were the supports received by practitioners?

In the Logic Model for this project, the short- to medium-term outcomes for the staff of LWPP and of the partner organisations include 'a dedicated human resource pool of highly trained practitioners to support parents'. So as to make progress towards attaining this outcome, during 2011 LWPP put in place a number of supports for practitioners. Results from the analysis of documentary data on supports provided to practitioners are presented below.

One **Practitioner Support Forum Meeting** was held in September 2010. It was attended by 3 practitioners, while 7 were absent. Attendees and absentees were from both Panel 1 and Panel 2. The meeting covered programmes already planned and the suggestion that, in recruitment, Triple P practitioners should use the contacts with parents that some workers have.

One further **Practitioner Support Forum Meeting** was held in November 2010. It was attended by 13 practitioners, while 8 were absent. Topics covered included completion of questionnaires; progress on

programme delivery; the establishment of Practitioner Area Teams in Athlone, Mullingar and Longford; and planning for the meeting of those teams in early 2011.

Seven **Skype calls** were held with Dominic Weston from Triple P UK during 2011 and 2012. The function of these calls was to promote fidelity to the programme through consultation and case discussion.

- The first Skype call was held in July 2011 and was attended by 5 Panel 1 practitioners, with one absentee. The discussion focused on a number of 'process issues' and 'content issues'. The discussion also looked at issues around Primary Care Triple P and the Triple P Seminars.
- The second Skype call, held in September 2011, was attended by 5 Panel 1 practitioners and the recruitment of parents was addressed.
- The third Skype call, held in November 2011, was attended by 5 Panel 1 practitioners, with 2 absentees. The topic discussed was supporting less experienced Triple P practitioners in delivering Groups and Workshops.
- The fourth Skype call, held in January 2012, was attended by 5 Panel 1 practitioners and focused on Level 5 Enhanced.
- The fifth Skype call in March 2012 was attended by 6 Panel 1 practitioners, along with an Intern from the Centre for Effective Services. The topic addressed was Level 5 Pathways.
- The sixth Skype call, held in May 2012, was attended by 6 Panel 1 practitioners and focused on the Seminars and the use of illustrative examples suited to the school context.
- The final Skype call was held in July 2012, with by 6 Panel 1 practitioners attending. It continued on the topic of Seminars and related process issues.

Support meetings were held specifically for **Public Health Nurses** (Panel 2 practitioners) in 3 areas on a monthly basis between September 2010 and June 2011. (No information was available on attendance numbers or topics covered.)

Area Team Meetings were held in 3 locations (Longford, Athlone and Mullingar). Panel 1 practitioners attended so as to provide support to those from Panel 2. These meetings ceased towards the end of 2011 'due to rate of delivery by local practitioners', as reported by the Project Management Team. The terms of reference for the meetings included support for practitioners, planning the recruitment of parents and discussing specific issues with the delivery of the programme.

- **Longford Practitioners Area Team Meetings** were held in January, May and September 2011. On the 3 occasions, the numbers attending were 10 (one absent), 8 (4 absent) and 7 (5 absent) respectively.
- **Athlone Practitioners Area Team Meetings** were held on 3 occasions between March and September 2011. On the three occasions, the numbers attending were 5 (no absentees), 9 (one absent) and 6 (5 absent) respectively.
- **Mullingar Practitioners Area Team Meetings** were held on 5 occasions between January and September 2011. The numbers attending were 8 (no absentees), 4 (4 absent), 4 (4 absent), 3 (5 absent) and 5 (4 absent) respectively.

The Core Team (including Panel 1 practitioners) also met regularly in 2010 and 2011. In 2010, they met 9 times between May and November. In 2011, they met 8 times between March and November. In 2012, they met 4 times between March and November.

Practitioners also received support and training in relation to **research/evaluation issues** and protocols. The Research Officer on the project developed protocols for information management, data protection, detecting clinical issues, explaining research to parents and collecting information. Once parents were recruited to the programme, relevant data were collected and returned to the LWPP offices. The Core Team collected data on the number of participants and the number of sessions attended (where appropriate) and the assessments

completed by parents. Meetings were held with practitioners to explain the data collection protocols. The Research Officer acknowledged that in all such projects it is always a problem getting data collected well. She believed that most practitioners were 'doing a great job', but there were 'gaps' in the information coming back from some Panel 2 practitioners (*see Appendix A.1 for information on data quality in the Parenting Study*). Panel 1 practitioners support Panel 2 in this area, in particular in the delivery of the Level 3 Workshops, where there is always a Panel 1 practitioner involved. Panel 1 practitioners would be 'more in tune with research matters', in large part due to the supportive environment within the LWPP offices. The Research Officer also drew attention to ongoing difficulties in establishing a working data management system for the delivery of the programme. The limitations of the existing system hampered efforts to monitor programme delivery and outcomes for parents at the level of detail required for implementation monitoring purposes.

KEY FINDINGS: What practitioner training and supports were planned and delivered?

- Attendance at Triple P Provider Training Courses was part of a 5-step training and accreditation process.
- Supports for Panel 1 practitioners included Trainer Support Forum Meetings, Practitioner Support Forum Meetings, Skype calls held with Triple P UK and Core Team meetings.
- Panel 2 practitioners were supported by Panel 1 practitioners at Area Team Meetings held in Longford, Athlone and Mullingar. These meetings ceased towards the end of 2011 due to rate of delivery by local practitioners.
- Practitioners also received support and training in relation to research/evaluation issues and protocols.

7.3.7 What were the views of practitioners on the supports they received, their confidence as practitioners and the helpfulness of the programme?

This section explores practitioners' views of the supports they received, their own confidence as practitioners and the helpfulness of the programme. Practitioners took part in surveys at two time points: T1 (November 2011) and T2 (November 2012) (*see Section 7.2.6.1 for a profile of survey participants*). As the data were received in an anonymous fashion, it was not possible to link the data at T1 and T2, and for that reason it was not possible to represent change over time. However, it was possible to identify which participants were Panel 1 and Panel 2 practitioners at each time point.

At T1, Panel 2 participants were drawn from a number of agencies; at T2, all Panel 2 participants were Public Health Nurses (PHNs). In the section below, qualitative data from focus groups with practitioners (*see Section 7.3.5 for profile of focus group participants*) are used to further illuminate the quantitative data from the surveys.

7.3.7.1 What supports did practitioners receive and how confident were they?

Practitioners from Panel 1 and Panel 2 provided data on the supports they received and how confident they were as practitioners. It should be noted that Panel 1 practitioners were working full-time or half-time as Triple P practitioners, while Panel 2 practitioners did not have the same commitments to programme delivery. However, these differences in levels of engagement with the programme may be expected to have different implications for the variables 'confidence' and 'support'. It may be expected that Panel 1 practitioners would report higher levels of confidence. At the same time, it may be expected that Panel 2 practitioners would require more support or support of a different kind than Panel 1 practitioners.

Supports received by practitioners

In the surveys completed at T1 (n=21) and T2 (n=13), practitioners gave their views on the supports they received. Although the amount of support practitioners reported receiving from either LWPP or other practitioners varied, Panel 1 practitioners reported receiving more support than Panel 2 practitioners.

Practitioners were asked how often they had attended supervision or peer support for Triple P in the previous 6 months. Panel 1 practitioners received supervision and support more frequently than Panel 2 practitioners. Five of the 6 PHNs from among the Panel 2 practitioners had not received any supervision or support at all, even though support meetings for PHNs were held monthly at the end of 2010 and during the first half of 2011. Other Panel 2 practitioners had received such support only once in the previous 6 months (T1, n=2) or once every 2-3 months (T1, n=8). In contrast, the majority of Panel 1 practitioners received such support either 'more than once per month' (T1, n=3; T2, n=2) or monthly (T1, n=3; T2, n=1).

Participants were asked how many times they had consulted with other Triple P practitioners in the previous 6 months. Panel 1 practitioners reported more frequent consultations than Panel 2 practitioners. The majority of Panel 1 practitioners reported consultations 'more than 10 times' (T1, n=6; T2, n=3) in comparison to just one Panel 2 facilitator at T1. Panel 1 practitioners also reported consultations 9-10 times over the previous 6 months (T1, n=1), 7-8 times (T2, n=1), 5-6 times (T2, n=1) and 1-2 times (T1, n=1; T2, n=2). In contrast, the majority of Panel 2 practitioners reported consultations 3-4 times per month or less frequently. Panel 2 practitioners reported consultations 7-8 times (T1, n=1), 5-6 times (T1, n=1), 3-4 times (T1, n=5), 1-2 times (T2, n=2; T2, n=3) and 'not at all' (T1, n=1; T2, n=4). The four Panel 2 practitioners who reported no consultations at all were all PHNs. While it is to be expected that Panel 1 practitioners would be in consultation more frequently than Panel 2 colleagues, nonetheless, the number of Panel 2 practitioners with no reported experience of consultation is noteworthy.

Participants were asked how many times they had consulted with another professional about a child with emotional or behavioural problem in the previous 6 months. There were no notable differences between the responses of Panel 1 and Panel 2 practitioners. At T1, the majority did so fewer than 5 times (n=12), while 4 did so more than 10 times; and at T2, the majority did so fewer than 5 times (n=8), while 3 did so more than 10 times. The practitioners were also asked which services they most frequently referred children or their parents to. In this case, they were allowed to choose more than one option. Again there were no differences between the responses of Panel 1 and Panel 2 practitioners. At T1, children and their families were most frequently referred to a Triple P facilitator (n=13), followed by Child and Family Services (n=9), GPs (n=8), psychiatrists (n=3), counselling (n=2), PHNs (n=1) and adult psychiatry services (n=1). At T2, children and their families were most frequently referred to a Triple P facilitator (n=8), followed by GPs (n=8), Child and Family Services (n=6), psychiatrists (n=1), counselling (n=1), and PHNs (n=1).

Practitioners' reported confidence and support

The next set of questions in the surveys related to the respondents' level of confidence as practitioners, as well as the support they received. In 8 of the questions, respondents were asked to select a response from a 4-point Likert-type scale, while the final two questions employed a 5-point Likert-type scale. The responses of both Panel 1 and Panel 2 participants combined are analysed first (*see Table 7.20*), while the results for the different panels are compared in the discussion below.

Table 7.20: Practitioners' confidence and support

Questions about confidence and support	T1 M (SD)	T2 M (SD)
1. How confident are you in providing consultation to parents about child behavioural, emotional, and developmental issues?	3.42 (.61)	3.38 (.51)
2. Overall, how would you rate your confidence in using Triple P?	3.35 (.67)	3.31 (.75)
3. Overall, to what extent is your workplace supportive of the use of Triple P?	3.55 (.69)	3.54 (.52)
4. Overall, to what extent are there barriers to the use of Triple P in your workplace?	3.26 (.93)	2.46 (1.27)
5. How easy has it been to incorporate Triple P in your job activities?	3.11 (.94)	2.92 (1.19)
6. What is the general attitude towards the use of Triple P in your workplace?	3.45 (.61)	3.23 (.93)
7. How much does this attitude influence your use of Triple P?	2.70 (1.17)	3.00 (.91)
8. How well does Triple P 'fit' with the goals, objectives, and priorities of your current position?	3.45 (.83)	3.23 (.93)
9. In general, how satisfied are you with the supervision/peer support for Triple P you have received?	4.40 (.75)	3.69 (1.25)
10. How helpful has discussion with colleagues been?	4.60 (.68)	4.34 (.79)
Total	**34.44 (3.13)**	**33.15 (7.14)**

M= mean; SD = standard deviation.

Questions 1-8 were scored on a 4-point Likert scale.

Questions 9-10 were scored on a 5 point Likert scale.

Question 4 has been reversed, meaning that higher scores represent lower barriers.

The mean (M) and standard deviation (SD) for each item on the questionnaire were calculated. At T1, the highest mean scores were for 'discussion with colleagues', 'how satisfied are you with the supervision/peer support for Triple P you have received?' and 'how supportive the workplace was in the use of Triple P'. Mean scores were lowest for 'how much the attitude of the workplace influences the use of Triple P', 'barriers to the use of Triple P in the workplace' (this score is reversed, so higher scores represent lower barriers) and 'incorporating Triple P in your job activities'. This suggests that while the workplace may be supportive of the use of Triple P, there were still barriers to its use among some colleagues.

As was the case at T1, at T2 the highest scores were recorded for 'discussion with colleagues', followed by 'how satisfied are you with the supervision/peer support for Triple P you have received?' and 'how supportive the workplace was in the use of Triple P'. Much the same as at T1, at T2 the lowest scores were for 'barriers to the use of Triple P in the workplace' (this score is reversed, so higher scores represent lower barriers) and 'incorporating Triple P in your job activities'.

The lowest mean score at T1 was for how much the attitude of the workplace influences the use of Triple P. However, this finding is not easy to interpret. If respondents reported that there was a negative attitude in the workplace, then if this attitude also influenced the use of Triple P it did so to the detriment of the use of Triple P. In contrast, if respondents reported that there was a positive attitude to Triple P in the workplace, then if this attitude influenced the use of Triple P it did so to its benefit.

A total confidence and support score was calculated. Scores from the eight 4-point scales and the two 5-point scales were summed. The possible range in scores was 10-42. At T1, the total scores for confidence and support ranged from 23-39, with a mean of 34.44. At T2, scores ranged from 22-42, with a mean of 33.15.

The data from this measure were then used to compare the confidence and support of Panel 1 and Panel 2 practitioners. The analysis shows that at T1, the Panel 1 participants scored significantly higher than the Panel 2 participants and that the effect size was large: at T1, a Mann-Whitney *U* test revealed a significant difference in the total confidence and support levels of Panel 1 (Md = 36, n=8) and Panel 2 participants (Md = 31, n=12), U = 13.00, z = -2.720, p = .007, r = .507 (*see Figure 7.5*). The sample size at T2 was

not large enough to run the same test, but as was the case at T1, the median scores of Panel 1 practitioners (Md = 41) was higher than Panel 2 practitioners (Md = 27) (*see Figure 7.6*). Therefore, Panel 1 practitioners reported higher levels of confidence and more positive perceptions of the supports they received.

Figure 7.5: Panel 1 and Panel 2 self-reported 'support and confidence' scores, at Time 1

Figure 7.6: Panel 1 and Panel 2 self-reported 'support and confidence' scores, at Time 2

Administrative and other support

In the 2011 focus group, both Panel 1 and 2 practitioners spoke highly of the administrative support received from LWPP:

> *'Well, we've a full-time administrator in the office … there's always somebody willing to help somebody.'*

> *'The Director of the project, he's had to come to our rescue a few times, I suppose.'*

A Panel 1 facilitator observed how beneficial it was to have colleagues to speak to about issues such as how to recruit parents and how to support parents:

> *'Just to have that support is huge, I think. It's what is making the programme work more efficiently and be more effective, even in advertising, talking about the programme. You couldn't do that on your own.'*

One Panel 1 facilitator spoke of themselves as having a *'family dynamic'*:

> *'I've never felt that there wasn't support and hopefully we give it wherever we can give it as well.'*

Clinical support

The practitioners also spoke highly of the clinical support they received. There was always someone to speak to and if there was *'a very stressful situation or a serious thing, yeah you'd ring the Project Director. It's great support that you have him there'*. As discussed in Section 7.3.6, the practitioners can attend Area Team Meetings every 6 weeks where clinical issues can be discussed, along with support from Triple P delivered by Skype every 3 months for Panel 1 practitioners. In addition, the role of the Programme Coordinator was to support Panel 2 facilitators concerning clinical issues, in particular through Area Team Meetings.

Practitioners spoke of how beneficial it was to have received training and accreditation in all levels of Triple P. Practitioners also felt that the Triple P materials and equipment were a very good back-up support. It was acknowledged that some of the material, in particular the DVD, was *'dated'* and uses some examples that needed to be explained in an Irish context. However, it was also noted that the *'the Workshop DVD is much more up to date'*.

Support from partner organisations

A Panel 2 facilitator spoke of not receiving support from her own organisation in the use of Triple P, although she felt strongly supported by LWPP:

> *'My agency supports Longford Westmeath partnership in theory, but as a practitioner I would say I'm very much out on my own and I get on with it.'*

She also felt under pressure when changing into Triple P *'mode'*:

> *'I might be doing a Triple P session in the morning or preparing for the evening, and then I have to do my other work, and chopping between the two can be quite stressful.'*

In interviews for the evaluation, the Project Management Team spoke of pairing Panel 1 and Panel 2 practitioners whenever possible in the delivery of Triple P. It was emphasised that this was not seen as *'monitoring'*, but rather *'support and mentoring'*, although this was a fidelity process as well (*see Section 7.3.8*).

In the focus group held in February 2013 with Panel 2 PHNs, the participants spoke about the challenges they faced with the original Primary Care version of Level 3. One participant who spoke of the *'stress'* associated with the requirement to recruit a certain number of parents. The need to have 3 or 4 sessions with each parent was described as *'very prescriptive'* for the PHN and also *'difficult for the parent'*. All agreed with and welcomed the decision to drop the Primary Care version of Level 3. In an interview for this evaluation, the Director of Public Health Nursing suggested that the Workshop version of Level 3 was better suited to PHNs than the Primary Care version. While one-to-one work was *'more difficult for PHNs'*, small group discussions were more in line with the methods PHNs have used in the past for the delivery of parenting courses (e.g. breastfeeding support groups).

Peer support

In focus groups for this study, Panel 1 practitioners highlighted the importance of peer support in delivery of Level 4 Group. It was acknowledged that delivering the Level 4 Group sessions was demanding work. For that reason, co-delivery was established as the norm from the start. According to a number of Panel 1 practitioners, Level 4 Group sessions in particular can be emotionally demanding for practitioners as well as participants because they involve working closely with families for an extended period: *'For the 8 weeks I feel you're bringing the parent from a starting point to a finishing point.'* Some sessions will be more demanding and for that reason *'sometimes you are going away carrying issues'*. In such situations, having colleagues to talk to afterwards was thought to be extremely important. As we have seen, various forms of support were provided for practitioners by LWPP in addition to the peer support mentioned here (*see Section 7.3.6*).

In the focus group held in March 2013 with Panel 1 practitioners, participants spoke of the supports they were then providing to practitioners recruited in the new catchment area of Laois and Offaly. The programme was rolled out to the two extra counties in 2013 and the remit of Panel 1 practitioners was extended to the provision of support for the new group of Panel 2 practitioners. Along with co-delivery and other face-to-face supports, information packs were put together, reflecting the experience of the Longford Westmeath team in implementing Triple P. The packs included copies of advertisements and letters, and advice on inputting data, booking venues, sending out reminder texts and other components of successfully delivering the programme. It was emphasised that this provided an opportunity to *'capture learning'* around programme implementation, that those in Laois and Offaly would benefit from this and that this was part of the process of mainstreaming the programme.

7.3.7.2 How helpful were various aspects of the Triple P programme for delivery?

Practitioners completing the surveys were asked a series of 15 questions concerning what they found 'helpful' about the Triple P Programme (see Table 7.21). Respondents were asked to select from a 5-point Likert scale the answer that best reflected their experiences, ranging from 1 ('not at all helpful') to 3 ('moderately helpful') and 5 ('extremely helpful').

Table 7.21: Practitioners' scores for the helpfulness of the programme

How helpful have the following been to using Triple P?	T1 M (SD)	T2 M (SD)
Support from colleagues	4.45 (.83)	4.17 (1.19)
Supervision, discussion and/or case discussion	3.95 (1.23)	4.00 (1.04)
Contact with LWPP project staff	4.30 (.92)	3.75 (1.14)
Seeing observable change in children or families	4.25 (.85)	3.67 (1.23)
Feedback from parents regarding the programme	4.40 (.75)	3.75 (1.22)
Knowledge and skills in behavioural family intervention	4.10 (.91)	4.08 (1.00).
The programme's ability to be tailored to the needs of individual families	4.25 (.96)	3.58 (1.51)
Knowledge of ways to track and measure behaviour change	4.20 (.77)	3.75 (1.49)
Setting specific goals or agendas for sessions	4.37 (.83)	3.67 (1.44)
Triple P resources	4.70 (.66)	4.58 (.90)
The theoretical framework of Triple P	4.42 (.90)	4.00 (1.13)
Studies showing Triple P's effectiveness	4.55 (.82)	3.67 (1.07)
Attending the Triple P training course	4.35 (.69)	4.33 (.89)
Rehearsal and role-play of consultation skills	4.35 (.75)	3.83 (.94)
Additional self-directed reading	3.75 (1.07)	3.92 (.90)
Total	**64.22 (9.01)**	**58.75 (13.14)**

M= mean; SD = standard deviation.

Scores are based on a 5-point Likert-type scale.

The mean (M) and standard deviation (SD) for each item on the questionnaire were calculated (*see Table 7.21*). At T1, the mean scores were between 4-5 on 13 of the 15 questions. Practitioners found most helpful 'Triple P resources', 'studies showing Triple P's effectiveness', the 'theoretical framework of Triple P' and 'feedback from parents regarding the programme'. Lowest scores were recorded for the helpfulness of 'supervision, discussion and/or case discussion', 'additional self-directed reading' and 'knowledge and skills in behavioural family intervention'.

Scores at T2 were lower. At T2, mean scores were between 4-5 on only 6 of the 15 questions. The highest scores were recorded for 'Triple P resources', 'attending the Triple P training course', 'support from colleagues' and 'knowledge and skills in behavioural family intervention'. As seen above, the latter was considered one of the least helpful components at T1. At T2, the lowest scores were recorded for 'the programme's ability to be tailored to the needs of individual families', 'studies showing Triple P's effectiveness' and 'seeing observable change in children or families'. Since the participants in the samples could not be identified and since there were some of the same participants in both T1 and T2 samples, no statistical analyses were run on the comparisons presented above.

A 'total helpfulness score' was calculated. The practitioners' scores on the 15 5-point scales above were summed. The possible range of scores was 15-75. At T1, scores ranged from 42-75, with a mean of 64.22. At T2, scores ranged from 36-75, with a mean of 58.75. The data from the 'total helpfulness score' were used to compare the scores for Panel 1 and Panel 2 practitioners. The analysis shows that at T1 the Panel 1 participants scored significantly higher than the Panel 2 participants and the effect size was large: A Mann-Whitney U test revealed a significant difference in the total helpfulness scores of Panel 1 (Md = 73, n=8) and Panel 2 participants (Md = 58.5, n=12), U = 3.50, z = -3.451, p = .001, r = .772. Therefore, at T1 Panel 1 practitioners were significantly more likely to rate aspects of the programme as helpful (*see Figure 7.7*). The sample size at T2 was not large enough to run the same test, but as was the case at T1, the median scores of Panel 1 practitioners (Md = 69) was higher than Panel 2 practitioners (Md = 46) (*see Figure 7.8*).

Figure 7.7: Panel 1 and Panel 2 self-reported 'helpfulness' scores, at Time 1

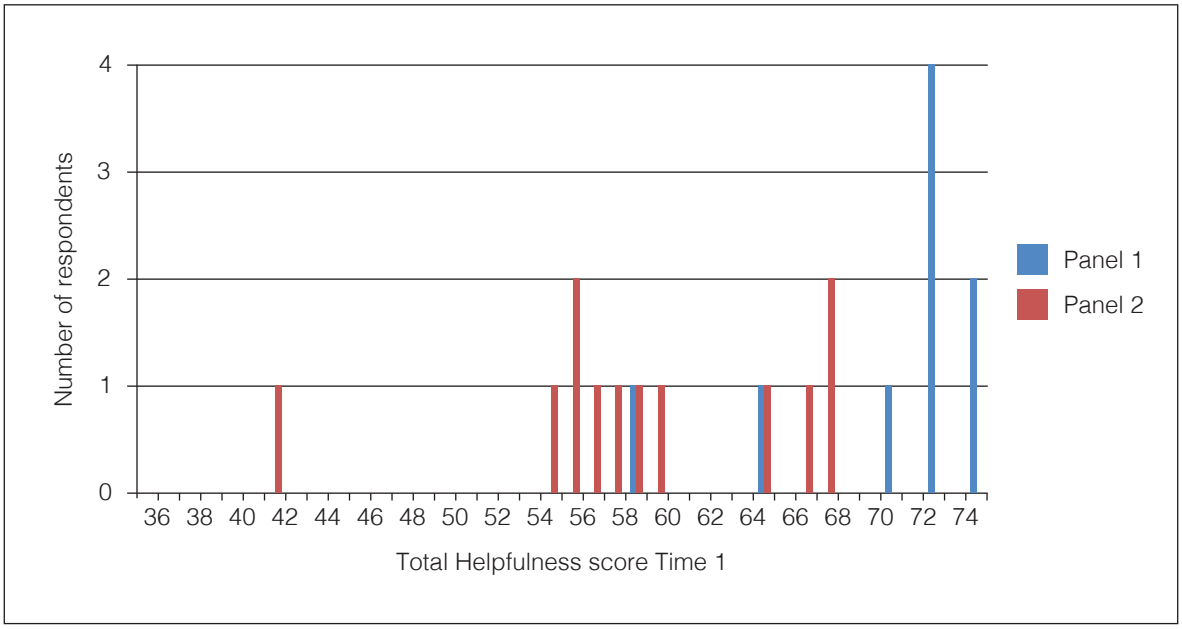
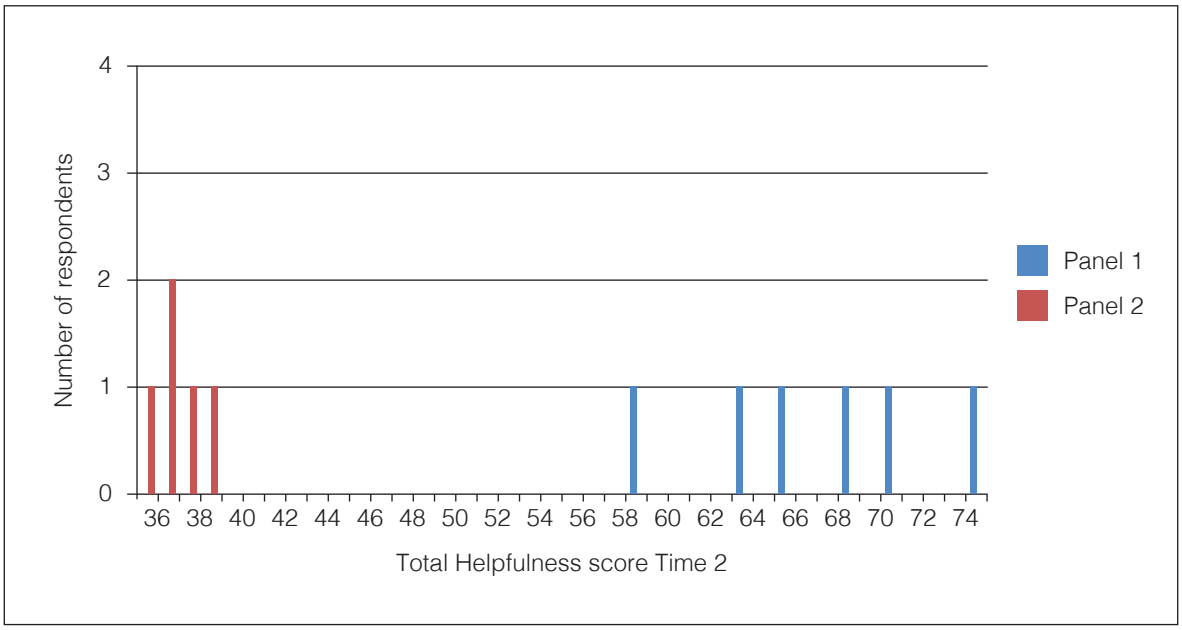


Figure 7.8: Panel 1 and Panel 2 self-reported 'helpfulness' scores, at Time 2



The participants in the focus group for Panel 2 PHNs expressed different views on whether there was compatibility between the Triple P approach to parenting and the conventional approach of PHNs. Some participants noted that in routine developmental checks, the PHNs are trained to look for milestones and also to impart their clinical knowledge to parents and in that way to *'educate'* and at times *'prescribe'* for parents. On the basis of their training as nurses, it is their responsibility to give advice and in that way to solve problems or show how they should be solved. For some participants, this was at odds with the Triple P approach and the centrality given to parents' self-regulation. This view – that there is a tension between approaches of PHNs and Triple P – was also expressed by Panel 1 practitioners in their focus group.

However, some PHNs did not believe that there was such a sharp distinction between the two approaches. Many of the focus group participants spoke of the need to *'encourage'* and *'promote'* good parenting, and also to encourage *'parents to take ownership'* and in this way, to lessen the stigma around receiving this support. Otherwise, there is the *'risk of losing them [parents]'* from the service altogether. In her interview, the Director of Public Health Nursing also drew attention to this difference – between the traditional PHN approach and what Triple P required – but she felt that making the transition from the former to the latter *'should not be a problem'* for PHNs. Finally, one Panel 1 facilitator with a background in nursing spoke of the need to make such a transition herself and the fact that she was *'trained to work in a different way'*.

7.3.7.3 Would practitioners change anything about the programme?

In the three focus groups with practitioners for this study, practitioners were asked what they would change about the Triple P Programme. Their comments related to the model of programme implementation adopted by LWPP rather than the programme itself.

The most significant concern was with the way in which parents were recruited. In the first focus group (2011), one practitioner said that their role should be to deliver the programme to parents, who in turn should be recruited through other channels. At this time, the practitioners believed that many referrals could and should come from PHNs.

In the first focus group (2011), Panel 1 practitioners also spoke of how *'stressful'* they found it to deliver the training sessions and also meet their targets, which were *'not realistic'*. They also highlighted the amount of time required in *'advertising and networking and inputting questionnaires'*. The participants expressed

concern about their lack of success in recruiting more parents: *'You can put all that work in and you feel so disheartened sometimes that you don't get the feedback.'*

The Project Management Team were asked whether the demands placed on Panel 1 practitioners were a challenge. Although the role may be made less onerous because of the positive feedback received and the immediate impacts observed in families, nonetheless, it was agreed that this was *'a very demanding role'* given the various responsibilities involved, including facilitation, mentoring, programme promotion, recruitment and data collection. Also, in the later focus group with Panel 1 practitioners (2013), the practitioners spoke of how much they had learned about programme delivery over the years and how their current efforts were more efficient and productive (*see Section 7.2.5*).

KEY FINDINGS: What were practitioners' views on the support they received?

- The amount of support practitioners reported receiving from LWPP and other practitioners varied and Panel 1 practitioners reported receiving more support than Panel 2 practitioners.
- Five of the 6 PHNs reported not having received any support, even though support meetings for PHNs were held monthly.
- While it is to be expected that Panel 1 practitioners would be in consultation more frequently than Panel 2 colleagues, nonetheless, the number of Panel 2 practitioners with no reported experience of consultation is noteworthy.
- Practitioners from Panel 1 and Panel 2 reported referring children and their families most frequently to a Triple P facilitator.

KEY FINDINGS: Practitioners' views on their own confidence and the helpfulness of the programme

- Practitioners reported high levels of satisfaction with administrative and clinical support.
- Being in Panel 1 significantly increased the likelihood of feeling confident as a facilitator, feeling supported in the workplace and perceiving various aspects of the programme to be helpful.
- During 2011, some Panel 1 practitioners reported feeling anxious and stressed due to the obligation to recruit parents and meet targets for the delivery of the programme. In later focus groups, practitioners indicated that much had been learned about how to improve programme delivery.
- Some PHN Panel 2 practitioners believed that the Workshop version of Level 3, because it was a once-off session, was more suited to their practice than the Primary Care version.
- Some PHNs believed that there was a tension between the Triple P principle of parents' self-regulation, on the one hand, and PHN practice, on the other, which is to give advice to parents based on their nursing experience and expertise. However, other PHNs believed that the role of the PHN was to help bring parents to a position where they were able to solve problems themselves.

7.3.8 What measures were put in place to ensure programme fidelity?

Fidelity to the Triple P Programme is one requirement of a 'strong partnership,' according to the LWPP Logic Model. Fidelity has been an important consideration throughout the implementation of Triple P, including prior to the evaluation period. During 2007, the LWPP minutes record that a 'method of quality control' was required. It was agreed that programme fidelity was to be ensured by the various partnership organisations themselves, but fidelity was also to be tackled by 'ongoing programme network meetings' and individual support contact with practitioners. Concern was expressed about the low number of practitioners attending support meetings and it was decided that line managers within each organisation were to encourage and ensure attendance.

During the evaluation period of 2011 and 2012, fidelity to the programme was to be ensured through a number of approaches:

- Panel 1 practitioners were to play an important role in ensuring fidelity. Although not a feature of previous implementations of Triple P in Brisbane and South Carolina, Panel 1 was created to solve *'what could have been ongoing difficulties around competence, frequency and fidelity'* (Project Management Team). Panel 1 practitioners have experience and expertise, act as mentors and provide supports to Panel 2 practitioners. In addition, Panel 1 and Panel 2 practitioners co-delivered the programme. Panel 1 practitioners also attended Area Team Meetings intended to support Panel 2 practitioners. Because of HSE restrictions on staff travel, attendance at support networks was to be made easier by holding separate meetings in Longford, Athlone and Mullingar.
- According to LWPP documents, fidelity to the programme was to be ensured in part through the accreditation of Triple P practitioners.
- Meetings of the Project Management Team and Panel 1 practitioners were intended as a further support for programme fidelity.
- Fidelity was to be ensured through ongoing support provided by Triple P International, including but not restricted to Skype calls attended by Panel 1 practitioners and the Project Management Team. It was planned to access these support mechanisms during the first year and then to phase them out so as to encourage programme sustainability. Consultation, support and technical assistance to be received from Triple P International were to include the following (Grant Proposal, p. 73):
    - organisational briefings to the project management team and panel 1 before the commencement of training;
    - consultation days for trained practitioners (Panel 1 and Panel 2) after training to support the practitioners' preparation for accreditation;
    - consultation days for trained practitioners after training to discuss implementation options and to review cases;
    - provision of strategic project support from senior Triple P UK management staff;
    - ongoing telephone and e-mail support throughout the first year of implementation to both managers and practitioners in both Longford and Westmeath.

Unlike other implementations of Triple P, there was no independent observation of sessions and no 'content fidelity checklist' completed by practitioners as part of a fidelity monitoring process (cf. Shapiro *et al*, 2010, p. 228). Therefore, there were no data collected for the express purpose of monitoring programme fidelity and as a result no such data were available to the Research Team to assess programme fidelity. This represents an important gap in terms of the information needed for the evaluation of programme implementation.

There were a number of different practice-related supports to promote ongoing fidelity and the Project Management Team have stated that co-delivery was a way in which Panel 1 practitioners could observe programme delivery by Panel 2 practitioners for the purposes of fidelity promotion. Data already presented on attendance at support meetings (*see Section 7.3.6*) can be seen as providing a proxy measure of fidelity. The data showed that meetings were held regularly for the Project Management Team, Panel 1 practitioners and Panel 2 practitioners. However, the data also indicated some absenteeism for these meetings, while findings in Section 7.3.7 have shown that practitioners in Panel 2 received far less support and felt less supported and less confident than those in Panel 1.

KEY FINDINGS: What measures were put in place to ensure programme fidelity?

- Ensuring programme fidelity was a key objective for partners from the outset. Fidelity was to be ensured by a number of means, including support from the Panel 1 practitioners (co-delivery, Area Team Meetings, mentoring), meetings of Project Management Team and Panel 1, the accreditation process, and finally the ongoing support to the Project Management Team and to Panel 1 practitioners provided by Triple P International.
- Data from questionnaires show variation in frequency of support received by practitioners and frequency of consultations with other practitioners.
- Data on the quality of programme content and delivery were collected from parents, who reported positively on the quality of facilitation and the content of the programme.
- Data on completion rates show that a high percentage of parents received the recommended number of sessions in Group Triple P.
- However, fidelity was not ensured through completion of a checklist by practitioners or through observation of sessions. Therefore, there were no data collected for the express purpose of monitoring programme fidelity and as a result no such data were available to the Research Team to assess programme fidelity.

7.3.9 Did parents receive the recommended programme dosage?

A further aspect of programme fidelity concerns whether participants in the programme received the recommended programme dosage. The recommended dosage is completion of the first 4 sessions. The Level 4 Group Triple P Programme consists of 8 sessions and the data on programme delivery can be used to examine whether the implementation of the programme was in line with the programme manual. The records show that at Level 4, of 807 participants where the information was recorded, the majority (85%, n=690) completed at least 4 sessions. A large minority completed either all 8 sessions (42%, n=126) or the first 7 sessions (26%, n=130) (*see Table 7.22*). For a large minority of parents, the only sessions missed were the telephone call sessions (34%, n=273). The Project Management Team believed that 'retention' within Level 4 was at a high level and the data give considerable support to that belief since only a minority of participants did not attend all 4 face-to-face Group sessions (14.5%, n=117). However, one area of concern is that only 144 reported having completed the follow-up telephone call (Session 9). This finding may be an artefact of uneven recording of data. The Project Management Team has stated that this information was not collected at all groups since the telephone calls were not originally part of the programme and when they were introduced, not all facilitators returned the information.

Table 7.22: Number of Level 4 sessions attended

Total number of sessions	Cumulative number of parents (n=807)	Cumulative percentage
1	60	7.4
2	37	12
3	12	13.5
4	19	15.9
5	36	20.4
6	83	30.7
7	213	57
8	339	99
9	8	100

1 = Received only 1 session; 9 = received all 9 sessions.

A further issue is the profile of those who did not remain in the programme. The concern here is whether some subgroups were more likely than others not to receive the recommended dosage. 'Non-completion' for Level 4 Group referred to:

(a) those who completed the Time 1 questionnaire only;
(b) those who completed less than 4 sessions.

Of those for whom data were collected, 53 dropped out and 467 remained in (a ratio of 1:8.81). Mothers (9%, n=41) were less likely to drop out of the programme than fathers (16%, n=12) (phi = .079, p = .072); older parents (7%, n=19) were less likely to drop out than younger parents (14%, n=33) (phi = .114, p = .010); and parents who had not experienced an inability to meet essential expenses in the preceding 12 months (9%, n=32) were less likely to drop out than those who had (14%, n=18) (phi = .079, p = .081) (*see Table A.28 in Appendix A.2*).

Parents who remained in the programme had received better scores for SDQ Total Difficulties Score (p = .046), SDQ Conduct Problems Sub-scale (p = .035), SDQ Inattention/Hyperactivity Sub-scale (p = .042), SDQ Impact Score (p = .085), the frequency of disruptive behaviours (Eyberg Intensity) (p = .000) and the number of disruptive behaviours that are a problem for the parents (Eyberg Problem) (p = .023).

Parents who remained in the programme had received better scores on the Parenting Scale for the Total score (p = .011), the Laxness Sub-scale (p = .010) and the Verbosity Sub-scale (p = .015). Parents who remained in the programme had received better scores on the DASS measure for the Depression Sub-scale (p = .006), the Relationship Quality Index (p = .017); and on the Parent Problem Checklist both for the number of problems (p = .010) and for the frequency of problems (p = .098) (*see Table A.29 in Appendix A.2*).

KEY FINDINGS: Did parents receive the recommended programme dosage?

- Retention of parents in Level 4 was high, with over half remaining until the penultimate or final session.
- Those who dropped out of Level 4 were more likely to be fathers, younger parents, parents experiencing financial difficulties and parents reporting higher levels of concern about child behaviour and parenting experiences.

8. Discussion

The Triple P – Positive Parenting Programme (Triple P) is a multi-level, public health approach to parenting. It was implemented in the Longford Westmeath region by a partnership comprising 9 organisations, the Longford Westmeath Parenting Partnership (LWPP). The Triple P Programme was targeted at parents of children aged 3-7 through the following four modes of delivery: Level 1 Media strategy; Level 2 Triple P Seminars (a series of 3 individual 90-minute presentations); Level 3 Workshop Triple P (a series of 4 individual 2-hour workshops); and Level 4 Group Triple P (an 8-week programme, including 5 2-hour group sessions and 3 one-to-one telephone sessions).

The evaluation of the Triple P implementation in Longford Westmeath was a multi-method, multi-stranded study with four components: (1) 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; (2) the Population Study used a quasi-experimental (non-randomised between-groups) design, with treatment and comparison counties, and analysed the population-level impact of Triple P; (3) the Partnership Study used qualitative and quantitative data to explore the success of the partners in establishing the partnership, supporting delivery of the programme and learning from adopting a partnership approach; and (4) the Implementation Study employed qualitative and quantitative data to analyse programme utilisation, organisation and fidelity.

In this chapter, the findings from the evaluation of the Triple P Programme in Longford and Westmeath are discussed. Each of the first 6 sections of this chapter addresses an over-arching objective of the evaluation and then discusses the findings from the current study in light of the relevant literature. The final section explores the strengths and limitations of the study.

8.1 What was the prevalence of need in the intervention counties?

For the success of a population approach, in the first instance 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 Study showed that households with children in the sample areas are 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%) is below the national level of 75% (CSO, Census, 2006) and entitlement to a medical card (approximately 50%) is higher than the national level of 36% (CSO, 2012). In the current study, medical card holders were more likely to have lower educational achievement, lower socio-economic status, difficulty meeting expenses and to live in rented accommodation.

In the Population Study, with regard to behavioural and emotional problems among children in the samples, the mean Strengths and Difficulties Score of 8.2 ± 5.5 is similar to that reported by a number of other studies in the UK, USA, China and Australia. The percentage of children in the current study with borderline to abnormal levels of symptoms on this scale (16%) 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.

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 was lower in the samples drawn from the population 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.

Data collected from participants in the programme also provide valuable information on prevalence. The Triple P Programme is universal and, therefore, is targeted at every family. However, Triple P is also preventative, and its aim is to 'prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents' (Sanders *et al,* 2005, p. 20). In addition, Group Triple P is targeted at 'high-risk' individuals or families (Sanders and Turner, 2005, p. 23). In the implementation of Triple P, LWPP did not screen parents for participation in the various levels. The intention was to allow parents to select the programme level that they felt best met their needs. Nonetheless, the question of the characteristics of the parents participating in the different levels (Group, Workshop and Seminars) remains important in evaluating the programme.

Across all levels of the programme, the average age of parents was between 36-38 and the majority of participants were married, female, born in Ireland, had received further education post-secondary school and were not in receipt of a medical card. Participants in Group Triple P were more likely to be in receipt of a medical card (39%) when compared with participants in the Seminars ('Power of positive parenting', 23%; 'Raising confident competent children', 27%; and 'Raising resilient children', 27%) and in the Workshops ('Dealing with disobedience', 33%; 'Managing fighting and aggression', 39%; and 'Developing good bedtime routines', 27%). The percentage of Group Triple P participants with a medical card was marginally higher than the national figure of 36%. Group Triple P participants also reported having insufficient money to purchase much of what they really wanted after essential expenses were paid. Parents attending Group Triple P also reported higher levels of need in terms of child conduct problems and the impact of child emotional and behavioural problems. The parents who attended Group Triple P and took part in the evaluation also reported higher levels of need for child conduct problems (M = 3.07, SD = 1.9) than the population of Longford and Westmeath in the Time 1 population survey (M = 1.77, SD = 1.7)

Therefore, the findings show that parents with higher levels of need were more likely to have participated in Group Triple P, while parents representative of the broader population were more likely to have participated in Workshop Triple P or Triple P Seminar. Although no screening was used in recruitment for Group Triple P, the programme was reaching its target population of children with emotional and behavioural problems.

8.2 What gains were made by programme participants for parent and child outcomes?

Improvements in child and parent outcomes associated with participation in the Triple P Programme were evaluated by measuring short-term and long-term gains for participating parents. The data provide empirical evidence for the success of the Triple P programme in an Irish context. Statistically significant gains were observed on measures of child behavioural and emotional problems, and parent strategies, experiences and opinions, and a statistically significant reduction in children categorised as borderline/abnormal for child emotional and behavioural problems. Short-term gains were observed at the completion of Group Triple P (at 8 weeks), as was the case in Brisbane (Sanders *et al,* 2005) and Western Australia (Zubrick *et al,* 2005), and after completion of the Workshops (at 6 weeks), and again similar findings to those reported in Brisbane (Joachim *et al,* 2010; Morawska et al., 2010). Long-term gains were observed 12 months after participation in Group Triple P, as was the case in Western Australia (Zubrick *et al,* 2005), and 6 months after participation in the Workshops, similar to findings reported in Brisbane (Joachim *et al,* 2010; Morawska *et al,* 2010). As these gains were associated with participation in the programme, this is vital for the sustainability of the project since one of the indicators of success for funders was that the project should lead to better support for families than had been available previously. The detailed findings on gains reported by participants in Group Triple P and in Workshop Triple P are discussed below.

8.2.1 Level 4 Group Triple P

The 'large' effect sizes in the current study can be interpreted alongside a recent meta-analysis of Triple P studies, which reported 'medium' effect sizes for participants in Group Triple P across 101 studies

(Parenting and Family Support Centre, 2013). These findings are important given that in one reported study no programme effects were observed (Little *et al,* 2012). The evidence shows the success of a universal programme for all families, including those with high baseline needs. Participants in Group Triple P reported higher levels of need prior to the intervention than did parents in the Workshops, with participants' mean score in the borderline/abnormal range for child conduct problems and the Strengths and Difficulties Impact score. 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. This provides further evidence for the success of a universal programme in targeting those with higher levels of need.

In the current study, improvements were observed after a 12-month period for the frequency and number of disruptive behaviours and for parental adjustment. The findings provide evidence for the long-term improvements experienced by parents who participate in Group Triple P. Similar results were reported from the Western Australia study. In a quasi-experimental, two-group longitudinal design, over a 2-year period participation in Group Triple P was associated with significant improvements in dysfunctional parenting and child behaviour problems (Zubrick *et al,* 2005).

The evaluation of Group Triple P in Brisbane also employed a within-group pre-test – post-test design (Sanders *et al,* 2005). Therefore, a direct comparison can be made between the effect sizes observed in the Brisbane study and in the current study (*see Table 8.1*). In both studies, participation in Group Triple P was associated with statistically significant improvements on both parent and child outcomes. However, while in the Brisbane intervention there were larger improvements primarily in regard to parenting experiences, practices and opinions (with the exception of the impact on child emotional symptoms), in the Longford Westmeath intervention there were larger improvements in both child outcomes and parent outcomes.

Table 8.1: Effect sizes for Group Triple P (within-group pre-test – post-test design) in Longford/ Westmeath and Brisbane

	Longford/Westmeath Cohen's *d*	Brisbane Cohen's *d*
SDQ Total Difficulties Score	1.510**	0.921**
Emotional symptoms#	0.611**	0.802**
Conduct problems	1.347**	0.936**
Hyperactivity	1.164**	0.383**
Peer problems#	0.466**	0.365**
SDQ Pro-social Scale	0.991**	0.677**
SDQ Impact Score	0.817**	0.546**
Parenting Scale – Total	1.992**	2.304**
Parenting Scale – Laxness	1.507**	1.126**
Parenting Scale – Over-reactivity	1.741**	1.798**
Parenting Scale – Verbosity	1.436**	2.034**
Problem Setting and Behaviour Checklist	1.328**	0.855**
DASS Depression Scale	0.745**	0.635**
DASS Stress Scale	0.885**	1.328**
DASS Anxiety Scale	0.598**	0.892**
Relationship Quality Index	0.429**	0.846**
Parent Problem Checklist – Problem	0.740**	0.846**

= Wilcoxon Signed Rank Test (non-parametric data).

** p<.01

Cohen's *d* values for the Brisbane study were calculated by the authors using the t values and sample size figures provided by Sanders *et al* (2005).

8.2.2 Level 3 Workshop Triple P

The Workshops were associated with improvements for children with behaviour problems, as well as for children scoring in the 'normal' range for child behaviour. The 'large' effect sizes observed in the current study can be interpreted in light of the recent meta-analysis of Triple P studies, which reported 'medium' effect sizes for parenting and child outcomes across 101 studies of Level 3, both for short-term and for long-term gains (Parenting and Family Support Centre, 2013). Although Workshops are designed for moderate levels of need and are less intensive than Group Triple P, nonetheless, for participants in Workshop Triple P in the current study there was a statistically significant reduction in children categorised as borderline/ abnormal for child emotional and behavioural problems. This provides further evidence for the success of a universal programme in targeting those with higher levels of need.

Although the evaluation of Workshop Triple P in Brisbane employed an RCT study design, it is possible to compare the areas where gains were made by parents in Longford Westmeath with those where gains were made by parents in Brisbane (Morawska *et al,* 2010). While the two studies reported positive outcomes for both the frequency and the number of disruptive behaviours, only the current study reported positive outcomes for parenting experience, namely for the following single item: 'How supported have you felt in your role as a parent?'

Long-term gains (i.e. 6 months) associated with Workshops were reported in the two Brisbane studies discussed above and in the current study. In each study, long-term improvements were measured using a within-group pre-test-follow-up design and similar results were observed in each study (Joachim *et al,* 2010; Morawska *et al,* 2010). In all three studies, the findings provide evidence for long-term improvements for both the frequency and the number of disruptive behaviours. In the two studies where the outcome was measured, significant gains were made for parenting experience: long-term gains were observed on a total parenting experience score in the Brisbane study, while in the current study long-term gains were observed for the following single item: 'How supported have you felt in your role as a parent?'

Was the programme equally effective for all groups?

Although there were some differences in outcomes for different subgroups, the findings do not suggest that Triple P was only appropriate for some parents and not for others. The 'Dealing with disobedience' workshop was more effective on some outcomes for mothers, parents of girls and younger parents, while Group Triple P was more effective on one outcome (SDQ Pro-social Sub-scale) for younger parents and parents from the lowest socio-economic group. However, it should be noted that these differences were observed on only a minority of outcomes and therefore do not suggest a strong or consistent variation in the effectiveness of Workshop Triple P or Group Triple P. Also, the findings do not suggest that previous exposure to the programme was a reliable indicator of the improvements associated with Triple P. Attendance at another Triple P component did not have an impact on the gains associated with Workshop or Group Triple P.

In the evaluation of Group Triple P, there were some differences in socio-demographics and child and parent outcomes between those who did and did not complete both the pre- and post-questionnaires. Those who remained in the study were older ($p<.01$). They reported lower levels of child problems for the frequency of problematic behaviours ($p<.01$) and the number of perceived problematic behaviours ($p<.01$). They also reported better scores for parenting laxness ($p<.05$) and parenting verbosity ($p<.05$), and also for parental depression ($p<.01$), parental stress ($p<.05$) and parental anxiety ($p<.05$). Therefore, the positive results for programme participants must be set against the difference in profile of responders and non-responders.

In the evaluation of Workshop Triple P, differences between responders and non-responders were observed on only one variable and therefore this has little bearing on the interpretation of findings. Those who remained in the evaluation were more likely to find parenting depressing ($p<.01$).

8.3 Was the Triple P programme effective at the population level in reducing child behavioural and emotional problems and negative parental strategies, experiences and opinions?

For the success of a population approach, 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 group, from two intervention counties and two comparison counties. In order to demonstrate a positive population impact, the intervention must have a more positive effect than any change found between the population surveys conducted in the comparison counties. Change at this level (the population level) is particularly valuable because it links the actions of the intervention to change across the broader population and not just limited to those parents who took part directly in the various levels of Triple P. The data collected show a number of significant impacts at the population level in 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.

On child outcomes, effects were observed on the Total Difficulties score on the SDQ and for the sub-scales for emotional symptoms and pro-social behaviours. These findings are coherent with similar population-level improvements found by Sanders *et al* (2008) in a population-level study among 4-7 year-olds in Australia. As in the current study, these authors also found no significant impact on the mean values for the child behavioural sub-scales on hyperactivity, conduct problems and peer relationship difficulties. Sanders *et al* (2008) suggested that the lack of changes in these sub-scales may have been due to the majority of parents sampled in their study having been exposed to 'light touch' interventions of the Triple P Programme. This 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 other levels of the programme. However, it is of considerable interest to note that when the group of interest is taken to comprise those most in need – those who report either abnormal or borderline levels of strengths and difficulties – the current study has identified a significant positive population impact on 4 of the 5 possible sub-scales (i.e. emotional symptoms, conduct problems, hyperactivity and peer problems) and on total difficulties. These are more positive findings that those reported by Sanders *et al* (2008), who reported a positive population impact for only emotional symptoms and total difficulties. These improved impacts in the Irish study may be related to the context of implementation or indeed to the differences in the approach taken to partnership within the implementation strategy and certainly deserve further consideration. If these findings were maintained over time, such reductions in caseness may lead to a reduction in demand for services. This suggests potentially substantial impacts on service delivery issues, including resource requirements and improved service quality for those in need.

There were also significant impacts at the population level for parenting strategies, with higher scores in the intervention counties for the likelihood of using appropriate discipline and appropriate discipline for anxious behaviour. Sanders *et al* (2008) have highlighted the importance of positive changes in these factors in light of the Triple P Programme's advocacy by Sanders and Cann (2002) as a prevention strategy for the maltreatment of children. Subsequently, Prinz *et al* (2009) have demonstrated a population-level preventative impact of the Triple P Programme on child maltreatment in an 18-county population trial in the USA. 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 counties. Parental functioning, partially measured in the current study as the level of parental psychological distress, reflects similar improvements to those demonstrated by Sanders *et al* (2008) in parental depression levels. Similar positive impacts were found both when analysing mean scores over time across the intervention and comparison counties, and also when looking at 'caseness' or rates of high level of parenting need. In addition, significant

improvements in rates of 'caseness' were identified for feeling stressed and feeling supported, and for consistent parenting, engaging in parental responsibilities and having appropriate opinions on smacking and parenting. These significant reductions in the population percentages reporting a high level of parenting need may well translate into reduced risk of child maltreatment (Prinz *et al,* 2009), but such a claim would require to be explicitly tested in the Irish context.

Finally, and important for issues of sustainability, significant population impacts were identified for help-seeking, specifically for satisfaction with parenting information and services, and likelihood to engage in future help-seeking. Taken together, these findings support a positive population-level impact of the multi-level intervention, in line with that proposed in the initial logic model.

8.4 How successful was the use of a partnership approach to the implementation of an evidence-based programme using a population approach?

A population approach involves the use of multiple settings, disciplines and service modalities. A partnership approach was chosen in Longford Westmeath so as to engage a wide range of service providers and in that way to better recruit parents. The partnership approach was successful in first establishing LWPP and also the initial implementation of the Triple P Programme. Although some representatives outside of the HSE felt that their contribution was limited, most identified the added value in having Statutory, Community and Voluntary sector organisations involved in the partnership. According to partner representatives, partnership working increased programme reach and acceptance, ensured population-wide coverage, improved 'networking' between agencies and enhanced the value of individual partners' work. The representatives believed that partnership was necessary for the success of a population approach. While Statutory, Community and Voluntary sector partners helped recruit parents and de-stigmatise the parenting programme, the involvement of the HSE was needed to secure the trust of parents. Both are needed for a population approach that is aimed at both the 'reduction of prevalence rates' for child and family problems and also reaching 'many segments of the community' in non-stigmatising ways (Sanders and Prinz, 2008, p. 131). In addition, the good quality of relationships between the partners and the positive roles played by both the Chair and the Project Director were important for the successful implementation of Triple P.

A key strategy for the partners was to establish a Memorandum of Understanding (MoU) and this proved to be successful. According to partner representatives, the MoU had value not just as a text that was referred to, but rather as 'a living document.' The example offered was the way that partners 'worked together' to agree changes to the commitments that were required because of increasing resource constraints. The MoU was used to help identify potential areas of conflict and was 'process driven' for each issue, and therefore was seen as an 'objective' way to proceed. While good working relations and an effective MoU enabled partner organisations to re-negotiate their commitments to deliver the programme, in part as a result the scale and level of programme delivery by partner organisations varied considerably.

The literature suggests that the successful delivery of the Triple P Programme 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). This study found evidence of considerable success in training staff for the delivery of Triple P, but the engagement of partners in delivery was uneven and some partner organisations delivered less than they had committed to. The findings show that the partnership was less successful in its attempts to involve certain professions and disciplines as direct providers of Triple P. For one professional group, this was explained by a perceived tension between the Triple P model and their own approach to parenting interventions. As the literature shows, professionals can have a different mode of understanding and intervening in the world (Frost, 2005) due to subtle, but significant differences in professional culture, linguistic conventions and ethical practices (Johnson *et al,* 2003; Horwath and Morrison, 2007). Other partners reported that they were unable to release staff to deliver Triple P because of funding cutbacks in their agency, which is one of the key challenges of any partnership (Johnson *et al,*

2003). Ensuring that all partners contribute what is expected of them is a common feature of partnerships and interagency working can be hindered by an insufficient commitment from services and staff to work together (Valentine *et al,* 2006).

The level and quality of partnership working is closely associated with the success of a population approach. While partner representatives believed that partnership working increased programme reach and acceptance and ensured population-wide coverage, 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).

8.5 To what extent did programme delivery attain required objectives and what obstacles/barriers to implementation of the programme were identified?

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 as 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).

Different programme delivery targets were set for the different Triple P levels. This was a direct result of the principle of 'programme 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). For that reason, the Project Management Team planned that the level of Triple P suited to parents with higher needs (Group Triple P) would be offered to fewer parents than those levels suited to parents with lower needs (Seminars and Workshops). Over the course of the evaluation, Workshops were delivered to 12% of parents with children aged 3-7 in the intervention counties and Group Triple P was delivered to 8%. (These figures do not include those who participated in the programme, but did not have children in the target age range.) However, the partners did not meet programme delivery targets for Seminars and Workshops, although they exceeded targets in the delivery of Group Triple P.

The partners also had planned that each Panel 1 practitioner would have a greater role in programme delivery than each Panel 2 practitioner. The findings show that some Panel 2 practitioners reported work-related barriers to the delivery of Triple P, which were also found in the evaluation of the Brisbane implementation (Sanders *et al,* 2005, p. 64), that fewer Panel 2 practitioners were engaged in programme delivery than was planned, and that Panel 2 practitioners engaged less in delivery where targets were not met (i.e. Seminars and Workshops). As Sanders *et al* (2005, p. 56) have noted, it is 'a complex task' to ensure the engagement of the available workforce from different disciplines and agencies required by a population-based approach. However, the Project Management Team have stated that practitioners need considerable experience in programme delivery before they will have the capacities needed to successfully deliver the Seminars and that Panel 2 practitioners' commitment in terms of hours to be spent delivering Triple P is less than what is required to develop the necessary levels of experience. Delivery by Panel 2 practitioners also will be affected by many factors such as organisational readiness and commitment, the suitability of the programme to the practitioner and the opportunities for delivery.

The aim of the media strategy (Level 1 Triple P) 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 children and 'preventing the development of adverse outcomes' (Turner *et al,* 2005, p. 20). The findings suggest that parents were most likely to hear about the programme from professionals connected in some way with programme delivery and also from other parents who had attended the programme. Fewer reported that the Triple P newspaper, the Tippaper, was a source of initial information, and the figure varied between a high of 15% of participants in the 'Raising resilient children' seminar who completed

questionnaires, to lows of 6% and 7% of participants in other workshops and seminars. Both parents and practitioners also were critical of the 'Stay Positive!' posters used in the media strategy. However, Panel 1 practitioners believed that they had learned a great deal about awareness-raising, recruitment and programme delivery, and that these lessons were to be used in the further roll-out of the programme. In addition, 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.

The implementation of Triple P in Longford Westmeath was facilitated considerably since 2010 by a Programme Coordinator, Panel 1 practitioners and also a broader Core Team. As Fixsen *et al* (2009, p. 536) 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.

There was considerable evidence that the LWPP Triple P Programme was well organised. Both parents and Panel 1 practitioners had a very positive experience of the programme. 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. In addition, Panel 2 practitioners reported feeling less supported and less confident as Triple P facilitators. The role for Panel 2 practitioners was limited because of the innovation in Longford Westmeath in creating a 'Panel 1' of practitioners. However, as Panel 2 practitioners are still expected to play a role, then successful implementation requires facilitator confidence and support for implementation among this group of practitioners (Shapiro *et al,* 2010, p. 228). In addition, some Panel 2 practitioners believed the Triple P principle of parental self-regulation was at odds with the practice of giving advice on the basis of clinical expertise. Therefore, Panel 2 practitioners require greater clarity about the compatibility of Triple P with their professional training.

Fidelity is important because the programme may do agencies, families and the field a 'disservice' if there is significant programme 'drift' (Sanders and Prinz, 2008, p. 131-32). Triple P's 'self-regulation framework' places responsibility for ensuring fidelity on the 'adoptive organisation' (*ibid*). Fidelity was to be ensured through a number of means, including accreditation, mentoring of Panel 2 practitioners by Panel 1 practitioners, co-delivery of sessions, support from Triple P International, clinical and administrative support from LWPP and support meetings. 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 (85%) and for a large minority of parents, the only sessions missed were the telephone call sessions (34%). Parents also were highly satisfied with the Triple P Programme overall. They reported the highest levels of satisfaction for the Seminars, followed by Group Triple P. These satisfaction levels were higher than those reported in Brisbane for Group Triple P and for Seminars (Sanders *et al,* 2005). Parents also praised the high-quality facilitation. This supports the finding that the programme was delivered to a high quality. Parents also valued the various ways in which they were encouraged to self-regulate: to set their own targets, to be consistent and to avoid the escalation trap. Practitioners also believed the programme was successful, in part because it encouraged parents to self-regulate and children to be problem-solvers.

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, there were no data collected for the express purpose of monitoring programme fidelity and as a result no such data were available to the Research Team to assess programme fidelity. This represents an important gap in terms of the information needed for the evaluation of programme implementation. In addition, although supports were offered by LWPP, Panel 2 practitioners were not as well supported and did not feel as confident as Panel 1 practitioners. Given that

Triple P played a far smaller role in the professional lives of Panel 2 practitioners than Panel 1 practitioners, differences in confidence levels are to be expected. For the same reasons, however, Panel 2 practitioners may have higher support needs in some areas than Panel 1 practitioners. A key finding from this evaluation is that, in order to prioritise fidelity, the Project Management Team should place greater emphasis on the supports targeted at Panel 2 practitioners and should also introduce a system to record ongoing fidelity monitoring.

8.6 Has the partnership succeeded in its objective to utilise what is learned from the Triple P Longford Westmeath implementation in order to promote the further roll-out of population-based programmes to other counties?

The application of learning about implementation and partnership is central to the sustainability of the project. Funders have stated that indicators of success include evidence that Triple P can be transferred to the Irish context and that there is potential for replication of this model of programme implementation.

The lessons learned from programme implementation and partnership in Longford and Westmeath have been applied to the replication of the programme by the new partnership in Laois and Offaly. A key finding is the importance of a Core Team for successful implementation, including the role of Programme Coordinator as well as a group of dedicated Panel 1 practitioners. The Core Team also have created information packs based on their learning from the Longford Westmeath implementation and these are being used to support and inform implementation in Laois and Offaly. One lesson learned from Longford Westmeath is that the Triple P Programme was not suited to all those trained to deliver it. On the basis of this learning, the partners in Laois and Offaly have decided to interview potential Panel 2 practitioners before they are accepted for training.

A further proposed development in Laois and Offaly is the establishment of a two-tier partnership, where 'core' partners provide staff for programme delivery and the second tier of 'associative' or 'supporting' partners will be expected to make other contributions instead. The proposed development does raise two important issues. Partners should be aware of what is expected of them and roles and responsibilities must be clearly identified (Duggan and Corrigan, 2009; Williams *et al,* 2003). The explicit adoption of a two-tier approach may improve clarity around roles, expectations, responsibilities and accountability. However, in replicating the project it is important to consider that perceived differences in status and power among agencies can affect relationships (Milbourne, 2005) and that interagency working can be hindered by an insufficient commitment from services and staff to work together (Valentine *et al,* 2006). In addition, the findings from this evaluation indicate that better engagement by all partner organisations within the partnership and better engagement by Panel 2 practitioners in programme delivery are required to sustain the partnership and to meet programme delivery targets.

A further consideration relevant to project replication is the support required from funders. Funders indicated that one measure of the success of the partnership was evidence that the programme was effective at the population level, which this evaluation has provided. Funders also indicated that a further measure of the success of the partnership was the continued support of the statutory sector. Members of the Project Management Team also noted that this was an important consideration for the future viability of the partnership.

8.7 Study limitations and strengths

No control group in the Parenting Study

In the Parenting Study, the evaluation of Group Triple P and Workshop Triple P was a quasi-experimental pre-test – post-test within-groups design (Shadish *et al,* 2002, p. 108). As the study did not include a control

group and random allocation of participants, conclusions cannot be inferred with confidence about causality and 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 (as recommended for this type of quasi-experimental design – Shadish *et al*, 2002, p. 110), it is reasonable to infer that changes reported by parents were associated with their participation in the programme.

Strong ethical grounds existed for the choice of study design in this evaluation. Other evaluations of Triple P had shown that the programme was effective in other settings and had done so using a randomised controlled trial design. Therefore, there was sufficient evidence to assume the programme would be beneficial for participating parents. It follows there were strong grounds not to carry out a study that allocated some participants to a control group whose members would have been denied a promising programme.

Design of the Population Study

Similar limitations apply to the quasi-experimental approach taken to the design of the Population Study. While a comparison group was included, this is not the same as a control group with random allocation to conditions and this means that care must be exercised in the interpretation of findings. Nevertheless, considerable care was taken in the choice of the comparison counties and all socio-demographic inequalities within samples have been taken into account in the analyses presented. The sampling design, which involved clustering at local levels, presented some challenges to analysis and interpretation, primarily because taking this approach meant that the data points were not independent of one another. Nevertheless, and as noted in Section 5.1.1, on analysis of the Population Study data, the inter-cluster correlations were generally less than 5% and thus the data were treated as independent. Finally, given that the comparison counties were geographically adjacent to the intervention counties, it is likely that there was some exposure to the intervention in the comparison counties – and this can be seen in the levels of exposure reported in the population survey at Time 2. However, the exposure was not so substantial as to threaten the utility of the comparison group for the purposes of evaluation.

Non-participation in Partnership Study

As noted in Chapter 6, some partner representatives did not take part in interviews for the Partnership Study. This raises issues concerning the representative nature of the sample of participants. It also raises issues about the reasons why some partner representatives did not take part in the research or did so less frequently than others. The Research Team spoke to two representatives about this issue and different reasons were given for their non-participation: one no longer saw themselves as a partner due to workload pressures and the other claimed to have had 'a limited role' in the partnership. Chapter 6 also reported that the percentage of Statutory, Community and Voluntary sector partners who participated at T4 (25%) was lower than at previous time points, but no definitive reason could be provided to explain this change in partners' engagement with the research. It is not possible to say whether it was explained by research fatigue or that it was an indication of the level of engagement with the partnership.

Data on programme fidelity

The literature supports the view that fidelity to the programme is a crucial requirement of a successful programme (Sanders and Prinz, 2008). However, as seen in Section 7.3.8, fidelity was not ensured through completion of a checklist by practitioners or through a written record of the observation of sessions. Therefore, there were no data collected for the express purpose of monitoring programme fidelity and as a result no such data were available to the Research Team to assess programme fidelity. This represents an important gap in terms of the information needed for the evaluation of programme implementation. However, a number of other sources of data were available and could be used to provide strong indications of the quality of programme delivery. Data on the quality of programme content and delivery were collected

from parents, who reported positively on the quality of facilitation and the content of the programme. Data on completion rates show that a high percentage of parents received the recommended number of sessions in Group Triple P. In addition, documentary data were available on efforts made by the Project Management Team to ensure fidelity through a number of means, including accreditation, mentoring of Panel 2 practitioners by Panel 1 practitioners, co-delivery of sessions, support from Triple P International, clinical and administrative support from LWPP and support meetings.

9. Conclusions

This concluding chapter reflects on the partners' success in attaining their aims and objectives, before drawing out the implications of the findings for practice and for policy.

In summary, participation in Triple P was associated with statistically significant gains for child and parent outcomes. The implementation of Triple P in the two intervention counties (Longford and Westmeath) led to statistically significant gains on child and parent outcomes for the whole population when compared with the two comparison counties (Laois and Offaly). The partners were successful in establishing LWPP and implementing the Triple P Programme. The partners met and exceeded targets for the delivery of Group Triple P. Parents expressed positive views about the quality of programme delivery, as well as speaking with other parents about Triple P and passing on parenting tips. Practitioners believed the programme was successful.

9.1 To what extent has the partnership succeeded in attaining its aims and objectives?

The partners agreed a number of 'key high-level aims' and 'strategic objectives' which are reflective of the logic model for the programme implementation. The partnership had considerable success in attaining its aims and objectives. Key points in this evaluation include:

1. This evaluation contributes to the first aim of establishing the prevalence of parent-reported emotional/behavioural problems for their children and parenting confidence levels.

   The results of the Population Study show the need for parenting support programmes such as Triple P in the intervention counties and that this need is consistent across socio-economic groups.

2. The parenting data show the partners were successful in achieving their aim of 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.

3. The population data collected demonstrate a population effect of the overall intervention on children's problems and on parenting outcomes.

   There was also a population effect for those with the highest levels of need since there was a significant difference between intervention and comparison counties in the proportion (number per 100 families) of abnormal or borderline cases.

4. This study also meets the aim of evaluating the use of an interagency approach to implement an evidence-based programme using a population approach.

   The evaluation shows the partners developed an integrated and collaborative approach to service delivery that maximised the use of all core competencies among the partnership members. They also made considerable progress in implementing the necessary structures and processes within the collaborative initiative to enable the achievement of agreed strategic objectives.

   This study has found that better engagement by all partner organisations within the partnership, and better engagement by Panel 2 practitioners in programme delivery, would be required to sustain the partnership and to meet programme delivery targets. In this respect, reliance on Panel 1 practitioners for the majority of programme delivery proved to be a limitation. However, this group of confident and committed practitioners can also be said to be responsible for successful programme implementation and positive outcomes at the level of participating parents and the wider population.

5. Substantial success was enjoyed in delivering clear and coherent messages to all stakeholders in relation to the role, remit and capacity of the collaborative initiative, in particular the acknowledgement that all core partners should provide staff to deliver Triple P.

   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 required for a partnership to prosper.

6. The partners ensured that the training requirements of all associated staff were met and exceeded where possible.

   One area where the partners have made innovations based on learning from the Longford Westmeath implementation concerns the selection of staff for training. The partners believed that some of those trained to deliver Triple P were not well placed to do so and that in the Laois and Offaly partnership, potential practitioners will be interviewed before they are accepted for training.

7. The partners successfully coordinated a media and information strategy focused on promoting positive parenting and healthy family relationships in target areas, including enhanced awareness of childhood social and emotional problems.

   Notably, the evaluation found that parents and practitioners did not react well to the 'Stay Positive!' posters and that parents were more likely to hear about the programme from informal sources and those involved in programme delivery than directly through the Triple P media strategy.

8. The evaluation shows the partners successfully met the aim of implementing a community-based intervention focused on reducing childhood emotional and behavioural problems, and improving parents' sense of confidence and competence.

9. The positive views expressed by 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, an objective checklist is required that takes into account both programme content and process.

10. Finally, this study contributes to the objective of designing and constructing an Irish evidence base for Triple P that influences and facilitates the planning of future associated services.

    The partners have 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 to other counties.

    The partners have also succeeded in advancing the sustainability of the collaborative initiative through a range of targeted and focused measures, as evidenced by the roll-out of the initiative in Laois and Offaly.

9.2 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.

9.3 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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Appendix A – PARENTING STUDY

Appendix A.1: Data checking – Parenting Study

Group Triple P data checking

Data entry corrections

The datafile has been corrected of any mistakes found during the data check. In total, 142 random questionnaires of the total 712 Booklet 1 questionnaires were checked, and 108 of the 533 Booklet 2 questionnaires were checked. None of the booklets for Time 3 were checked, but there are data entered for 76 participants.

Table A.1: Number of booklets checked

Summary	Total	Checked
Booklet 1	712	142
Booklet 2	533	108
Booklet 3	76	0

Missing values

The data was manually entered into the datafile, taking into account the rules and protocols of dealing with missing data. Missing values analyses were conducted. As can be seen from Table 5, the missing data is less than 10% across all but three variables (age and gender of child number 4 and 6).

Ranges and distribution

The ranges of all variables have been checked, and are correct; see Table 6. Normal distribution was assessed for all data. A number of variables reached above the cut-off of .80, indicating non-normal distribution. These are highlighted in bold.

Cronbach's alpha was calculated to determine the internal reliability of each of the scores. The majority of variables reached the required level (Cronbach's $\alpha = .80$).

Calculations

The total and mean sub-scales of all the questionnaires were recalculated in SPSS, and checked against those that were calculated by hand. For the most part, the manually calculated scores were correct. Those that did not match were changed. There are a number of problems with the Parenting Problem Checklist (e.g. those who were single parents were not entered correctly or the scores for intensity and problems were switched). These changes have all been made.

Child's age was calculated by subtracting the assessment date from the child's date of birth. There are 7 questionnaires that did not enter in child's age, so these cannot be calculated.

Table A.2: Sample Size and Missing Values – Group Triple P

Variable	N	Missing	%
Age Parent 1	697	12	2.10
Gender	710	2	0.30
Age Parent 2	556	36	6.10
Gender	595	0	0.00
Marital Status	707	5	0.70
Education	704	8	1.10
Internet access	691	1	2.90
Medical Card	691	21	2.90
Work	700	12	1.70
Expenses	685	27	3.80
Money over	678	34	4.80
Child's gender	709	3	0.40
Relationship to child	710	2	0.30
No. of parents	709	3	0.40
Child's age	705	7	0.10
No. of children	704	8	1.10
Siblings	703	9	1.30
Brothers	701	11	1.50
Sisters	701	11	1.50
Child Age 1	541	10	1.80
Gender	545	6	1.00
Child Age 2	248	6	2.40
Gender	250	2	0.80
Child Age 3	71	1	1.40
Gender	71	1	1.40
Child Age 4	14	3	17.80
Gender	14	3	17.80
Child Age 5	2	0	0.00
Gender	2	0	0.00
Child Age 6	1	0	0.00
Gender	0	1	100.00
Triple P Knowledge			
Friend	697	15	2.10
Teacher	697	15	2.10
Religious	697	15	2.10
GP	697	15	2.10
Childcare	697	15	2.10
Pre-school	697	15	2.10
Radio	697	15	2.10
Newspaper	697	15	2.10
Website	697	15	2.10
Other Internet	697	15	2.10
Triple P paper	705	7	1.00

Table A.3: Psychometric Properties of the Demographic and Psychological Variables – Group Triple

Variable	n	M	SD	α	Range Potential	Actual	Skew
Booklet 1 (N=712)							
SDQ (Strengths and Difficulties Questionnaires)	699	12.64	5.99	–	0-40	0-34	0.68
Emotional Symptoms	699	2.64	2.64	.66	0-10	0.10	**0.95**
Conduct Problems	700	3.11	1.90	.62	0-10	0-10	0.75
Hyperactivity	700	4.78	2.59	.75	0-10	0-10	0.40
Peer Problems	700	2.10	1.83	.56	0-10	0-10	**1.05**
Pro-social Behaviour	699	7.09	1.98	.68	0-10	0-10	-0.57
ECBI (Eyberg Child Behaviour Inventory)							
Total	681	116.03	34.17	.94	36-252	37-228	0.49
Problems	657	12.86	8.03	–	0-36	0-36	-0.46
Mean Parenting Score	706	3.32	0.66	–	1-7	1-6.09	0.30
Laxness	706	3.13	0.99	.83	1-7	1-6.30	0.13
Over-reactivity	706	3.12	0.94	.78	1-7	1-6.30	0.13
Verbosity	706	3.88	0.76	.27	1-7	1.43-6.43	0.06
DASS (Depression-Anxiety-Stress Scales)							
Depression	707	6.18	8.01	.95	0-42	0-41	**2.40**
Anxiety	706	4.28	6.27	.92	0-42	0-41	**2.35**
Stress	706	11.05	8.52	.93	0-42	0-41	0.54
PSBC (Problem Setting and Behaviour Checklist)	685	207.77	40.88	.95	0-280	39-280	-0.38
PPC (Parent Problem Checklist)							
Total Intensity	601	32.70	14.97	.96	16-112	16-88	**1.29**
Mean Intensity	601	2.04	0.93	–	0-16	1-5.50	**1.33**
Total Problems	601	5.30	3.77	–	0-16	0-16	0.59
RQI	624	36.20	9.09	.94	6-45	6-45	**-1.69**
Booklet 2 (N=533)							
SDQ (Strengths and Difficulties Questionnaires)	528	8.96	4.92	–	0-40	0-29	0.58
Emotional Symptoms	528	1.72	1.75	.61	0-10	0-8	**0.95**
Conduct Problems	528	2.04	1.54	.54	0-10	0-7	0.64
Hyperactivity	528	3.67	2.19	.73	0-10	0-10	0.60
Peer Problems	528	1.50	1.52	.48	0-10	0-8	**1.23**
Pro-social Behaviour	528	7.97	1.72	.65	0-10	2-10	**-0.83**
ECBI (Eyberg Child Behaviour Inventory)I							
Total	518	2.82	27.46	.93	36-252	36-198	0.35
Problems	501	6.42	6.55	–	0-36	0-29	1.11
Parenting Scale	534	2.63	0.74	–	1-7	1-5.23	0.36
Laxness	534	2.43	0.89	.85	1-7	1-5.36	0.62
Over-reactivity	534	2.36	0.90	.83	1-7	1-5.30	0.79
Verbosity	534	3.16	0.90	.58	1-7	1-5.57	0.03
DASS (Depression-Anxiety-Stress Scales)							
Depression	535	2.95	5.29	.94	0-42	0-40	**3.50**
Anxiety	535	2.28	4.54	.91	0-42	0-36	**3.87**
Stress	535	6.03	5.90	.92	0-42	0-38	**1.24**

PSBC (Problem Setting and Behaviour Checklist)	527	234.31	42.14	.98	0-280	3-280	**-1.85**
PPC (Parent Problem Checklist)							
Total Intensity	475	25.95	11.97	.94	16-112	16-99	**2.07**
Mean Intensity	474	1.63	0.79	–	0-16	1-9	**3.43**
Total Problems	475	3.15	3.38	–	0-16	0-16	**1.19**
RQI (Relationship Quality Index)	477	38.69	7.40	.95	6-45	6-45	**-2.17**
CSQ (Client Satisfaction Survey)	532	79.30	9.37	.91	13-91	34-91	**-1.00**

Non-normal distributions are indicated in bold.

Workshop Triple P Data Checking

Data entry corrections

The datafile has been corrected of any mistakes found during the data check. In total, 175 random questionnaires of the Booklet 1 questionnaires were checked, and 83 Booklet 2 questionnaires were checked. Seven of the booklets for Time 3 were also checked. The booklets were representative of the differing numbers of participants in each of the four different workshops. For example, of the 175 (out of 863) checked in Booklet 1, 123 (out of 593) were dealing with disobedience, 32 (out of 170) were managing fighting and aggression, 3 (out of 11) were hassle free shopping, and 17 (out of 89) were the developing good bedtime routines workshop.

Table A.4: Percentage of booklets checked

Summary	Total	Checked	%
Booklet 1	863	175	20.30
Booklet 2	388	83	21.40
Booklet 3	34	7	20.60

Calculations

The total and mean sub-scales of all the questionnaires were recalculated in SPSS, and checked against those that were calculated by hand. For the most part, the manually calculated scores were correct. Those that did not match were changed. These changes have all been made.

The assessment date was added into the datafile, and the target child's age was calculated by subtracting the assessment date from the child's date of birth. There are 15 questionnaires that did not enter in child's age, so these cannot be calculated. A variable indicating whether Booklet 3 was completed (Yes/No) was also included in the datafile.

Missing values

The data was manually entered into the datafile, taking into account the rules and protocols of dealing with missing data. Missing values analyses were conducted. As can be seen from Tables 2 and 3, missing data is less than 15% across all variables.

Ranges and distribution

The ranges of all variables have been checked, and are correct, see Table 4. Normal distribution was assessed for all data. A number of variables reached above the cut-off of a skew value of greater than .80, indicating non-normal distribution. These are highlighted in bold.

Cronbach's alpha was calculated to determine the internal reliability for the total child's behaviour (ECBI) and Client Satisfaction Questionnaire (CSQ). All of these variables reached the required level (Cronbach's $\alpha = .80$).

Table A.5: Sample Size and Missing Values – Workshop Triple P

Variable	N	Missing	%
Workshop	862	1	0.10
Parent age	788	75	8.70
Parent gender	863	0	0.00
Country of origin	863	0	0.00
Marital status	860	3	0.30
Education	848	15	1.70
Medical card	854	9	1.00
Work	852	11	1.30
Expenses	827	36	4.20
Money over	835	28	3.20
No. of children in household	860	3	0.30
Child Age 1	858	1	0.10
Child Age 2	649	5	0.10
Child Age 3	285	3	0.10
Child Age 4	87	1	0.10
Child Age 5	21	0	0.00
Child Age 6	2	0	0.00
Childs age	848	15	1.70
Child's gender	858	5	0.60
Relationship to child	862	1	0.10
Type of household	861	2	0.20
Triple P knowledge			
Friend	863	0	0.00
Teacher	863	0	0.00
Religious	863	0	0.00
GP	863	0	0.00
Childcare	863	0	0.00
Preschool	863	0	0.00
Radio	863	0	0.00
Newspaper	863	0	0.00
Website	863	0	0.00
Other Internet	863	0	0.00
Triple P paper	863	0	0.00

Triple P Seminar	863	863	863
Primary Care Seminar	863	863	863
Other Events	863	863	863
Total Events	863	863	863

Table A.6: Sample Size and Missing Values of Eyberg Child Behaviour Inventory and Parenting

Variable	N	Missing	%
Booklet 1 (N=863)			
ECBI (Eyberg Child Behaviour Inventory)			
Total ECBI	793	70	8.10
Total Problems	764	99	11.50
Parenting (Parenting Experience Survey)			
Item 1	798	65	7.50
Item 2a	765	98	11.40
Item2b	772	91	10.50
Item2c	764	99	11.50
Item2d	738	125	14.50
Item2e	739	124	14.40
Item 3	812	51	5.90
Item 4	816	47	5.40
Item 5	805	58	6.70
Item 6	811	52	6.00
Item 7	810	53	6.10
Booklet 2 (N=388)			
ECBI (Eyberg Child Behaviour Inventory)			
Total ECBI	357	31	8.00
Total Problems	359	29	7.50
Parenting (Parenting Experience Survey)			
Item 1	375	13	3.40
Item 2a	366	22	5.70
Item2b	365	23	5.90
Item2c	365	23	5.90
Item2d	359	29	7.50
Item2e	360	28	7.20
Item 3	380	8	2.10
Item 4	383	5	1.30
Item 5	382	6	1.50
Item 6	382	6	1.50
Item 7	382	6	1.50
Total CSQ (Client Satisfaction Survey)	385	3	0.80

Table A.7: Psychometric Properties Eyberg and the Parenting Scale – Workshop Triple P

Variable	n	M	SD	α	Range Potential	Actual	Skew
Booklet 1 (N=863)							
ECBI (Eyberg Child Behaviour Inventory)							
Total	793	109.48	32.40	.94	36-252	36-233	0.45
Problems	764	10.13	7.72	–	0-36	0-36	0.54
Parenting (Parenting Experience Survey)							
Item 1	798	2.73	0.92	–	1-5	1-5	0.30
Item2a	765	4.00	0.93	–	1-5	1-5	-0.75
Item2b	772	3.77	0.92	–	1-5	1-5	-0.56
Item2c	764	3.32	1.02	–	1-5	1-5	-0.16
Item2d	738	4.12	0.93	–	1-5	1-5	**-0.90**
Item2e	739	1.64	0.97	–	1-5	1-5	**1.73**
Item3	812	3.71	0.82	–	1-5	1-5	-0.35
Item4	816	3.62	0.93	–	1-5	1-5	-0.46
Item5	805	3.89	1.09	–	1-6	1-6	0.11
Item6	811	4.10	1.09	–	1-6	1-6	-0.28
Item7	810	7.31	1.24	–	0-7	0-7	-0.63
Booklet 2 (N=388)							
ECBI (Eyberg Child Behaviour Inventory)							
Total	378	98.86	27.78	.94	36-252	36-203	0.02
Problems	379	6.83	6.40	–	0-36	0-33	0.87
Parenting (Parenting Experience Survey)							
Item 1	396	2.43	0.86	–	1-5	1-5	0.22
Item2a	387	4.11	0.78	–	1-5	1-5	-0.78
Item2b	386	3.66	0.93	–	1-5	1-5	**-0.89**
Item2c	386	3.03	0.96	–	1-5	1-5	-0.07
Item2d	380	4.18	0.79	–	1-5	1-5	-0.51
Item2e	381	1.55	0.82	–	1-5	1-5	**0.97**
Item3	401	3.89	0.70	–	1-5	1-5	0.24
Item4	404	3.76	0.86	–	1-5	1-5	-0.52
Item5	403	40.04	1.04	–	1-6	1-6	0.52
Item6	403	4.15	1.04	–	1-6	1-6	0.55
Item7	403	4.35	1.22	–	0-7	0-7	-0.08
CSQ (Client Satisfaction Questionnaire)	406	70.25	11.19	.93	13-91	25-91	-0.33
Booklet 3 (N=34)							
ECBI (Eyberg Child Behaviour Inventory)							
Total	33	87.18	25.05	.94	36-252	41-153	0.76
Problems	32	5.84	5.51	–	0-36	0-20	**0.81**
Parenting (Parenting Experience Survey)							
Item 1	34	2.24	0.85	–	1-5	1-4	0.23
Item2a	34	4.24	0.61	–	1-5	3-5	-0.03
Item2b	34	3.65	0.98	–	1-5	2-5	-0.07
Item2c	34	2.94	0.98	–	1-5	1-5	0.15
Item2d	34	4.47	0.61	–	1-5	3-5	**-0.84**

Item2e	34	1.45	0.71	–	1-5	1-4	**0.92**
Item3	34	4.06	0.55	–	1-5	3-5	0.09
Item4	34	4.09	0.71	–	1-5	2-5	**-0.88**
Item5	34	4.18	0.97	–	1-6	2-6	0.22
Item6	34	4.36	0.92	–	1-6	2-6	-0.14
Item7	34	4.41	1.10	–	0-7	2-6	-0.25

Non-normal distributions are indicated in bold.

Triple P Seminars data checking

Data entry corrections

The datafile has been corrected of any mistakes found during the data check of 400 random questionnaires of the total 1981 questionnaires entered in the database. This includes the labelling of the variable county, and the correction of the seminar number from 4 to 1.

Missing values

Missing values analyses were conducted. As can be seen from Table A.8, the missing data is less than 10% across all variables.

The total Client Satisfaction Questionnaire (CSQ) was re-computed so that the total score was computed for individuals with one missing value. Those two or more missing values across the nine items are considered missing (n=10).

Ranges and distribution

The ranges of all variables have been checked, and are correct.

Distribution of the CSQ was conducted, indicating that it is negatively skewed (skew value = -1.16 , SE = 0.06). The nature of the questions would possibly lend the data for this variable to be non-normally distributed, so was not transformed.

Figure A.1: Histogram depicting distribution of Client Satisfaction Questionnaire (CSQ)

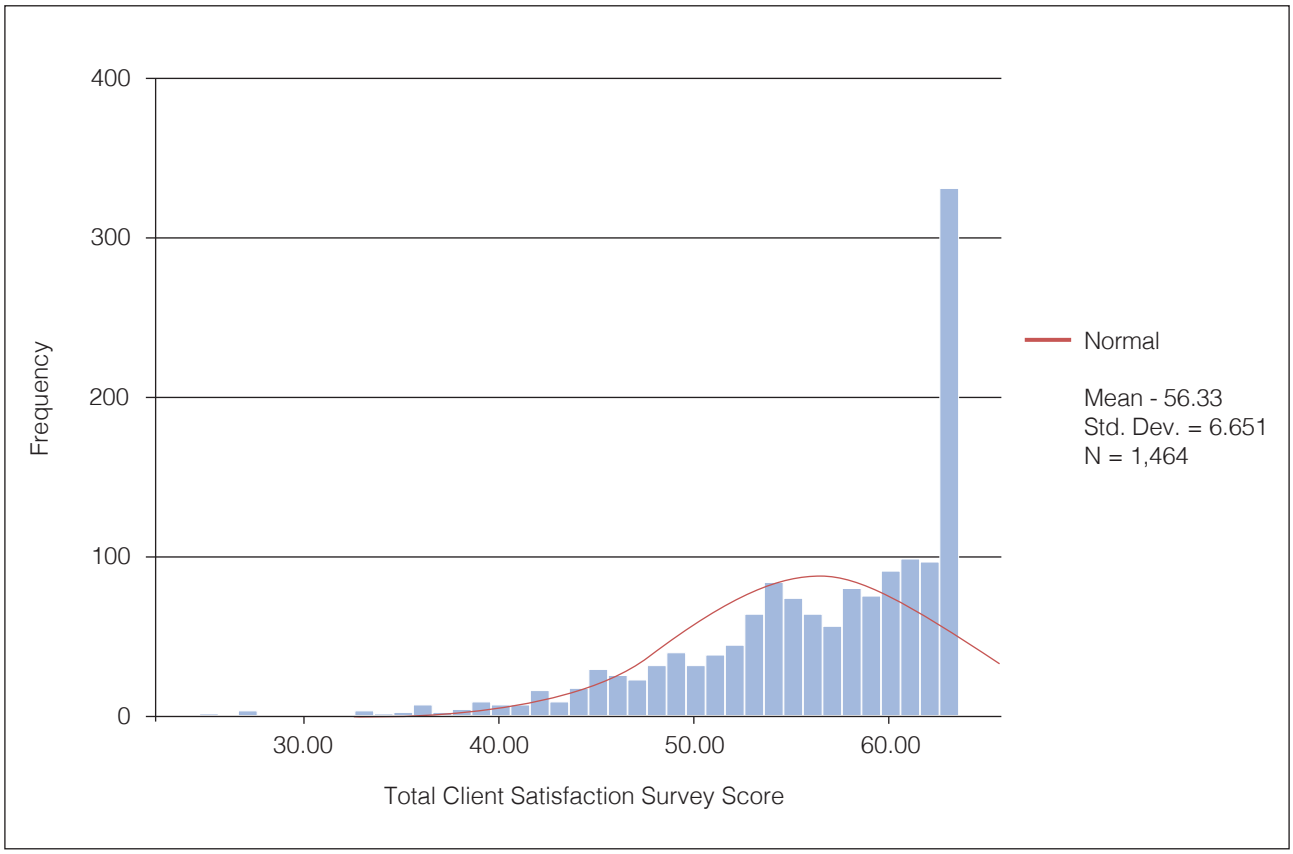


Table A.8: Sample Size and Missing Values – Triple P Seminars

Variable	N	Missing	%
Seminar type	1,981	0	0.00
County	1,981	0	0.00
Client satisfaction (Client Satisfaction Questionnaire/CSQ)			
Total CSQ	1,464	10	0.70
CSQ1	1,474	0	0.00
CSQ2	1,444	30	2.00
CSQ3	1,469	5	0.30
CSQ4	1,466	8	0.50
CSQ5	1,464	10	0.70
CSQ6	1,461	13	0.90
CSQ7	1,466	8	0.50
CSQ8	1,464	10	0.70
CSQ9	1,461	13	0.90
No. of Children	1,431	0	0.00
Child Age 1	1,383	21	1.50
Child Age 2	1,135	18	1.60
Child Age 3	537	6	1.10
Child Age 4	193	6	3.10
Child Age 5	42	3	7.10
Child Age 6	7	0	0.00

Other Seminars			
Seminar 1	1,448	26	1.80
Seminar 2	1,474	0	0.00
Seminar 3	1,474	0	0.00
Triple P knowledge			
Friend	1,448	26	1.80
Teacher	1,449	25	1.70
Religious	1,448	26	1.80
GP	1,448	26	1.80
Childcare	1,449	25	1.70
Preschool	1,448	26	1.80
Radio	1,448	26	1.80
Newspaper	1,448	26	1.80
Website	1,448	26	1.80
Other Internet	1,448	26	1.80
Triple P paper	1,449	25	1.70

Appendix A.2 Group Triple P

Table A.9: Descriptive data on participant characteristics – Group Triple P

Child demographic variables		
	Mean/SD	**Range**
Age	61.99 months (16.5)	36 to 95 months
Gender	**Frequency**	**%**
Male	311	59.7%
Female	210	40.3%
Parent and Family demographic variables		
	Mean/SD	**Range**
Participant age	36.75 (6.2)	21 to 63
Gender and relationship to the child	**Frequency**	**%**
Male/Father	75	14.4%
Female/Mother	446	85.6%
Marital status	**Frequency**	**%**
Single	45	8.7%
Married	387	74.9%
Divorced/separated	31	6%
Living with partner	51	9.9%
Widowed	3	6%
No. of children in the household	**Frequency**	**%**
1	86	16.6%
2	229	44.2%
3	141	27.2%
4	49	9.5%
5	11	2.1%
6	2	0.4%
Type of family	**Frequency**	**%**
Original family	425	82%
Step family	18	3.5%
Sole parent family	64	12.4%
Other	11	2.1%
Country of birth – Respondent	**Frequency**	**%**
Ireland	388	75.6%
Other	125	24.4%
Socio-economic variables		
Parent education level	**Frequency**	**%**
Primary	6	1.2%
Some secondary	48	9.3%
Completed secondary	127	24.5%
Post-secondary training	126	24.3%
University degree	143	27.6%
Postgraduate	68	13.1%
Parent's work status	**Frequency**	**%**

Yes, Full-time	139	27%
Yes, part-time	107	20.8%
Not working but looking for a job	92	17.9%
Home-based work	27	5.2%
Not working by choice (including retired)	72	14%
Unable to work due to illness/disability	23	4.5%
Other	44	8.5%
Medical card status	**Frequency**	**%**
Yes	197	38.6%
No	313	61.3%
Don't know	1	0.2%
Difficulty meeting essential household expenses (last 12 months)	**Frequency**	**%**
Yes	128	25.3%
No	366	72.3%
Don't know	12	2.4%
After essential expenses, how much money is left over?	**Frequency**	**%**
Enough to comfortably afford most of what we want	105	20.9%
Enough to purchase only some of the things we want	256	51%
Not enough to purchase much of anything we really want	141	28.1%
Sample characteristics – Social Class		
Social Class	**Respondent Frequency/%**	**Partner Frequency/%**
Professional	23 / 4.4%	60 / 11.5%
Managerial and Technical	89 / 17.1%	117 / 22.5%
Non-manual	78 / 15%	47 / 9%
Skilled manual	29 / 5.6%	80 / 15.4%
Semi-skilled	18 / 3.5%	22 / 4.2%
Unskilled	0 / 0%	0 / 0%
Other/Unknown	55 / 10.6%	72 / 13.8%
Not applicable (incl. unemployed, housewife, asylum-seeker)	229 / 44%	123 / 23.6%
Sources of knowledge of Triple P*		
	Frequency	**%**
Friend, relative, neighbour	147	28.7%
Teacher/school official	113	22%
Religious organisation	1	0.2%
GP/Nurse	49	9.6%
Public Health Nurse	41	8%
Childcare Centre	36	7%
Pre-school	62	12%
Radio	1	0.2%
Newspaper	27	5.3%
Triple P website	15	2.9%
Other Internet	6	1.2%
Triple P Tippapers	71	13.7%

Attendance at other Triple P events in the last 12 months**		
Type of event	**Frequency**	**%**
Triple P Seminar	139	27.1%
Primary Care Triple P	7	1.4%
Other Triple P event	35	6.8%
Number of additional Triple P events attended	**Frequency**	**%**
0	337	65.8%
1	168	32.8%
2	7	1.4%

* Participants could pick as many options as were relevant, therefore the total percentage exceeds 100.

** Participants could pick as many options as were relevant.

Table A.10: Interaction of gender of parent and short-term gains on Child Behaviour – Group Triple P

	Gender of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
SDQ Total Difficulties Score	M (n=54) F (n=337)	12.42 (6.4) 12.27 (5.9)	9.11 (4.9) 8.71 (4.9)	(1, 389) 0.395	.53	.001
SDQ Emotional Symptoms	M (n=54) F (n=337)	2.37 (2.0) 2.66 (2.1)	1.76 (1.7) 1.80 (1.8)	(1, 389) 0.834	.36	.002
SDQ Conduct Problems Scale	M (n=54) F (n=338)	2.98 (2.0) 3.08 (1.9)	2.17 (1.7) 1.93 (1.5)	(1, 390) 1.93	.17	.005
SDQ Inattention/Hyperactivity Scale	M (n=54) F (n=338)	5.06 (2.7) 4.65 (2.6)	3.67 (2.2) 3.59 (2.2)	(1, 390) 1.37	.24	.003
SDQ Peer Problems Scale	M (n=54) F (n=338)	1.83 (1.8) 1.86 (1.8)	1.48 (1.5) 1.35 (1.5)	(1, 390) 0.54	.47	.001
SDQ Pro-social Scale	M (n=54) F (n=338)	7.09 (1.9) 7.28 (1.9)	7.62 (1.4) 8.20 (1.7)	(1, 390) 3.42	.14	.006
SDQ Impact Score	M (n=54) F (n=336)	1.35 (2.4) 0.99 (1.6)	0.39 (0.9) 0.47 (1.1)	**(1, 388) 4.43**	**.04**	**.011**
ECBI Intensity	M (n=54) F (n=331)	119.22 (32) 115.76 (32)	97.83 (27.4) 92.07 (27.1)	(1, 383) 0.34	.56	.001
ECBI Problem	M (n=51) F (n=307)	12.29 (7.9) 13.24 (7.8)	6.27 (7.5) 6.51 (6.4)	(1, 356) 0.44	.51	.001

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.11: Interaction of gender of parent and short-term gains on Parenting Scales – Group Triple P

	Gender of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Parenting Scale Total	M (n=54) F (n=339)	3.41 (0.6) 3.31 (0.6)	2.83 (0.7) 2.63 (0.7)	(1, 391) 1.11	.29	.003
Parenting Scale – Laxness	M (n=54) F (n=339)	3.18 (0.9) 3.03 (0.9)	2.51 (0.8) 2.42 (0.9)	(1, 391) 0.28	.596	.001
Parenting Scale – Over-reactivity	M (n=54) F (n=339)	3.17 (1.0) 3.17 (0.9)	2.50 (0.95) 2.38 (0.9)	(1, 391) 0.82	.37	.002
Parenting Scale – Verbosity	M (n=54) F (n=339)	4.03 (0.7) 3.90 (0.8)	3.58 (0.7) 3.15 (0.9)	**(1, 391) 4.33**	**.04**	**.011**
PSBC – Problem Setting and Behaviour Checklist	M (n=53) F (n=336)	216.51 (41.7) 210.80 (39.1)	235.92 (42.4) 238.33 (38.4)	(1, 387) 1.91	.17	.005

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.12: Interaction of gender of parent and short-term gains on Personal and Marital Adjustment – Group Triple P

	Gender of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
DASS Depression Scale	M (n=54) F (n=339)	4.81 (6.8) 5.78 (7.5)	2.78 (3.8) 2.83 (5.4)	(1, 391) 1.09	.297	.003
DASS Stress Scale	M (n=54) F (n=339)	10.54 (8.5) 10.75 (8.0)	6.5 (5.4) 6.6 (6.96)	(1, 391) 0.02	.896	.000
DASS Anxiety Scale	M (n=54) F (n=339)	3.06 (4.0) 4.15 (6.2)	1.91 (2.8) 2.34 (4.9)	(1, 391) 0.81	.37	.002
Relationship Quality Index	M (n=50) F (n=229)	37.02 (8.97) 37.14 (8.2)	38.6 (7.5) 38.86 (7.5)	(1, 347) 0.021	.88	.000
Parent Problem Checklist – Problem	M (n=50) F (n=283)	4.92 (3.9) 4.95 (3.8)	2.78 (3.4) 3.09 (3.3)	(1, 331) 0.28	.60	.001
Parent Problem Checklist – Intensity	M (n=49) F (n=289)	32.55 (15.1) 32.00 (14.7)	26.06 (10.1) 25.25 (11.2)	(1, 336) 0.02	.90	.000

η_p^2 = partial eta squared

Table A.13: Interaction of gender of child and short-term gains on Child Behaviour – Group Triple P

	Gender of child	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
SDQ Total Difficulties Score	M (n=232) F (n=159)	12.81 (6.0) 11.47 (5.7)	9.10 (4.8) 8.28 (5.1)	(1, 389) 1.195	.275	.003
SDQ Emotional Symptoms	M (n=232) F (n=159)	2.70 (2.2) 2.49 (2.1)	1.72 (1.7) 1.90 (1.9)	**(1,389) 7.39**	**.04**	**.011**
SDQ Conduct Problems Scale	M (n=233) F (n=159)	3.06 (1.8) 3.09 (1.97)	1.93 (1.4) 2.03 (1.6)	(1, 390) 0.15	.697	.000
SDQ Inattention/Hyperactivity Scale	M (n=233) F (n=159)	5.09 (2.7) 4.14 (2.6)	3.92 (2.2) 3.13 (2.1)	(1, 390) 0.75	.39	.002
SDQ Peer Problems Scale	M (n=233) F (n=159)	1.97 (1.9) 1.69 (1.6)	1.47 (1.6) 1.22 (1.4)	(1, 390) 0.05	.82	.000
SDQ Pro-social Scale	M (n=233) F (n=159)	7.05 (1.9) 7.54 (1.9)	7.91 (1.7) 8.43 (1.6)	(1, 390) 0.03	.86	.000
SDQ Impact Score	M (n=231) F (n=159)	1.10 (1.7) 0.96 (1.6)	0.49 (1.2) 0.40 (1.0)	(1, 388) 0.097	.76	.000
ECBI Intensity	M (n=230) F (n=155)	118.96 (33.6) 112.21 (29.2)	93.47 (27.4) 91.99 (26.8)	(1, 383) 3.63	.06	.009
ECBI Problem	M (n=212) F (n=146)	13.47 (8.2) 12.58 (7.3)	6.23 (6.3) 6.89 (6.9)	**(1, 356) 3.96**	**.05**	**.011**

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.14: Interaction of gender of child and short-term gains on Parenting Scales – Group Triple P

	Gender of child	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Parenting Scale Total	M (n=234) F (n=159)	3.33 (0.6) 3.33 (0.6)	2.66 (0.7) 2.66 (0.7)	(1, 391) 0.00	.991	.000
Parenting Scale – Laxness	M (n=234) F (n=159)	3.07 (0.9) 3.02 (0.9)	2.46 (0.9) 2.39 (0.9)	(1, 391) 0.013	.909	.000
Parenting Scale – Over-reactivity	M (n=234) F (n=159)	3.15 (0.9) 3.19 (0.9)	2.36 (0.9) 2.44 (0.9)	(1, 391) 0.136	.712	.000
Parenting Scale – Verbosity	M (n=234) F (n=159)	3.93 (0.8) 3.90 (0.7)	3.23 (0.9) 3.19 (0.8)	(1, 391) 0.024	.876	.000
PSBC – Problem Setting and Behaviour Checklist	M (n=232) F (n=157)	212.67 (37.8) 209.96 (41.8)	238.3 (38.6) 237.57 (39.5)	(1, 387) 0.229	.633	.001

η_p^2 = partial eta squared

Table A.15: Interaction of gender of child and short-term gains on Personal and Marital Adjustment – Group Triple P

	Gender of child	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
DASS Depression Scale	M (n=234) F (n=159)	5.41 (7.3) 6.00 (7.7)	2.41 (4.2) 3.42 (6.3)	(1, 391) 0.443	.51	.001
DASS Stress Scale	M (n=234) F (n=159)	10.39 (7.9) 11.2 (8.4)	6.27 (6.1) 7.01 (7.7)	(1, 391) 0.009	.93	.000
DASS Anxiety Scale	M (n=234) F (n=159)	3.8 (5.7) 4.29 (6.3)	2.13 (4.2) 2.51 (5.3)	(1, 391) 0.045	.93	.000
Relationship Quality Index	M (n=211) F (n=138)	37.36 (8.1) 36.76 (8.6)	38.67 (7.2) 39.04 (7.8)	(1, 347) 2.25	.14	.006
Parent Problem Checklist – Problem	M (n=196) F (n=137)	4.91 (3.8) 4.99 (3.8)	3.15 (3.6) 2.89 (2.9)	(1, 331) 0.77	.38	.002
Parent Problem Checklist – Intensity	M (n=205) F (n=133)	32.45 (14.9) 31.51 (14.7)	25.69 (12.3) 24.88 (8.7)	(1, 336) 0.008	.93	.000

η_p^2 = partial eta squared

Table A.16: Interaction of age of parent and short-term gains on Child Behaviour – Group Triple P

	Age of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
SDQ Total Difficulties Score	≤ 36 (n=166) 37 + (n=222)	12.86 (6.0) 11.77 (5.8)	9.05 (5.0) 8.50 (4.9)	(1, 387) 1.241	.266	.003
SDQ Emotional Symptoms	≤ 36 (n=166) 37 + (n=222)	2.69 (2.2) 2.55 (2.1)	1.82 (1.8) 1.76 (1.8)	(1, 387) 0.171	.680	.000
SDQ Conduct Problems Scale	≤ 36 (n=166) 37 + (n=223)	3.07 (1.97) 3.06 (1.8)	1.93 (1.5) 1.97 (1.5)	(1, 388) 0.07	.791	.000
SDQ Inattention/Hyperactivity Scale	≤ 36 (n=166) 37 + (n=223)	5.04 (2.7) 4.44 (2.6)	3.75 (2.3) 3.46 (2.1)	(1, 388) 2.365	.125	.006
SDQ Peer Problems Scale	≤ 36 (n=166) 37 + (n=223)	2.02 (1.7) 1.74 (1.8)	1.51 (1.6) 1.26 (1.5)	(1, 388) 0.069	.720	.000
SDQ Pro-social Scale	≤ 36 (n=166) 37 + (n=223)	7.24 (1.9) 7.27 (1.9)	8.32 (1.7) 7.99 (1.6)	**(1, 388) 4.173**	**.042**	**.011**
SDQ Impact Score	≤ 36 (n=166) 37 + (n=222)	1.11 (1.8) 0.98 (1.6)	0.48 (1.1) 0.44 (1.1)	(1, 387) 0.427	.514	.001
ECBI Intensity	≤ 36 (n=162) 37 + (n=220)	116.29 (33.6) 116.05 (30.8)	91.40 (27.6) 93.93 (27.0)	(1, 381) 0.999	.318	.003
ECBI Problem	≤ 36 (n=149) 37 + (n=207)	13.34 (8.1) 12.92 (7.6)	6.49 (6.8) 6.40 (6.4)	(1, 355) 0.178	.673	.001

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.17: Interaction of age of parent and short-term gains on Parenting Scales – Group Triple P

	Age of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Parenting Scale Total	≤ 36 (n=167) 37 + (n=223)	3.81 (0.6) 3.28 (0.7)	2.68 (0.7) 2.64 (0.7)	(1, 389) 0.802	.371	.002
Parenting Scale – Laxness	≤ 36 (n=167) 37 + (n=223)	3.11 (0.8) 3.00 (1.0)	2.46 (0.9) 2.39 (1.0)	(1, 389) 0.326	.568	.001
Parenting Scale – Over-reactivity	≤ 36 (n=167) 37 + (n=223)	3.19 (0.9) 3.14 (0.9)	2.36 (0.9) 2.41 (0.9)	(1, 389) 1.490	.223	.004
Parenting Scale – Verbosity	≤ 36 (n=167) 37 + (n=223)	4.04 (0.7) 3.82 (0.8)	3.25 (0.9) 3.17 (0.9)	(1, 389) 2.035	.155	.005
PSBC – Problem Setting and Behaviour Checklist	≤ 36 (n=165) 37 + (n=221)	211.19 (37.8) 212.43 (40.13)	238.08 (37.4) 238.48 (40.0)	(1, 385) 0.044	.834	.000

η_p^2 = partial eta squared

Table A.18: Interaction of age of parent and short-term gains on Personal and Marital Adjustment – Group Triple P

	Age of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
DASS Depression Scale	≤ 36 (n=167) 37 + (n=223)	6.32 (7.9) 5.01 (6.8)	3.05 (5.0) 2.61 (5.3)	(1, 389) 2.026	.155	.005
DASS Stress Scale	≤ 36 (n=167) 37 + (n=223)	10.65 (8.3) 10.70 (7.9)	6.63 (6.9) 6.46 (6.9)	(1, 389) 0.104	.748	.000
DASS Anxiety Scale	≤ 36 (n=167) 37 + (n=223)	4.71 (6.4) 3.44 (5.6)	2.72 (4.8) 1.87 (4.3)	(1, 389) 0.671	.413	.002
Relationship Quality Index	≤ 36 (n=136) 37 + (n=211)	38.13 (8.1) 36.59 (8.4)	39.88 (7.0) 38.21 (7.6)	(1, 346) 0.040	.841	.000
Parent Problem Checklist – Problem	≤ 36 (n=128) 37 + (n=203)	5.04 (3.8) 4.84 (3.8)	2.89 (3.2) 3.14 (3.4)	(1, 330) 1.310	.255	.004
Parent Problem Checklist – Intensity	≤ 36 (n=132) 37 + (n=204)	32.70 (14.98) 31.54 (14.7)	25.35 (12.2) 25.36 (10.3)	(1, 335) 0.597	.440	.002

η_p^2 = partial eta squared

Table A.19: Interaction of social class and short-term gains on Child Behaviour – Group Triple P

	Social Class	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
SDQ Total Difficulties Score	1 (n=87) 2 (n=86) 3 (n=13)	11.38 (6.0) 11.92 (5.8) 12.92 (6.1)	8.05 (4.3) 9.15 (4.7) 7.85 (4.6)	(2, 184) 1.708	.184	.018
SDQ Emotional Symptoms	1 (n=87) 2 (n=86) 3 (n=13)	2.52 (2.1) 2.55 (1.8) 2.69 (2.0)	1.75 (1.8) 1.79 (1.6) 1.54 (1.5)	(2, 184) 0.365	.695	.004
SDQ Conduct Problems	1 (n=87) 2 (n=86) 3 (n=13)	3.03 (1.9) 3.01 (1.9) 2.77 (2.3)	2.00 (1.5) 1.98 (1.4) 1.38 (1.3)	(2, 184) 0.291	.748	.003
SDQ Inattention/Hyperactivity	1 (n=87) 2 (n=86) 3 (n=13)	4.14 (2.8) 4.76 (2.6) 5.15 (2.5)	3.17 (1.9) 3.79 (2.4) 3.60 (2.5)	(2, 184) 0.652	.522	.007
SDQ Peer Problems	1 (n=87) 2 (n=86) 3 (n=13)	1.57 (1.7) 1.60 (1.7) 2.31 (1.3)	1.09 (1.3) 1.15 (1.5) 1.31 (1.3)	(2, 184) 2.080	.076	.028
SDQ Pro-social	1 (n=87) 2 (n=86) 3 (n=13)	7.30 (2.0) 7.36 (1.7) 6.00 (1.8)	8.25 (1.4) 7.98 (1.7) 8.08 (1.3)	**(2, 184) 4.654**	**.011**	**.048**
SDQ Impact Score	1 (n=87) 2 (n=86) 3 (n=13)	0.63 (0.8) 0.77 (0.9) 0.38 (0.8)	0.39 (0.9) 0.45 (1.3) 0.15 (0.4)	(2, 184) 0.126	.882	.001
ECBI Intensity	1 (n=87) 2 (n=86) 3 (n=13)	116.69 (33.1) 117.77 (31.5) 121.08 (34.7)	95.49 (25.4) 96.72 (25.6) 98.31 (27.6)	(2, 184) 0.029	.972	.000
ECBI Problem	1 (n=83) 2 (n=79) 3 (n=11)	11.93 (7.3) 13.47 (7.8) 15.36 (7.5)	6.34 (6.5) 6.85 (7.1) 6.64 (6.5)	(2, 1171) 1.209	.301	.014

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.20: Interaction of social class and short-term gains on Parenting Scales – Group Triple P

	Social Class	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Parenting Scale Total	1 (n=87) 2 (n=86) 3 (n=13)	3.30 (0.5) 3.32 (0.6) 3.35 (0.8)	2.63 (0.6) 2.77 (0.7) 2.68 (0.7)	(2, 184) 0.917	.401	.010
Parenting Scale – Laxness	1 (n=87) 2 (n=86) 3 (n=13)	3.06 (0.9) 3.10 (0.9) 3.08 (1.2)	2.39 (0.8) 2.60 (0.9) 2.31 (1.1)	(2, 184) 1.226	.296	.013
Parenting Scale – Over-reactivity	1 (n=87) 2 (n=86) 3 (n=13)	3.13 (0.8) 3.07 (1.0) 3.27 (0.8)	2.39 (0.8) 2.44 (0.9) 2.56 (0.8)	(2, 184) 0.415	.661	.005
Parenting Scale – Verbosity	1 (n=87) 2 (n=86) 3 (n=13)	3.85 (0.7) 3.89 (0.6) 3.83 (0.9)	3.15 (0.8) 3.32 (0.7) 3.24 (1.0)	(2, 184) 0.420	.658	.005
PSBC – Problem Setting and Behaviour Checklist	1 (n=87) 2 (n=86) 3 (n=13)	215.41 (37.6) 211.28 (39.0) 209.23 (36.6)	241.55 (30.6) 240.67 (31.1) 235.54 (25.9)	(2, 184) 0.171	.843	.002

η_p^2 = partial eta squared

Table A.21: Interaction of social class and short-term gains on Personal and Marital Adjustment – Group Triple P

	Social Class	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
DASS Depression Scale	1 (n=87) 2 (n=86) 3 (n=13)	4.61 (6.0) 5.19 (7.1) 5.08 (7.8)	2.20 (3.9) 1.94 (3.1) 2.08 (2.6)	(2, 184) 0.441	.644	.005
DASS Stress Scale	1 (n=87) 2 (n=86) 3 (n=13)	10.26 (7.0) 10.92 (9.0) 10.08 (6.4)	6.33 (5.8) 5.67 (5.6) 7.15 (5.2)	(2, 184) 1.143	.321	.012
DASS Anxiety Scale	1 (n=87) 2 (n=86) 3 (n=13)	2.89 (5.0) 2.90 (3.1) 4.92 (8.6)	1.47 (2.6) 1.63 (3.3) 0.92 (1.1)	(2, 184) 2.113	.124	.023
Relationship Quality Index	1 (n=79) 2 (n=79) 3 (n=11)	37.18 (8.0) 36.54 (9.0) 33.81 (8.8)	38.53 (7.7) 39.35 (6.6) 34.73 (9.4)	(2, 167) 0.986	.375	.012
Parent Problem Checklist – Problem	1 (n=79) 2 (n=75) 3 (n=11)	5.16 (3.7) 5.45 (3.6) 6.09 (5.7)	3.29 (3.1) 3.51 (3.4) 2.73 (4.1)	(2, 163) 0.832	.437	.010
Parent Problem Checklist – Intensity	1 (n=79) 2 (n=75) 3 (n=11)	33.84 (15.8) 33.63 (13.4) 34.36 (18.4)	25.94 (10.2) 26.11 (10.1) 27.00 (12.5)	(2, 163) 0.047	.954	.001

η_p^2 = partial eta squared

Table A.22: Interaction of Expenses Problems and Short-term Gains on Child Behaviour – Group Triple P

	Expenses problems	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
SDQ Total Difficulties Score	Y (n=86) N (n=287)	13.80 (6.0) 11.68 (5.8)	9.80 (4.3) 8.13 (4.6)	(1, 372) 0.670	.413	.002
SDQ Emotional Symptoms	Y (n=86) N (n=287)	2.78 (2.10) 2.51 (2.1)	1.99 (1.7) 1.61 (1.7)	(1, 372) 0.261	.610	.001
SDQ Conduct Problems Scale	Y (n=86) N (n=288)	3.54 (2.0) 2.96 (1.9)	2.24 (1.3) 1.82 (1.5)	(1, 373) 0.586	.444	.002
SDQ Inattention/Hyperactivity Scale	Y (n=86) N (n=288)	5.64 (2.6) 4.40 (2.6)	4.22 (2.2) 3.35 (2.1)	(1, 373) 2.539	.112	.007
SDQ Peer Problems Scale	Y (n=86) N (n=288)	1.85 (1.6) 1.79 (1.8)	1.24 (1.2) 1.33 (1.5)	(1, 373) 0.654	.419	.002
SDQ Pro-social Scale	Y (n=86) N (n=288)	7.28 (1.9) 7.28 (1.9)	8.28 (1.5) 8.09 (1.7)	(1, 373) 0.784	.376	.002
SDQ Impact Score	Y (n=86) N (n=286)	1.42 (2.1) 0.94 (1.6)	0.63 (1.4) 0.34 (1.0)	(1, 371) 1.757	.186	.005
ECBI Intensity	Y (n=85) N (n=284)	121.60 (33.3) 114.60 (31.3)	96.54 (28.3) 91.70 (26.1)	(1, 368) 0.439	.508	.001
ECBI Problem	Y (n=80) N (n=265)	14.25 (8.7) 12.72 (7.4)	7.43 (6.9) 6.02 (6.1)	(1, 344) 0.018	.895	.000

η_p^2 = partial eta squared

Table A.23: Interaction of Expenses Problems and Short-term Gains on Parenting Scales – Group Triple P

	Expenses problems	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Parenting Scale Total	Y (n=86) N (n=288)	3.43 (0.6) 3.27 (0.6)	2.70 (0.7) 2.62 (0.7)	(1, 373) 1.180	278.	.003
Parenting Scale – Laxness	Y (n=86) N (n=288)	3.14 (0.9) 3.00 (0.9)	2.48 (0.9) 2.39 (0.9)	(1, 373) 0.321	.571	.001
Parenting Scale – Over-reactivity	Y (n=86) N (n=288)	3.28 (0.9) 3.11 (0.9)	2.42 (0.9) 2.35 (0.9)	(1, 373) 0.998	.343	.002
Parenting Scale – Verbosity	Y (n=86) N (n=288)	3.98 (0.8) 3.86 (0.7)	3.26 (0.9) 3.17 (0.9)	(1, 373) 0.080	.777	.000
PSBC – Problem Setting and Behaviour Checklist	Y (n=86) N (n=288)	213.01 (39.8) 212.56 (38.1)	236.15 (39.7) 240.71 (36.1)	(1, 373) 1.046	.307	.003

η_p^2 = partial eta squared

Table A.24: Interaction Expenses Problems and Short-term Gains Personal Marital Adjustment – Group Triple P

	Expenses problems	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
DASS Depression Scale	Y (n=86) N (n=288)	8.26 (9.3) 4.47 (6.0)	4.56 (6.6) 1.90 (3.4)	(1, 373) 2.451	.118	.007
DASS Stress Scale	Y (n=86) N (n=288)	12.86 (9.0) 9.82 (7.5)	8.30 (6.5) 5.69 (6.1)	(1, 373) 0.263	.606	.001
DASS Anxiety Scale	Y (n=86) N (n=288)	5.67 (7.2) 3.09 (4.8)	3.24 (4.8) 1.57 (3.2)	(1, 374) 2.546	.111	.007
Relationship Quality Index	Y (n=63) N (n=270)	36.00 (8.4) 37.29 (8.3)	38.19 (6.6) 39.01 (7.5)	(1, 332) 0.304	.582	.001
Parent Problem Checklist – Problem	Y (n=62) N (n=256)	5.48 (3.7) 4.79 (3.8)	3.53 (3.8) 2.89 (3.2)	(1, 317) 0.012	.913	.000
Parent Problem Checklist – Intensity	Y (n=63) N (n=259)	33.75 (14.4) 31.52 (14.5)	28.08 (14.7) 24.59 (9.7)	(1, 321) 0.460	.498	.001

η_p^2 = partial eta squared

Table A.25: Interaction attending other Triple P Level(s) and short-term gains on child behaviour – Group Triple P

	Other Triple P Level	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
SDQ Total Difficulties Score	No (n=251) Yes (n=136)	12.56 (6.5) 11.57 (4.7)	8.92 (5.2) 8.38 (4.3)	(1, 386) 0.813	.368	.002
SDQ Emotional Symptoms	No (n=251) Yes (n=136)	2.78 (2.2) 2.29 (1.9)	1.85 (1.8) 1.64 (1.8)	(1, 386) 1.902	.169	.005
SDQ Conduct Problems Scale	No (n=251) Yes (n=137)	3.08 (2.0) 3.02 (1.8)	2.04 (1.6) 1.80 (1.3)	(1, 387) 1.092	.297	.003
SDQ Inattention/Hyperactivity Scale	No (n=251) Yes (n=137)	4.79 (2.8) 4.46 (2.4)	3.57 (2.2) 3.63 (2.1)	**(1, 387) 3.782**	**.053**	**.010**
SDQ Peer Problems Scale	No (n=251) Yes (n=137)	1.90 (1.9) 1.75 (1.6)	1.45 (1.5) 1.20 (1.4)	(1, 387) 0.312	.548	.001
SDQ Pro-social Scale	No (n=251) Yes (n=137)	7.21 (2.0) 7.32 (1.8)	8.12 (1.8) 8.13 (1.4)	(1, 387) 0.277	.599	.001
SDQ Impact Score	No (n=250) Yes (n=136)	1.12 (1.8) 0.87 (1.4)	0.48 (1.1) 0.40 (1.1)	(1, 385) 1.214	.271	.003
ECBI Intensity	No (n=246) Yes (n=136)	117.30 (33.1) 113.52 (29.6)	92.09 (27.9) 93.72 (24.9)	(1, 380) 3.591	.059	.009
ECBI Problem	No (n=227) Yes (n=128)	13.14 (7.6) 12.77 (8.0)	6.31 (6.4) 6.49 (6.3)	(1, 354) 0.521	.471	.001

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.26: Interaction attending other Triple P Level(s) and Short-term Gains Parenting Scales – Group Triple P

	Other Triple P Level	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Parenting Scale Total	No (n=252) Yes (n=137)	3.35 (0.6) 3.26 (0.6)	2.66 (0.7) 2.66 (0.7)	(1, 388) 1.559	.213	.004
Parenting Scale – Laxness	No (n=252) Yes (n=137)	3.04 (0.9) 3.03 (0.9)	2.40 (0.9) 2.47 (0.9)	(1, 388) 0.915	.339	.002
Parenting Scale – Over-reactivity	No (n=252) Yes (n=137)	3.19 (0.9) 3.08 (0.9)	2.41 (0.9) 2.35 (0.9)	(1, 388) 0.374	.541	.001
Parenting Scale – Verbosity	No (n=252) Yes (n=137)	3.95 (0.8) 3.82 (0.7)	3.20 (0.9) 3.21 (0.9)	(1, 388) 1.791	.182	.005
PSBC – Problem Setting and Behaviour Checklist	No (n=252) Yes (n=137)	211.69 (40.0) 211.37 (38.6)	240.13 (35.4) 234.10 (44.5)	(1, 388) 1.827	.177	.005

η_p^2 = partial eta squared

Table A.27: Interaction of attending other Triple P Level(s) and Short-term Gains on Personal and Marital Adjustment – Group Triple P

	Other Triple P Level	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
DASS Depression Scale	No (n=252) Yes (n=137)	6.18 (8.3) 4.64 (5.7)	3.06 (5.6) 2.35 (4.3)	(1, 388) 1.707	.192	.004
DASS Stress Scale	No (n=252) Yes (n=137)	11.20 (8.5) 9.75 (7.4)	6.72 (7.0) 6.23 (6.5)	(1, 388) 1.794	.181	.005
DASS Anxiety Scale	No (n=252) Yes (n=137)	4.22 (6.4) 3.54 (5.1)	2.32 (4.7) 2.22 (4.6)	(1, 388) 1.176	.279	.003
Relationship Quality Index	No (n=221) Yes (n=124)	36.73 (8.9) 37.64 (7.2)	38.86 (7.7) 38.70 (7.3)	(1, 344) 2.580	.109	.007
Parent Problem Checklist – Problem	No (n=214) Yes (n=117)	5.15 (3.9) 4.56 (3.7)	3.13 (3.4) 2.85 (3.1)	(1, 330) 0.557	.456	.002
Parent Problem Checklist – Intensity	No (n=214) Yes (n=120)	33.29 (15.7) 30.13 (12.9)	25.6 (12.0) 24.96 (9.2)	(1, 333) 2.582	.109	.008

η_p^2 = partial eta squared

Table A.28: Participant characteristics of those who dropped out/remained in study (Demographics) – Group Triple P

		Dropped out	Remained	Test of significance
Parent's age	≤ 36 37 +	33 / 14% 19 / 7%	206 / 86% 256 / 93%	**phi = .114, p = .010**
Social Class	1 2 3	10 / 9% 8 / 8% 2 / 11%	102 / 91% 98 / 92% 16 / 89%	phi = .036, p = .857
Parent's gender	M F	12 / 16% 41 / 9%	63 / 84% 404 / 91%	phi = .079, p = .072
Child's gender	M F	30 / 10% 23 / 11%	280 / 90% 187 / 89%	phi = .079, p = .637
Expenses problem	Yes No	18 / 14% 32 / 9%	109 / 86% 334 / 91%	phi = .079, p = .081

phi = phi coefficient effect size calculated using chi-square cross-tabulation.

Statistically significant findings are indicated in bold.

Table A.29a: Participant characteristics of those who dropped out/remained in study – Group Triple P

		Pre-intervention	Test of significance
SDQ Total Difficulties Score	Dropped out (n=52) Remained (n=466)	14.31 (6.8) 12.50 (6.1)	**t = 2.003, p = .046**
SDQ Emotional Symptoms	Dropped out (n=52) Remained (n=466)	2.85 (2.7) 2.70 (2.2)	t = 0.453, p = .651
SDQ Conduct Problems Scale	Dropped out (n=52) Remained (n=467)	3.71 (1.9) 3.12 (1.5)	**t = 2.118, p = .035**
SDQ Inattention/Hyperactivity Scale	Dropped out (n=52) Remained (n=467)	5.48 (2.8) 4.70 (2.6)	**t = 2.035, p = .042**
SDQ Peer Problems Scale	Dropped out (n=52) Remained (n=467)	2.27 (1.9) 1.98 (1.9)	t = 1.053, p = .293
SDQ Pro-social Scale	Dropped out (n=52) Remained (n=467)	7.10 (1.9) 7.27 (1.9)	t = 0.620, p = .536
SDQ Impact Score	Dropped out (n=52) Remained (n=466)	0.92 (1.0) 0.70 (0.9)	t = 1.726, p = .085
ECBI Intensity	Dropped out (n=52) Remained (n=459)	134.50 (40.3) 116.83 (33.0)	**t = 3.571, p = .000**
ECBI Problem	Dropped out (n=52) Remained (n=437)	15.96 (8.7) 13.29 (7.9)	**t = 2.274, p = .023**
Parenting Scale Total	Dropped out (n=52) Remained (n=466)	3.57 (0.7) 3.33 (0.6)	**t = 2.563, p = .011**
Parenting Scale – Laxness	Dropped out (n=52) Remained (n=466)	3.44 (1.0) 3.08 (1.0)	**t = 2.592, p = .010**
Parenting Scale – Over-reactivity	Dropped out (n=52) Remained (n=466)	3.30 (0.9) 3.17 (0.9)	t = 0.989, p = .323
Parenting Scale – Verbosity	Dropped out (n=52) Remained (n=466)	3.17 (0.9) 4.20 (0.9)	**t = 2.447, p = .015**
PSBC – Problem Setting and Behaviour Checklist	Dropped out (n=47) Remained (n=417)	202.06 (43.4) 210.03 (39.7)	t = 1.310, p = .191

t = t statistic calculated using independent-samples t-test

Statistically significant findings are indicated in bold.

Table A.29b: Participant characteristics of those who dropped out/remained in study (Child problems and Parenting scores) – Group Triple P

		Pre-intervention	Test of significance
DASS Depression Scale	Dropped out (n=51) Remained (n=466)	9.26 (10.2) 6.01 (7.6)	t = 2.773, p = .006
DASS Stress Scale	Dropped out (n=51) Remained (n=466)	12.55 (8.3) 11.03 (8.3)	t = 1.211, p = .226
DASS Anxiety Scale	Dropped out (n=51) Remained (n=466)	5.47 (7.6) 4.27 (6.3)	t = 1.279, p = .202
Relationship Quality Index	Dropped out (n=47) Remained (n=417)	33.8 (9.9) 36.90 (8.4)	t = 2.399, p = .017
Parent Problem Checklist – Problem	Dropped out (n=46) Remained (n=400)	6.74 (4.5) 3.17 (3.8)	t = 2.585, p = .010
Parent Problem Checklist – Intensity	Dropped out (n=46) Remained (n=400)	36.46 (17.7) 32.52 (15.0)	t = 1.658, p = .098

t = t statistic calculated using independent-samples t-test

Statistically significant findings are indicated in bold.

Appendix A.3 Workshop Triple P

Table A.30: Workshop Triple P – Dealing with disobedience

Child demographic variables		
	Mean/SD	**Range**
Age	61.82 (15.6) months	36 to 95 months
Gender	**Frequency**	**%**
Male	206	50.5%
Female	202	49.5%
Parent and Family demographic variables		
	Mean/SD	**Range**
Participant age	36.41 (6.8)	21 to 65
Gender and relationship to the child	**Frequency**	**%**
Male/Father	51	12.5%
Female/Mother	357	87.5%
Marital status	**Frequency**	**%**
Single	41	10.1%
Married	326	80.1%
Divorced/separated	10	2.5%
Living with partner	28	6.9%
Widowed	2	0.5%
No. of children in the household	**Frequency**	**%**
1	72	17.6%
2	183	17.4%
3	116	28.4%
4	31	7.6%
5	6	1.5%
Type of family	**Frequency**	**%**
Original family	348	85.3%
Step family	11	2.7%
Sole parent family	47	11.5%
Country of birth – Respondent	**Frequency**	**%**
Ireland	318	78.1%
Other	90	21.92%
Socio-economic variables		
Parent education level	**Frequency**	**%**
Primary	10	2.5%
Some secondary	32	8%
Completed secondary	103	25.6%
Post-secondary training	78	19.4%
University degree	112	27.9%
Postgraduate	67	16.7%
Parent's work status	**Frequency**	**%**
Yes, Full-time	156	38.5%
Yes, part-time	91	22.5%

Not working but looking for a job	63	15.6%
Home-based work	16	4%
Not working by choice (including retired)	49	12.1%
Unable to work due to illness/disability	9	2.2%
Other	18	4.4%
Medical card status	**Frequency**	**%**
Yes	132	32.8%
No	267	66.4%
Don't know	3	0.7%
Difficulty meeting essential household expenses (last 12 months)	**Frequency**	**%**
Yes	79	20.4%
No	299	77.3%
Don't know	9	2.3%
After essential expenses, how much money is left over?	**Frequency**	**%**
Enough to comfortably afford most of what we want	99	25.1%
Enough to purchase only some of the things we want	202	51.3%
Not enough to purchase much of anything we really want	93	23.6%
Sample characteristics – Social Class		
Social Class	**Respondent Frequency/%**	**Partner Frequency/%**
Professional	32 / 7.9%	40 / 9.8%
Managerial and Technical	74 / 18.2%	97 / 23.8%
Non-manual	74 / 18.2%	43 / 10.5%
Skilled manual	34 / 8.4%	61 / 15%
Semi-skilled	20 / 4.9%	61 / 15%
Unskilled	0 / 0%	0
Other/Unknown	36 / 8.8%	68 / 16.7%
Not applicable (incl. unemployed, housewife, asylum-seeker)	137 / 33.7%	79 / 19.4%

Table A.31: Sources of Knowledge of Triple P and Attendance at other Triple P events in the last 12 months: Workshop Triple P – Dealing with disobedience*

Sources of knowledge of Triple P		
	Frequency	**%**
Friend, relative, neighbour	71	17.4%
Teacher/school official	137	33.6%
Religious organisation	2	0.5%
GP/Nurse	31	7.6%
Public Health Nurse	36	8.8%
Childcare Centre	36	8.8%
Pre-school	68	16.7%
Radio	0	0%
Newspaper	20	4.9%
Triple P website	15	3.7%
Other Internet	3	0.7%
Triple P Tippapers	30	7.4%

Attendance at other Triple P events in the last 12 months		
Type of event	**Frequency**	**%**
Triple P Seminar	80	19.6%
Primary Care Triple P	14	3.4%
Other Triple P event	36	8.8%
Number of additional Triple P events attended	**Frequency**	**%**
0	289	70.8%
1	109	26.7%
2	9	2.2%
3	1	0.2%

* Participants could pick as many options as were relevant.

Table A.32: Workshop Triple P – Managing fighting and aggression

Child demographic variables		
	Mean/SD	**Range**
Age	64.46 (15.5) months	36 to 93 months
Gender	**Frequency**	**%**
Male	72	59%
Female	50	41%
Parent and Family demographic variables		
	Mean/SD	**Range**
Participant age	37.48 (7.0)	23 to 65
Gender and relationship to the child	**Frequency**	**%**
Male/Father	7	5.7%
Female/Mother	116	94.3%
Marital status	**Frequency**	**%**
Single	9	7.3%
Married	102	82.9%
Divorced/separated	5	4.1%
Living with partner	7	5.7%
Widowed	0	0%
No. of children in the household	**Frequency**	**%**
1	22	17.9%
2	51	41.5%
3	32	26%
4	14	11.4%
5	3	2.4%
6	1	0.8%
Type of family	**Frequency**	**%**
Original family	108	87.8%
Step family	13	10.6%
Sole parent family	2	1.6%
Country of birth – Respondent	**Frequency**	**%**
Ireland	96	80%
Other	27	20%

Socio-economic variables		
Parent education level	**Frequency**	**%**
Primary	2	1.7%
Some secondary	8	6.6%
Completed secondary	24	19.8%
Post-secondary training	35	28.9%
University degree	39	32.2%
Postgraduate	13	10.7%
Parent's work status	**Frequency**	**%**
Yes, Full-time	32	26.4%
Yes, part-time	26	21.5%
Not working but looking for a job	24	19.8%
Home-based work	8	6.6%
Not working by choice (including retired)	23	19%
Unable to work due to illness/disability	2	1.7%
Student	4	3.3%
Other	2	1.7%
Medical card status	**Frequency**	**%**
Yes	47	38.5%
No	75	61.5%
Don't know	0	0
Difficulty meeting essential household expenses (last 12 months)	**Frequency**	**%**
Yes	30	24.8%
No	88	72.5%
Don't know	3	2.5%
After essential expenses, how much money is left over?	**Frequency**	**%**
Enough to comfortably afford most of what we want	37	30.3%
Enough to purchase only some of the things we want	59	48.4%
Not enough to purchase much of anything we really want	26	21.3%
Sample characteristics – Social Class		
Social Class	**Respondent Frequency/%**	**Partner Frequency/%**
Professional	2 / 1.6%	11 / 8.9%
Managerial and Technical	22 / 17.9%	30 / 24.4%
Non-manual	23 / 18.7%	10 / 8.1%
Skilled manual	7 / 5.7%	29 / 23.6%
Semi-skilled	3 / 2.4%	3 / 2.4%
Unskilled	0 / 0%	0
Other/Unknown	14 / 11.4%	22 / 17.9%
Not applicable (incl. unemployed, housewife, asylum-seeker)	52 / 42.3%	18 / 14.6%

Table A.33: Sources of knowledge of Triple P: Workshop Triple P – Managing fighting and aggression*

Sources of knowledge of Triple P		
	Frequency	**%**
Friend, relative, neighbour	34	27.6%
Teacher/school official	35	28.5%
Religious organisation	0	0%
GP/Nurse	10	8.1%
Public Health Nurse	11	8.9%
Childcare Centre	9	7.3%
Pre-school	27	22%
Radio	0	0%
Newspaper	2	1.6%
Triple P website	2	1.6%
Other Internet	0	0%
Triple P Tippapers	15	12.2%
Attendance at other Triple P events in the last 12 months**		
Type of event	**Frequency**	**%**
Triple P Seminar	28	22.8%
Primary Care Triple P	5	4.1%
Other Triple P event	27	22%
Number of additional Triple P events attended	**Frequency**	**%**
0	71	57.7%
1	44	35.8%
2	8	6.5%
3	0	0

* Participants could pick as many options as were relevant, therefore the total percentage exceeds 100.

** Participants could pick as many options as were relevant.

Table A.34: Workshop Triple P – Developing good bedtime routines

Child demographic variables		
	Mean/SD	**Range**
Age	60 (15.4) months	37 to 90 months
Gender	**Frequency**	**%**
Male	22	52.4%
Female	20	47.6%
Parent and Family demographic variables		
	Mean/SD	**Range**
Participant age	36.61 (5.7) years	21 to 50 years
Gender and relationship to the child	**Frequency**	**%**
Male/Father	5	11.9%
Female/Mother	37	88.9%
Marital status	**Frequency**	**%**
Single	4	9.5%
Married	29	69%

Divorced/separated	3	7.1%
Living with partner	6	14.3%
Widowed	0	0%
No. of children in the household	**Frequency**	**%**
1	8	19%
2	18	42.9%
3	13	31%
4	2	4.8%
5	1	2.4%
Type of family	**Frequency**	**%**
Original family	35	83.3%
Step family	5	11.9%
Sole parent family	2	4.8%
Country of birth – Respondent	**Frequency**	**%**
Ireland	38	90.5%
Other	4	9.5%
Socio-economic variables		
Parent education level	**Frequency**	**%**
Primary	1	2.4%
Some secondary	4	9.8%
Completed secondary	8	19.5%
Post-secondary training	10	24.4%
University degree	11	26.8%
Postgraduate	7	17.1%
Parent's work status	**Frequency**	**%**
Yes, Full-time	17	40.5%
Yes, part-time	11	26.2%
Not working but looking for a job	8	19%
Home-based work	2	4.8%
Not working by choice (including retired)	3	7.1%
Unable to work due to illness/disability	0	0%
Other	1	2.4%
Medical card status	**Frequency**	**%**
Yes	11	26.8%
No	30	73.2%
Don't know	0	0
Difficulty meeting essential household expenses (last 12 months)	**Frequency**	**%**
Yes	9	22%
No	32	78%
Don't know	0	0
After essential expenses, how much money is left over?	**Frequency**	**%**
Enough to comfortably afford most of what we want	8	20%
Enough to purchase only some of the things we want	22	55%
Not enough to purchase much of anything we really want	10	25%

Sample characteristics – Social Class		
Social Class	**Respondent Frequency/%**	**Partner Frequency/%**
Professional	2 / 4.8%	3 / 7.1%
Managerial and Technical	8 / 19%	11 / 26.2%
Non-manual	10 / 23.8%	2 / 4.8%
Skilled manual	2 / 4.8%	7 / 16.7%
Semi-skilled	2 / 4.8%	3 / 7.1%
Unskilled	0 / 0%	0 / 0%
Other/Unknown	6 / 14.3%	9 / 21.4%
Not applicable (incl. unemployed, housewife, asylum-seeker)	12 / 28.6%	7 / 16.7%

Table A.35: Sources of knowledge of Triple P: Workshop Triple P – Developing good bedtime routines*

Sources of knowledge of Triple P		
	Frequency	**%**
Friend, relative, neighbour	11	26.2%
Teacher/school official	11	26.2%
Religious organisation	0	0%
GP/Nurse	5	11.9%
Public Health Nurse	6	14.3%
Childcare Centre	2	4.8%
Pre-school	9	21.4%
Radio	0	0%
Newspaper	4	9.5%
Triple P website	2	4.8%
Other Internet	0	0%
Triple P Tippapers	5	11.9%
Attendance at other Triple P events in the last 12 months**		
Type of event	**Frequency**	**%**
Triple P Seminar	14	33.3%
Primary Care Triple P	0	0%
Other Triple P event	4	9.5%
Number of additional Triple P events attended	**Frequency**	**%**
0	25	59.5%
1	16	38.1%
2	1	2.4%
3	0	0

* Participants could pick as many options as were relevant, therefore the total percentage exceeds 100.

** Participants could pick as many options as were relevant.

Table A.36: Interaction of inability to meet essential expenses in preceding 12 months and short-term effects: Workshop Triple P – Dealing with disobedience

Measure	Expense problems	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity	Yes (n=37) No (n=136)	107.54 (35.7) 111.15 (28.3)	96.46 (27.2) 98.74 (23.0)	(1, 172) 0.125	.724	.001
ECBI Problem	Yes (n=35) No (n=130)	10.34 (9.1) 10.09 (7.4)	6.74 (6.3) 6.79 (5.7)	(1, 164) 0.067	.796	.000
Parenting Experience Scale (PES)						
How difficult has your child's behaviour been in the last 6 weeks?	Yes (n=33) No (n=134)	2.91 (1.0) 2.65 (0.8)	2.45 (0.9) 2.38 (0.7)	(1, 166) 1.668	.198	.010
Parenting is rewarding	Yes (n=32) No (n=127)	3.82 (1.0) 3.92 (0.9)	4.09 (0.8) 4.12 (0.7)	(1, 158) 0.018	.895	.000
Parenting is demanding	Yes (n=31) No (n=127)	3.84 (0.9) 3.77 (0.9)	3.61 (1.1) 3.76 (0.8)	(1, 157) 1.374	.243	.009
Parenting is stressful	Yes (n=32) No (n=132)	3.41 (1.1) 3.24 (1.0)	3.00 (1.1) 3.11 (1.0)	(1, 165) 1.754	.187	.011
Parenting is fulfilling	Yes (n=31) No (n=122)	4.03 (1.0) 4.02 (0.9)	4.29 (0.8) 4.12 (0.8)	(1, 152) 1.049	.307	.007
Parenting is depressing	Yes (n=31) No (n=124)	2.13 (1.3) 1.65 (0.9)	1.74 (1.0) 1.51 (0.8)	(1, 154) 1.936	.166	.012
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	Yes (n=36) No (n=136)	3.61 (1.0) 3.74 (0.7)	3.72 (0.8) 3.90 (0.7)	(1, 171) 0.082	.776	.000
How supported have you felt in your role as a parent?	Yes (n=36) No (n=136)	3.36 (1.1) 3.68 (0.8)	3.36 (1.1) 3.80 (0.8)	(1, 171) 0.448	.504	.003
To what extent do you both agree over the methods of disciplining your child?	Yes (n=35) No (n=134)	3.86 (1.3) 4.00 (1.0)	4.03 (1.3) 3.87 (1.0)	(1, 168) 3.623	.059	.021
How supportive has your partner been towards you in your role as a parent?	Yes (n=35) No (n=135)	3.97 (1.4) 4.11 (1.0)	3.97 (1.3) 4.03 (1.0)	(1, 169) 0.231	.631	.001
How happy do you consider your relationship to your partner to be?	Yes (n=35) No (n=135)	4.11 (1.7) 4.30 (1.2)	4.26 (1.7) 4.21 (1.2)	(1, 169) 0.231	.631	.001

η_p^2 = partial eta squared

Table A.37: Interaction of age of parent and short-term effects on child behaviour and parenting experience: Workshop Triple P – Dealing with disobedience

Measure	Age of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity	≤ 37 (n=99) 38 + (n=73)	110.27 (33.6) 109.27 (24.7)	98.38 (25.6) 98.57 (21.6)	(1, 171) 0.132	.717	.001
ECBI Problem	≤ 37 (n=96) 38 + (n=69)	10.74 (8.4) 9.36 (6.9)	6.49 (5.9) 7.13 (6.2)	**(1, 164) 4.176**	**.043**	**.025**
Parenting Experience Scale (PES)						
How difficult has your child's behaviour been in the last 6 weeks?	≤ 37 (n=93) 38 + (n=71)	2.81 (0.9) 2.61 (0.8)	2.42 (0.8) 2.42 (0.7)	(1, 163) 2.751	.099	.017
Parenting is rewarding	≤ 37 (n=93) 38 + (n=67)	3.92 (1.0) 3.87 (0.9)	4.08 (0.8) 4.20 (0.7)	(1, 159) 0.911	.341	.006
Parenting is demanding	≤ 37 (n=92) 38 + (n=98)	3.85 (0.9) 3.68 (0.8)	3.80 (0.9) 3.68 (0.9)	(1, 159) 0.082	.775	.001
Parenting is stressful	≤ 37 (n=93) 38 + (n=71)	3.33 (1.0) 3.30 (1.0)	3.03 (1.0) 3.11 (0.9)	(1, 163) 0.533	.466	.003
Parenting is fulfilling	≤ 37 (n=91) 38 + (n=63)	4.02 (0.9) 4.11 (0.9)	4.14 (0.8) 4.21 (0.7)	(1, 153) 0.042	.838	.000
Parenting is depressing	≤ 37 (n=92) 38 + (n=65)	1.87 (1.1) 1.75 (1.0)	1.68 (1.0) 1.51 (0.6)	(1, 156) 0.192	.662	.001
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	≤ 37 (n=96) 38 + (n=74)	3.71 (0.8) 3.69 (0.8)	3.84 (0.7) 3.89 (0.7)	(1, 169) 0.349	.556	.002
How supported have you felt in your role as a parent?	≤ 37 (n=97) 38 + (n=74)	3.53 (1.0) 3.66 (0.8)	3.62 (0.9) 3.84 (0.8)	(1, 170) 0.440	.508	.003
To what extent do you both agree over the methods of disciplining your child?	≤ 37 (n=95) 38 + (n=72)	4.05 (1.2) 4.00 (1.0)	3.97 (1.1) 3.90 (1.1)	(1, 166) 0.020	.995	.000
How supportive has your partner been towards you in your role as a parent?	≤ 37 (n=95) 38 + (n=72)	4.21 (1.1) 4.04 (1.1)	4.13 (1.2) 4.04 (0.9)	(1, 166) 0.389	.534	.002
How happy do you consider your relationship to your partner to be?	≤ 37 (n=96) 38 + (n=72)	4.45 (1.4) 4.33 (1.2)	4.49 (1.2) 4.14 (1.3)	(1, 168) 2.777	.098	.016

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.38: Interaction of gender of parent and short-term effects on child behaviour and parenting experience: Workshop Triple P – Dealing with disobedience

Measure	Gender of parent	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity	M (n=18) F (n=166)	96.44 (24.1) 111.29 (30.2)	92.67 (23.0) 99.07 (24.5)	(1, 183) 2.686	.103	.015
ECBI Problem	M (n=16) F (n=160)	5.5 (2.2) 10.54 (7.7)	6.19 (7.5) 6.78 (5.8)	**(1, 175) 7.912**	**.005**	**.043**
Parenting Experience Scale (PES)						
How difficult has your child's behaviour been in the last 6 weeks?	M (n=16) F (n=160)	2.13 (0.6) 2.76 (0.9)	1.81 (0.8) 2.49 (0.8)	(1, 175) 0.046	.830	.000
Parenting is rewarding	M (n=15) F (n=155)	3.80 (1.0) 3.89 (0.9)	4.13 (0.6) 4.07 (0.8)	(1, 169) 0.418	.519	.002
Parenting is demanding	M (n=15) F (n=134)	3.53 (0.9) 3.79 (0.9)	4.07 (0.8) 3.69 (0.9)	(1, 168) 6.157	.014	.036
Parenting is stressful	M (n=15) F (n=160)	2.87 (1.4) 3.33 (1.0)	3.13 (1.1) 3.06 (1.0)	(1, 174) 3.649	.058	.021
Parenting is fulfilling	M (n=13) F (n=150)	4.00 (0.7) 4.03 (0.9)	4.00 (0.6) 4.14 (0.9)	(1, 162) 0.226	.614	.002
Parenting is depressing	M (n=14) F (n=152)	1.79 (1.2) 1.84 (1.1)	1.43 (0.6) 1.60 (0.9)	(1, 165) 0.255	.635	.001
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	M (n=17) F (n=165)	3.89 (0.8) 3.69 (0.8)	3.88 (0.6) 3.84 (0.7)	(1, 181) 0.543	.462	.003
How supported have you felt in your role as a parent?	M (n=18) F (n=165)	4.00 (0.7) 3.55 (0.9)	4.00 (0.3) 3.67 (0.9)	(1, 182) 0.322	.571	.002
To what extent do you both agree over the methods of disciplining your child?	M (n=18) F (n=161)	4.06 (0.8) 4.01 (1.1)	4.06 (1.0) 3.91 (1.1)	(1, 178) 0.186	.657	.001
How supportive has your partner been towards you in your role as a parent?	M (n=18) F (n=161)	4.22 (0.6) 4.12 (1.4)	4.33 (0.6) 4.01 (1.1)	(1, 178) 0.968	.326	.005
How happy do you consider your relationship to your partner to be?	M (n=18) F (n=162)	4.50 (1.1) 4.33 (1.4)	4.39 (1.0) 4.27 (1.3)	(1, 179) 0.041	.841	.000

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.39: Interaction of gender of child and short-term effects on child behaviour and parenting experience: Workshop Triple P – Dealing with disobedience

Measure	Gender of child	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity	M (n=92) F (n=92)	106.87 (30.2) 112.80 (29.4)	97.98 (25.0) 98.91 (23.9)	(1,183) 2.671	.104	.014
ECBI Problem	M (n=85) F (n=91)	9.96 (7.2) 10.19 (8.1)	6.91 (6.3) 6.56 (5.7)	(1, 175) 0.374	.542	.002
Parenting Experience Scale (PES)						
How difficult has your child's behaviour been in the last 6 weeks?	M (n=88) F (n=88)	2.65 (0.9) 2.76 (0.8)	2.40 (0.8) 2.47 (0.8)	(1, 175) 0.151	.698	.001
Parenting is rewarding	M (n=87) F (n=83)	3.92 (1.0) 3.84 (0.9)	4.14 (0.7) 4.01 (0.9)	(1, 169) 0.137	.711	.001
Parenting is demanding	M (n=86) F (n=83)	3.77 (0.9) 3.76 (0.8)	3.87 (0.9) 3.59 (0.9)	**(1, 168) 3.925**	**.049**	**.023**
Parenting is stressful	M (n=87) F (n=88)	3.22 (1.1) 3.35 (1.1)	3.15 (1.0) 2.98 (1.0)	**(1, 174) 3.807**	**.053**	**.022**
Parenting is fulfilling	M (n=83) F (n=80)	4.06 (0.9) 3.99 (1.0)	4.20 (0.8) 4.05 (0.9)	(1, 162) 0.456	.501	.003
Parenting is depressing	M (n=83) F (n=83)	1.84 (1.1) 1.82 (1.0)	1.62 (0.8) 1.55 (0.9)	(1, 165) 0.066	.798	.000
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	M (n=91) F (n=91)	3.79 (0.8) 3.63 (0.8)	3.86 (0.7) 3.84 (0.7)	(1, 181) 1.433	.233	.008
How supported have you felt in your role as a parent?	M (n=92) F (n=91)	3.62 (0.9) 3.57 (0.9)	3.74 (0.8) 3.66 (0.9)	(1, 182) 0.069	.794	.000
To what extent do you both agree over the methods of disciplining your child?	M (n=89) F (n=90)	3.98 (1.0) 4.04 (1.2)	3.91 (1.0) 3.94 (1.2)	(1, 178) 0.067	.796	.000
How supportive has your partner been towards you in your role as a parent?	M (n=89) F (n=90)	3.98 (1.0) 4.04 (1.2)	3.91 (1.0) 3.94 (1.2)	(1, 178) 0.183	.669	.001
How happy do you consider your relationship to your partner to be?	M (n=89) F (n=90)	3.98 (1.0) 4.04 (1.2)	3.91 (1.0) 3.94 (1.2)	(1, 179) 0.020	.888	.000

η_p^2 = partial eta squared

Statistically significant findings are indicated in bold.

Table A.40: Interaction of social class and short-term effects on child behaviour and parenting experience: Workshop Triple P – Dealing with disobedience

Measure	Social Class	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity	1 (n=43) 2 (n=52) 3 (n=7)	111.26 (24.9) 108.12 (24.2) 109.14 (32.2)	96.77 (25.3) 97.87 (21.8) 100.00 (27.3)	(2, 100) 0.601	.550	.012
ECBI Problem	1 (n=42) 2 (n=49) 3 (n=7)	9.02 (7.1) 10.53 (7.1) 11.29 (4.8)	6.24 (6.3) 7.23 (5.1) 6.86 (5.0)	(2, 96) 0.277	.759	.006
Parenting Experience Scale (PES)						
How difficult has your child's behaviour been in the last 6 weeks?	1 (n=43) 2 (n=50) 3 (n=6)	2.70 (0.8) 2.60 (0.9) 2.83 (0.4)	2.44 (0.8) 2.38 (0.7) 2.17 (0.4)	(2, 97) 1.070	.347	.022
Parenting is rewarding	1 (n=41) 2 (n=49) 3 (n=6)	4.15 (0.9) 3.78 (0.9) 3.67 (0.8)	4.10 (0.9) 4.08 (0.7) 3.83 (0.8)	(2, 94) 2.069	.140	.041
Parenting is demanding	1 (n=41) 2 (n=48) 3 (n=5)	3.83 (0.9) 3.90 (0.8) 3.80 (0.8)	3.76 (0.9) 3.73 (0.8) 3.40 (0.9)	(2, 92) 0.342	.707	.008
Parenting is stressful	1 (n=42) 2 (n=50) 3 (n=6)	3.10 (1.1) 3.22 (1.1) 3.17 (1.3)	3.02 (0.9) 3.01 (1.0) 3.00 (0.9)	(2, 96) 0.178	.837	.004
Parenting is fulfilling	1 (n=39) 2 (n=48) 3 (n=5)	4.15 (0.8) 4.00 (0.9) 4.20 (0.8)	4.18 (0.9) 4.13 (0.8) 4.60 (0.6)	(2, 90) 0.785	.459	.017
Parenting is depressing	1 (n=41) 2 (n=48) 3 (n=5)	1.51 (0.7) 1.63 (0.8) 1.40 (0.6)	1.41 (0.6) 1.50 (0.7) 1.40 (0.6)	(2, 92) 0.078	.925	.002
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	1 (n=43) 2 (n=52) 3 (n=7)	3.58 (0.7) 3.83 (0.7) 3.43 (0.7)	3.77 (0.6) 3.90 (0.7) 3.86 (0.9)	(2, 100) 0.658	.520	.013
How supported have you felt in your role as a parent?	1 (n=43) 2 (n=52) 3 (n=7)	3.74 (0.8) 3.40 (0.9) 3.71 (1.0)	3.72 (0.8) 3.62 (0.8) 3.71 (0.8)	(2, 100) 1.313	.274	.026
To what extent do you both agree over the methods of disciplining your child?	1 (n=43) 2 (n=51) 3 (n=7)	3.70 (0.7) 4.04 (1.2) 3.71 (0.8)	3.70 (0.7) 3.92 (1.2) 3.86 (0.7)	(2, 99) 0.490	.614	.010
How supportive has your partner been towards you in your role as a parent?	1 (n=43) 2 (n=51) 3 (n=7)	3.70 (0.7) 4.04 (1.2) 3.71 (0.8)	3.70 (0.7) 3.92 (1.2) 3.86 (0.7)	(2, 100) 0.211	.810	.004
How happy do you consider your relationship to your partner to be?	1 (n=43) 2 (n=52) 3 (n=7)	3.93 (1.1) 4.33 (1.3) 4.00 (1.0)	4.05 (1.0) 4.21 (1.3) 4.71 (1.0)	(2, 100) 2.546	.084	.049

η_p^2 = partial eta squared

Social Class 1 = professional, managerial and technical; Social Class 2 = non-manual and skilled manual; Social Class 3 = semi-skilled and unskilled.

Table A.41: Interaction of attending other Triple P Level(s) and short-term effects on child behaviour and parenting experience: Workshop Triple P – Dealing with disobedience

Measure	Attended other Level(s)	Pre-intervention	Post-intervention	ANOVA F	p	η_p^2
Eyberg Child Behaviour Inventory (ECBI)						
ECBI Intensity	No (n=128) Yes (n=56)	107.56 (31.1) 115.04 (28.6)	96.96 (25.1) 101.84 (22.6)	(1, 183) 0.602	.439	.003
ECBI Problem	No (n=125) Yes (n=51)	9.49 (7.6) 11.53 (7.7)	6.57 (5.7) 7.12 (6.8)	(1, 175) 2.15	.144	.012
Parenting Experience Scale (PES)						
How difficult has your child's behaviour been in the last 6 weeks?	No (n=118) Yes (n=58)	2.71 (0.9) 2.69 (0.8)	2.42 (0.8) 2.69 (0.8)	(1, 175) 0.141	.708	.001
Parenting is rewarding	No (n=113) Yes (n=57)	3.80 (1.0) 4.05 (0.8)	4.00 (0.8) 4.21 (0.7)	(1, 169) 0.147	.702	.001
Parenting is demanding	No (n =112) Yes (n=57)	3.74 (0.9) 3.81 (0.9)	3.66 (1.0) 3.86 (0.8)	(1, 168) 0.748	.388	.004
Parenting is stressful	No (n=118) Yes (n=57)	3.23 (1.1) 3.40 (1.0)	3.03 (1.0) 3.12 (1.0)	(1, 174) 0.258	.612	.001
Parenting is fulfilling	No (n=108) Yes (n=55)	4.00 (1.0) 4.07 (0.8)	4.09 (0.9) 4.20 (0.8)	(1, 162) 0.073	.788	.000
Parenting is depressing	No (n=110) Yes (n=56)	1.84 (1.1) 1.82 (1.1)	1.59 (0.9) 1.57 (0.8)	(1, 165) 0.001	.976	.000
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	No (n=123) Yes (n=59)	3.71 (0.8) 3.71 (0.8)	3.79 (0.7) 4.00 (0.6)	(1, 181) 1.844	.176	.010
How supported have you felt in your role as a parent?	No (n=124) Yes (n=59)	3.55 (1.0) 3.69 (0.8)	3.65 (0.8) 3.80 (0.9)	(1, 182) 0.001	.981	.000
To what extent do you both agree over the methods of disciplining your child?	No (n=122) Yes (n=57)	3.89 (1.1) 4.26 (1.0)	3.86 (1.1) 4.07 (1.1)	(1, 178) 1.415	.236	.008
How supportive has your partner been towards you in your role as a parent?	No (n=122) Yes (n=57)	4.00 (1.1) 4.40 (1.0)	3.96 (1.0) 4.23 (1.1)	(1, 178) 0.894	.346	.005
How happy do you consider your relationship to your partner to be?	No (n=123) Yes (n=57)	4.21 (1.4) 4.63 (1.2)	4.23 (1.3) 4.39 (1.3)	(1, 179) 2.788	.097	.015

η_p^2 = partial eta squared

Table A.42: Participant characteristics of responders/non-responders in study (Demographics) (Full sample): Workshop Triple P – Dealing with disobedience

		Non-responder	Responder	Test of significance
Parent's age	≤ 36 37 +	56% (n=176) 50% (n=110)	44% (n=140) 50% (n=110)	phi = .056, p = .193
Social Class	1 2 3	59% (n=85) 53% (n=81) 62% (n=16)	41% (n=58) 47% (n=71) 48% (n=10)	phi = .066, p = .495
Parent's gender	M F	63.5% (n=40) 52.5% (n=273)	36.5% (n=23) 47.5% (n=247)	phi = .068, p = .098
Expenses problem	M F	57.5% (n=69) 52% (n=222)	42.5% (n=51) 48% (n=204)	phi = .045, p = .296
Child's gender	Yes No	51% (n=155) 57% (n=156)	49% (n=151) 43% (n=119)	phi = .061, p = .143

phi = phi coefficient effect size calculated using chi-square cross-tabulation.

Table A.43: Participant characteristics of responders/non-responders in study (Full Sample) non responders not drop outs: Workshop Triple P – Dealing with disobedience

Measure		Pre-intervention	Test of significance
Eyberg Child Behaviour Inventory (ECBI)			
ECBI Intensity	Non-responder (n=299) Responder (n=261)	112.79 (31.4) 110.92 (28.9)	t = 0.730, p = .466
ECBI Problem	Non-responder (n=286) Responder (n=253)	10.54 (7.9) 10.44 (7.5)	t = 0.144, p = .885
Parenting Experience Scale (PES)			
How difficult has your child's behaviour been in the last 6 weeks?	Non-responder (n=285) Responder (n=252)	2.73 (0.9) 2.75 (0.9)	t = 0.265, p = .791
Parenting is rewarding	Non-responder (n=269) Responder (n=245)	3.97 (0.9) 3.91 (0.9)	t = 0.646, p = .519
Parenting is demanding	Non-responder (n=274) Responder (n=252)	3.77 (0.9) 3.82 (0.9)	t = 0.650, p = .519
Parenting is stressful	Non-responder (n=268) Responder (n=252)	3.37 (1.0) 3.31 (1.0)	t = 0.624, p = .533
Parenting is fulfilling	Non-responder (n=261) Responder (n=240)	4.10 (0.9) 4.07 (0.9)	t = .455, p = .649
Parenting is depressing	Non-responder (n=261) Responder (n=242)	1.54 (0.9) 1.81 (1.0)	**t = 3.177, p = .002**
In the past 6 weeks, how confident have you felt to undertake your responsibilities as a parent?	Non-responder (n=288) Responder (n=257)	3.69 (0.8) 3.69 (0.8)	t = 0.023, p = .982
How supported have you felt in your role as a parent?	Non-responder (n=191) Responder (n=260)	3.57 (0.9) 3.56 (1.0)	t = 0.069, p = .945
To what extent do you both agree over the methods of disciplining your child?	Non-responder (n=285) Responder (n=256)	3.78 (1.1) 3.96 (1.1)	t = 1.908, p = .057
How supportive has your partner been towards you in your role as a parent?	Non-responder (n=287) Responder (n=257)	3.99 (1.1) 4.07 (1.1)	t = 0.820, p = .413
How happy do you consider your relationship to your partner to be?	Non-responder (n=286) Responder (n=257)	4.26 (1.2) 4.35 (1.3)	t = 0.817, p = .414

t = t statistic calculated using independent-samples t-test

Statistically significant findings are indicated in bold.

Appendix A.4: Triple P Seminars

Table A.44: Characteristics of participant group – Triple P Seminars

	Seminar 1 ***Power of positive thinking***	**Seminar 2** ***Raising confident competent children***	**Seminar 3** ***Raising resilient children***
Gender			
Female	83.3% (897)	85.7% (576)	86.4% (102)
Male	16.7% (180)	14.3% (96)	13.6% (16)
Marital status			
Single	5.9% (64)	4.2% (28)	2.5% (3)
Married	80.4% (865)	87.5% (589)	86.8% (105)
Divorced/separated	2.5% (27)	2.8% (19)	2.5% (3)
Living with partner	10.9% (117)	5.2% (35)	6.6% (8)
Widowed	0.3% (3)	0.3% (2)	1.7% (2)
County			
Longford	26.4% (287)	26.1% (177)	9.9% (12)
Westmeath	73.6% (799)	73.9% (500)	90.1% (109)

Figures represent percentages followed by number of participants in parentheses

Table A.45: Participant characteristics – Education and Employment – Triple P Seminars

	Seminar 1 ***Power of positive thinking***	**Seminar 2** ***Raising confident competent children***	**Seminar 3** ***Raising resilient children***
Education			
Primary	2.3% (24)	2.7% (18)	2.5% (3)
Some secondary	5.7% (61)	5.1% (34)	5% (6)
Completed secondary	23.6% (251)	19.5% (131)	16.7% (20)
Post-secondary technical training	23.7% (252)	23.5% (158)	22.5% (27)
University degree	27.4% (291)	32.9% (221)	35.8% (43)
Postgraduate	17.2% (183)	16.2% (109)	17.5% (21)
Current medical card			
Yes	27.4% (294)	22.8% (152)	28.2% (29)
No	72.2% (774)	77.1% (514)	75.8% (91)
Don't know	0.4% (4)	0.1% (1)	0
Employment outside of home			
Yes, full-time	41.5% (447)	39.3% (263)	34.7% (41)
Yes, part-time	23.2% (250)	28.8% (193)	21.2% (25)
Not working but looking for a job	13.6% (147)	11.2% (75)	16.1% (19)
Home-based work	5.2% (56)	6% (40)	7.6% (9)
Not working by choice (including retired)	12.7% (137)	11.5% (77)	16.9% (20)
Unable to work due to illness/disability	1.1% (12)	1.6% (11)	0.8% (1)
Student	0.7% (8)	0.3% (2)	0
Other	1.9% (21)	1.2% (8)	2.5% (3)

Figures represent mean number of children followed by standard deviations in parentheses.

Table A.46: Participant characteristics - Social Class – Triple P Seminars

Social Class	S1 Respondent	S1 Partner	S2 Respondent	S2 Partner	S3 Respondent	S3 Partner
Professional	6.3% (68)	9.6% (104)	8.1% (55)	11.2% (76)	11.6% (14)	17.4% (21)
Managerial and Technical	24% (261)	25.6% (278)	25.3% (171)	25% (169)	17.4% (21)	32.2% (39)
Non-manual	18.2% (198)	10.5% (114)	16.7% (113)	9.9% (67)	14.9% (18)	9.1% (11)
Skilled manual	6.1% (66)	14.7% (160)	6.5% (44)	14.8% (100)	5% (6)	6.6% (8)
Semi-skilled	4.4% (48)	4.1% (45)	4% (27)	5.5% (37)	1.7% (2)	3.3% (4)
Unskilled						
Unemployed/welfare						
Unknown/other	11.4% (124)	21.5% (234)	13% (88)	24.5% (166)	10.7% (13)	15.7% (19)
Not applicable	29.6% (321)	13.9% (151)	26.4% (179)	9.2% (62)	38.8% (47)	15.7% (19)

Figures represent mean number of children followed by standard deviations in parentheses.

Table A.47: Sources of knowledge of Triple P and attendance at other seminars – Triple P Seminars

	Seminar 1 *Power of positive thinking*	Seminar 2 *Raising confident competent children*	Seminar 3 *Raising resilient children*
Attendance at other seminars			
Seminar 1	17.5% (190)	30% (203)	52.1% (63)
Seminar 2	4.6% (50)	10.6% (72)	50.4% (61)
Seminar 3	3.3% (36)	3.4% (23)	43% (52)
Sources of knowledge for this seminar			
Friend, relative, neighbour	17.6% (191)	15.1% (102)	25.6% (31)
Teacher/school official	48.2% (522)	66.6% (451)	30.6% (37)
Religious organisation	0.5% (5)	0.6% (4)	0
GP/Nurse	2.9% (31)	1.3% (9)	0.8% (1)
Public Health Nurse	3.3% (36)	2.1% (14)	4.1% (5)
Childcare Centre	5.3% (57)	3.5% (24)	13.2% (16)
Pre-school	14.7% (159)	10.6% (72)	19% (23)
Radio	0.2% (2)	0.1% (1)	0
Newspaper	5.3% (57)	3% (20)	6.6% (8)
Triple P website	3% (32)	2.5% (17)	5.8% (7)
Other Internet	1.4% (15)	0.4% (3)	2.5% (3)
Triple P paper (Tippaper)	6.4% (69)	5.8% (39)	14.9% (18)

Figures represent mean number of children followed by standard deviations in parentheses.

Table A.48: Seminar 1: Class by Satisfaction – Triple P Seminars

Class		How would you rate the quality of the seminar presentation	Did the seminar provide enough opportunities for questions?	Was the seminar interesting to you?	Did the presenter use clear examples to illustrate parenting issues?	Did the presenter provide clear explanations	Did you gain sufficient knowledge or information to be able to implement the parenting advice you heard about?	Overall, how would you rate the content of the seminar?	Was the seminar helpful in gaining an understanding of what you can do to help your child learn new skills and behaviour?	Do you intend to implement the parenting advice you received	Total Client Satisfaction Survey score
1	M	6.1400	6.1200	6.1633	6.4082	6.4490	6.2041	6.3265	6.3265	6.4167	56.5208
	N	50	50	49	49	49	49	49	49	48	48
	SD	.94782	1.27199	1.06745	.76153	.76543	.93496	.89879	.89879	.87113	7.15182
2	M	6.1283	5.9570	6.2576	6.3788	6.3473	6.1250	6.2500	6.1939	6.4735	56.1304
	N	265	256	264	264	262	264	264	263	264	253
	SD	.92449	1.30238	.93207	.90651	.86080	.89967	.85331	.84959	.74460	6.55281
3	M	6.1313	6.0093	6.2716	6.2776	6.2853	5.9849	6.1497	6.1048	6.4209	55.6635
	N	335	324	335	335	333	332	334	334	335	318
	SD	.86208	1.09456	.93866	.88430	.86411	1.05000	.96253	.94810	.84707	6.81689

Table A.49: Seminar 2: Class by Satisfaction – Triple P Seminars

Class		How would you rate the quality of the seminar presentation	Did the seminar provide enough opportunities for questions?	Was the seminar interesting to you?	Did the presenter use clear examples to illustrate parenting issues?	Did the presenter provide clear explanations	Did you gain sufficient knowledge or information to be able to implement the parenting advice you heard about?	Overall, how would you rate the content of the seminar?	Was the seminar helpful in gaining an understanding of what you can do to help your child learn new skills and behaviour?	Do you intend to implement the parenting advice you received	Total Client Satisfaction Survey score
1	M	6.4074	6.0741	6.7778	6.7037	6.7037	6.7778	6.6296	6.5556	6.6296	59.2593
	N	27	27	27	27	27	27	27	27	27	27
	SD	.74726	1.35663	.42366	.54171	.46532	.42366	.68770	.75107	.68770	4.10059
2	M	6.2308	6.3052	6.3654	6.4295	6.4679	6.4103	6.4038	6.4295	6.5355	57.6275
	N	156	154	156	156	156	156	156	156	155	153
	SD	.90051	.99231	.84309	.88070	.82243	.82596	.83302	.85090	.74098	6.47249
3	M	6.1600	6.2000	6.2876	6.3244	6.3540	6.2000	6.2743	6.2133	6.5089	56.6186
	N	225	220	226	225	226	225	226	225	224	215
	SD	.86148	1.05813	.93406	.77723	.79911	.87627	.86150	.87566	.76932	6.13810

Table A.50: Seminar 3: Class by Satisfaction – Triple P Seminars

Class		How would you rate the quality of the seminar presentation	Did the seminar provide enough opportunities for questions?	Was the seminar interesting to you?	Did the presenter use clear examples to illustrate parenting issues?	Did the presenter provide clear explanations	Did you gain sufficient knowledge or information to be able to implement the parenting advice you heard about?	Overall, how would you rate the content of the seminar?	Was the seminar helpful in gaining an understanding of what you can do to help your child learn new skills and behaviour?	Do you intend to implement the parenting advice you received	Total Client Satisfaction Survey score
1	M	6.5000	7.0000	7.0000	7.0000	6.5000	7.0000	7.0000	6.5000	7.0000	61.5000
	N	2	2	2	2	2	2	2	2	2	2
	SD	.70711	.00000	.00000	.00000	.70711	.00000	.00000	.70711	.00000	2.12132
2	M	6.1667	6.5417	6.4583	6.4167	6.3750	6.2500	6.4167	6.3750	6.6667	57.6667
	N	24	24	24	24	24	24	24	24	24	24
	SD	.86811	.58823	.65801	.82970	.76967	.67566	.71728	.76967	.56466	5.44272
3	M	6.1429	6.1714	6.2571	6.3429	6.4571	6.2571	6.2000	6.3143	6.5143	56.6571
	N	35	35	35	35	35	35	35	35	35	35
	SD	.77242	1.09774	.81684	.76477	.65722	.70054	.75926	.71831	.56211	5.28562

Appendix B – POPULATION STUDY

Appendix B.1: Data management – Population Study

Demographic variables

The Time 1 and Time 2 surveys recorded a number of socio-demographic characteristics of the index child, the respondent and their family setting. These included age and gender of children and parents in the household, the responding parent's employment status, education level, marital status, housing tenure, medical card status, number of others living in the household and ethnic background. Rurality was defined according to OECD methodology[10] where a population density below 150 inhabitants per km^2 was categorised as rural and those 150 and above as urban.

Scales

Scales were constructed as outlined below. Cases with missing values were excluded during this process.

Strengths and Difficulties Questionnaire Scales

The main outcome variables were scales derived from the Strengths and Difficulties Questionnaire (SDQ)[11] which comprises 25 items with scores from 0 to 2, where 0 = 'Not true', 1 = 'Somewhat true' and 2 = 'Certainly true'. Positively oriented statements were reverse coded before summing scores. The Total Difficulties Scale was comprised of 20 of the SDQ items and 4 sub-scales are derived from this scale, each consisting of 5 items: the emotional symptoms, the conduct problems, peer problems and hyperactivity sub-scales. For each of these scales, higher scores denoted a greater level of reported emotional or behavioural symptoms. A further sub-scale consisting of 5 items was summed to form the Pro-social Behaviour Scale. For this scale, lower scores denoted difficulties with social behaviour.

Where relevant, clinical categories were defined using banding from the Youth in Mind website SDQ (UK) scoring file (*see* http://www.sdqinfo.com/py/doc/c0.py). Categories were defined as follows for each scale:

- Total Difficulties Scale: normal 0-13; borderline 14-16; abnormal 17-40.
- Emotional Symptoms Scale: normal 0-3; borderline 4; abnormal 5-10.
- Conduct Problems Scale: normal 0-2; borderline 3; abnormal 4-10.
- Hyperactivity Scale: normal 0-5; borderline 6; abnormal 7-10.
- Peer Problems Scale: normal 0-2; borderline 3; abnormal 4-10.
- Pro-social Behaviour Scale: normal 6-10; borderline 5; abnormal 0-4.

Scales were dichotomised into 'normal' and 'borderline to abnormal' as follows: borderline to abnormal range scores for the Total Difficulties Scale = 14 – 40; Emotional Symptom Scale = 4-10; Conduct Problem Scale 3-10; Peer Problem Scale = 3-10; Hyperactivity Scale = 6-10.

10. Eurostat: Urban rural typology. http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Urban-rural_typology
11. Goodman, R. (1997) 'The Strengths and Difficulties Questionnaire: A research note', *Journal of Child Psychology and Psychiatry*, Vol. 38, pp. 581-86.

Table B.1a: Scale reliability (Cronbach's alpha) for behavioural and emotional problems as reported by parents, at Time 1 – Population Study

Scale	Intervention (α) Time 1/Time 2	Comparison (α) Time 1/Time 2	No. of items
Total Difficulties Scale	.82/.84	.82/.89	20
Emotional Symptom Sub-scale	.67/.70	.67/.80	5
Conduct Problem Sub-scale	.63/.58	.63/.72	5
Peer Problem Sub-scale	.53/.45	.54/.60	5
Hyperactivity Sub-scale	.63/.68	.67/.69	5
Pro-social Scale	.72/.72	.72/.76	5

α = Cronbach's alpha

Parenting strategies: Experiences, practices and opinions

A number of scales were derived from the questions relating to respondents' experiences as parents, their parenting practices and their opinions on parenting practices.

Kessler Psychological Distress Scale, K10

The Kessler Psychological Distress Scale was used to assess parent's feelings over the previous month (Andrews and Slade, 2001). The scale consisted of 10 items to which parents were asked to respond on a 5-point scale, from 1 = 'none of the time' to 5 = 'all of the time'. Items included how often parents felt: 'tired out for no good reason', 'so nervous that nothing could calm them', 'hopeless', 'restless or fidgety', 'so restless that you could not sit still', 'depressed', 'so depressed that nothing could cheer you up' and 'worthless'. Summed scores ranged between 10-50; high scores denoted more severe distress.

Parenting Confidence Scale

The Parenting Confidence Scale comprised 9 items concerning how confident the responding parent was in successfully dealing with their child's behaviours, including: 'your child gets upset when not getting his/her own way', 'whines or complains', 'constantly seeks attention', 'refuses to do as told', 'misbehaves when out', 'becomes anxious and tense', 'easily becomes self conscious embarrassed when watched by others', 'your child becomes unhappy, sad or depressed about something' and 'your child worries that something bad will happen'. Responses were selected on a 5-point scale, from 1 = 'not at all confident' to 5 = ' extremely confident'. The summed items formed the Parenting Confidence Scale ranging from 9-45; higher scores represented higher parental confidence.

Parenting Experience Scale

The Parenting Experience Scale consisted of 5 items for which parents were asked to respond on a 5-point scale, from 1 = 'not at all' to 5 = 'extremely'. Parents were asked if they would describe their experience as a parent as 'rewarding', 'demanding', 'stressful', 'fulfilling' and 'depressing'. Items 2, 3 and 5 were reverse coded before summing all items. Summed scores range between 5-25; higher scores denoted a more positive experience of parenting.

Family Climate Scale

The Family Climate Scale comprised 4 items, each with a 7-point scale, from 1 = 'never true' to 7= 'always true'. Items included: 'family members helped and supported each other', 'feeling of togetherness', 'fought in our family' and 'family members criticised each other'. The last two items were reverse coded prior to summing all items. Scores ranged from 4-28; higher scores represented a more positive family climate.

Relationship with Child Scale

The Relationship with Child Scale comprised 3 items for which responding parents could select on a 7-point scale, from strongly disagree = 1 to strongly agree = 7. Items included: 'have a close relationship', 'easily frustrated with my child' (reverse coded) and 'enjoy spending time with my child'. All items were summed with possible scores ranging from 3-21; higher scores represented a better relationship with the index child.

Positive Parenting Scale

The Positive Parenting Scale comprised 3 items, each with a 5-point response scale, from 1 = 'very unlikely' to 5 = 'very likely', to which parents could report their likeliness, after their child has behaved well, to: 'praise their child by describing what their child had done to please them', 'give a treat for behaving well' and 'give attention such as a hug, wink, smile or kiss'. Items were summed with possible scores range from 3-15; higher scores indicated that parents were likely to engage in positive parenting.

Parental Responsibility Scale

The Parental Responsibility Scale comprised 5 items, each with a 5-point response scale, from 1 = 'never' to 5 = 'all of the time', to which parents could report how often they were responsible for 'preparing breakfast', 'taking their child to the doctor', 'getting up at night if their child is ill', 'putting their child in bed or making sure their child goes to bed' and 'making school lunches'. Items were summed with possible scores ranging from 5-25, higher scores indicated that parents were more likely to engage in responsible parenting activities.

Discipline Scales

The 'appropriate discipline' sub-scale comprised 6 items, each with a 5-point response scale (1 = 'very unlikely' to 5 = 'very likely'), to which parents could respond concerning their likelihood, after their child has misbehaved, to: 'hold, cuddle or physically contact their child to calm them', 'not give the problem behaviour any attention', 'tell your child to stop misbehaving', 'take planned action for breaking a family rule', 'send your child for quiet time' and 'take away something or have your child repeat the correct behaviour'. These items were summed with possible scores ranging from 6-30; higher scores indicated that parents were more likely to engage in appropriate discipline strategies.

The 'inappropriate discipline' sub-scale comprised 5 items, each with a 5-point response scale (1 = 'very unlikely' to 5 = 'very likely'). Items included: 'threaten to do something the child would not like but not follow through', 'shout or become angry', give a single spank with your hand', 'give more than one spank with your hand' and 'spank your child with an object such as a belt or wooden spoon'. The last 3 items included an additional option: 6 = 'refused' recoded as missing. Items were reverse coded and summed with possible scores ranging from 5-25; higher scores denoted that parents were unlikely to engage in inappropriate discipline strategies.

Inappropriate Parenting for Anxious or Fearful Behaviour Scale

The Inappropriate Parenting for Anxious or Fearful Behaviour Scale comprised 6 items concerning parenting strategies on a 4-point response scale (1 = 'very likely' to 4 = 'very unlikely'). Parents were asked to consider how likely they were to use each strategy. Items included: 'holding, cuddling or using physical contact to settle or calm the child' (reverse coded), 'ignoring the distress by not giving attention', 'telling the child to stop being so silly', 'talking to the child in a soothing way until the fear has passed' (reverse coded), 'allowing the child to avoid the thing he/she is scared of' and 'encouraging the child to be brave' (reverse coded). All items included the additional response options 'don't know' and 'refused', which were recoded as missing. All items were summed with possible scores ranging from 6-24; higher scores denoted that parents were unlikely to engage in inappropriate strategies.

Parental Opinions Scales

Two Parental Opinions Scales were formed. The 'Opinion on Parenting Scale' consisted of 4 items for which parents could respond to on a 6-point scale (from 1= 'strongly disagree' to 6 = 'strongly agree') their responses to statements concerning the 'right to raise children any way they choose', 'people should mind their own business when it comes to other people's children', 'disciplining children is a private matter' and 'government has no right deciding how parents should discipline their children'. All items were summed with possible scores ranging from 6-24; higher scores denoted that parents were likely to have inappropriate opinions of parenting.

A second scale, the 'Parent Opinion of Smacking Scale', was formed from responses to 4 statements concerning use of smacking to discipline children: 'It is OK to give your child a smack if he/she misbehaves', 'Sometimes spanking children is the only way to make them understand', 'As long as it doesn't leave a mark smacking your child is not a big deal' and 'It is not alright to smack your child' (reverse coded). Responding parents were similarly asked to respond on a 6-point scale, from 1= 'strongly disagree' to 6 = 'strongly agree'. All items were summed with possible scores ranging from 6-24; higher scores denoted that parents were likely to have inappropriate opinions on smacking children.

Single items relating to parenting experiences, strategies and opinions

A single item asked how happy responding parents considered their relationship with their child. Responses options were on an 8-point scale, from 1= 'extremely unhappy' to 8 = 'perfectly happy'. A number of other single items related to questions on parenting inconsistency (from 1 = 'always consistent' to 5 = 'not at all consistent'), the extent to which parents felt supported in their role (from 1= 'not at all supported' to 5 = 'extremely supported'), if they had felt stressed (no = 1, yes = 2) and to what extent they had felt stressed (from 1 = 'slightly' to 4 = 'extremely').

Table B.1b: Scale reliability for parenting strategies, experiences and opinions reported by parents, at Time 1 – Population Study

Scale	Intervention (α) Time 1/Time 2	Comparison (α) Time 1/Time 2	No. of items
Parenting confidence	.93/.96	.94/.96	9
Parenting experience	.50/.53	.50/.52	5
Parental psychological distress	.90/.93	.92/.94	10
Family climate	.69/.73	.70/.72	4
Relationship with child	.48/.55	.44/.54	3
Positive parenting	.75/.63	.76/.71	3
Appropriate discipline	.43/.52	.45/.54	6
Inappropriate discipline	.63/.60	.54/.67	5
Parenting responsibilities	.89/.90	.89/91	5
Inappropriate parenting for anxious or fearful behaviour	.47/.36	.41/.38	6
Parent opinions	.75/.82	.82/.86	4
Parent opinions on smacking	.82/.77	.80/.81	4

α = Cronbach's alpha

Help-seeking behaviour

A number of single items were related to parents' help-seeking behaviours and their use of parenting programmes. These included whether parents had heard of specific parenting programmes, including the Triple P, Parenting Plus or Incredible Years programmes (multiple options); whether parents had participated in a parenting programme within the past 12 months (Yes/No) or within the past 2 years (Yes/No); whether parents would participate in a parenting programme (Yes/No); and whether they would recommend a parenting programme to a friend (Yes/No). Parents were also asked about their level of satisfaction with services to support parenting and information about parenting within their county (from 1 = 'not at all satisfied' to 5= 'extremely satisfied').

Appendix B.2: Geographical distributions

Table B.2a: Geographical distribution of the Intervention sample, Time 2 – Population Study

Aggregated area	Families with 4-8* year-olds	Number sampled, Time 1	Number sampled, Time 2	% of 4-8** year-olds sampled, Time 1	% of 4-8** year-olds sampled, Time 2
1 Athlone	367	60	50	16.57	13.62
2 Athlone environs	606	139	86	25.50	14.19
3 Mullingar	659	101	106	15.71	16.08
4 Mullingar environs	968	186	194	19.33	20.04
5 Moate	232	59	32	47.20	13.79
6 Kinnegad	363	81	57	30.68	15.70
7 Longford	318	35	22	8.84	6.92
8 Athlone No.1 R/D	862	38	108	13.43	12.53
9 Ballymore, Coole and Delvin R/Ds	1,005	15	132	11.63	13.13
10 Mullingar R/D1	2,204	15	291	8.72	13.20
11 Ballymahon R/D	589	45	79	28.48	13.41
12 Granard No.1 R/D	736	3	116	2.34	15.76
13 Longford R/D	1,547	11	248	8.80	16.03

* Based on families with children aged 2-6 years in Census 2011

** Age at next birthday

Table B.2b: Geographical distribution of the Comparison sample, Time 2 – Population Study

Aggregated area	Families with 4-8* year-olds	Number sampled, Time 1	Number sampled, Time 2	% of 4-8** year-olds sampled, Time 1	% of 4-8** year-olds sampled, Time 2
14 Thurles	413	89	46	20.65	11.14
15 Nenagh	605	192	78	38.32	12.89
16 Roscrea and RD No.1 and Templemore and Borrisokane R/D	1,764	228	142	14.43	8.05
17 Nenagh R/D	1,881	149	293	9.25	15.58
18 Thurles R/D	1,164	97	151	9.31	12.97
19 Clonmel and environs	762	108	116	13.37	15.22
20 Carrick-on-Suir Town and No.1 R/D	563	67	76	11.28	13.50
21 Tipperary	263	37	48	12.98	18.25
22 Cashel and Cahir	355	52	75	15.57	21.13
23 Cashel R/D	1,312	104	168	9.42	12.80
24 Clogheen and Clonmel No.1 R/D	1,661	99	173	7.38	10.42
25 Slieveardagh R/D	474	53	51	13.42	10.76
26 Tipperary No.1 R/D	1,052	128	127	14.63	12.07

* Based on families with children aged 2-6 years in Census 2011

** Age at next birthday

Appendix B.3: Population Survey – Demographic characteristics

Table B.3a: Child demographic characteristics, by group and time

Age next birthday	Intervention Time 1 n (%)	Comparison Time 1 n (%)	Cramer's V, Time 1	Intervention Time 2 n (%)	Comparison Time 2 n (%)	Cramer's V, Time 2
4	406 (27)	350 (23.4)		339 (22.3)	333 (21.6)	
5	361 (24.1)	359 (24)		327 (21.5)	307 (19.9)	
6	319 (21.3)	327 (21.9)		321 (21.1)	322 (20.9)	
7	272 (18.1)	268 (17.9)		309 (20.3)	325 (21.0)	
8	143 (9.5)	191 (12.8)		225 (14.8)	257 (16.6)	
p	0.025*		0.061	0.55		0.032
Gender	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Cramer's V, Time 2**
Male	790 (52.6)	766 (51.2)		802 (52.5)	740 (52.6)	
Female	711 (47.4)	729 (48.8)		722 (47.5)	738 (47.4)	
p	0.445		0.445	.941		.001

* p<.05

Table B.3b: Parental and family demographic characteristics, by group and time

Relationship to target child	Intervention Time 1 n (%)	Comparison Time 1 n (%)	Phi or Cramer's V, Time 1	Intervention Time 2 n (%)	Comparison Time 2 n (%)	Phi or Cramer's V, Time 2
Mother	1195 (79.6)	1152 (77.1)		1126 (74.0)	1183 (76.6)	
Father	289 (19.3)	329 (22)		384 (25.2)	327 (21.1)	
Step, foster parent or other	17 (1.1)	14 (0.9)		11 (0.8)	32 (2.2)	
p	0.161		.035	0.000***		.076
Age of respondent	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
< 21	10 (0.7)	5 (0.4)		2 (0.1)	8 (0.5)	
21-25	134 (9.8)	124 (8.7)		73 (4.8)	85 (5.5)	
26-30	314 (22.9)	343 (24.1)		241 (15.8)	232 (15.0)	
31-40	685 (49.9)	721 (50.7)		790 (51.9)	741 (48.0)	
41-50	215 (15.7)	221 (15.6)		395 (26.0)	456 (29.5)	
51+	15 (1.1)	7 (0.5)		20 (1.3)	22 (1.4)	
p	0.267		0.048	.061		0.059
Social Class#	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
Professional	93 (6.2)	79 (5.3)		100 (6.6)	99 (6.4)	
Managerial and Technical	337 (22.5)	291 (19.5)		422 (27.7)	405 (26.2)	
Non-manual	231 (15.4)	229 (15.3)		287 (18.9)	250 (16.2)	
Skilled manual	222 (14.8)	216 (14.4)		203 (13.3)	192 (12.4)	
Semi-skilled	165 (11)	240 (16.1)		116 (7.6)	128 (8.3)	
Unskilled	49 (3.3)	52 (3.5)		37 (2.4)	81 (5.2)	
Unemployed/ welfare	290 (19.3)	278 (18.6)		344 (22.6)	364 (23.6)	
Unknown	114 (7.6)	110 (7.4)		12 (0.8)	25 (1.6)	
p	0.009*		0.079	0.001**		0.91

Marital status	Intervention Time 1 n (%)	Comparison Time 1 n (%)	Phi or Cramer's V, Time 1	Intervention Time 2 n (%)	Comparison Time 2 n (%)	Phi or Cramer's V, Time 2
Single	282 (18.8)	333 (22.3)		185 (12.2)	285 (18.5)	
Married/Living as married	1102 (73.4)	1067 (71.4)		1083 (71.2)	907 (58.7)	
Divorced/ Separated	106 (7.1)	78 (5.2)		76 (5.0)	147 (9.5)	
Widowed	11 (0.7)	17 (1.1)		166 (10.9)	197 (12.8)	
p	0.016*		0.059	0.000***		0.132
Education level	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
Primary school or less	37 (2.5)	30 (2)		28 (1.8)	36 (2.3)	
Some secondary school	248 (16.5)	263 (17.6)		174 (11.4)	215 (13.9)	
Completed secondary school	624 (41.6)	648 (43.3)		508 (33.4)	469 (30.4)	
Post secondary school technical training	338 (22.5)	311 (20.8)		505 (33.2)	432 (28.0)	
University degree	206 (13.7)	193 (12.9)		243 (16.0)	288(18.7)	
Postgraduate degree	48 (3.2)	50 (3.3)		63 (4.1)	104 (6.7)	
p	0.669		0.033	0.000***		0.093
Work status	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
Yes, full time	370 (24.7)	404 (27.0)		414 (27.2)	422 (27.3)	
Yes, part time	268 (17.9)	288 (19.3)		285 (18.7)	319 (20.7)	
Not working, but looking for a job	228 (15.2)	250 (16.7)		315 (20.7)	224 (14.5)	
Home-based work (child care, sewing, Internet or phone-based work, etc)	85 (5.7)	82 (5.5)		200 (13.1)	190 (12.3)	
Not working by choice (includes retired)	550 (36.6)	471 (31.5)		307 (20.2)	389 (25.2)	
p	0.052		0.056	0.000***		0.094
No. children in household	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
1	285 (19.0)	298 (19.9)		257 (16.9)	321 (20.8)	
2	645 (43.0)	587 (39.3)		613 (40.3)	560 (36.3)	
3	347 (23.1)	392 (26.2)		396 (26.0)	396 (25.6)	
4	152 (10.1)	140 (9.4)		170 (11.2)	155 (10.0)	
5	50 (3.3)	43 (2.9)		61 (4.0)	53 (3.4)	
6	14 (0.9)	20 (1.3)		19 (1.2)	20 (1.3)	
≥7	8 (0.5)	15 (1)		5 (0.4)	39 (2.6)	
p	0.126		0.058	0.000***		0.115

Ethnic or cultural background	Intervention Time 1 n (%)	Comparison Time 1 n (%)	Phi or Cramer's V, Time 1	Intervention Time 2 n (%)	Comparison Time 2 n (%)	Phi or Cramer's V, Time 2
Irish National	1263 (84.1)	1286 (86)		1236 (81.3)	1335 (86.5)	
Irish Traveller	14 (0.9)	17 (1.1)		50 (3.3)	47 (3.0)	
GB/UK						
(excl. NI)	52 (3.5)	64 (4.3)		3 (0.2)	2 (0.1)	
USA/Canada	1 (0.1)	0 (0)		69 (4.5)	42 (2.7)	
Eastern Europe	50 (3.3)	53 (3.5)		36 (2.4)	22 (1.4)	
Other Europe	33 (2.2)	19 (1.3)		9 (0.6)	3 (0.2)	
South Africa	8 (0.5)	3 (0.2)		24 (1.6)	2 (0.1)	
Other Africa	25 (1.7)	2 (0.1)		24 (1.6)	10 (0.6)	
India/Pakistan/ Bangladesh	15 (1)	7 (0.5)		3 (0.2)	0 (0)	
China/ Vietnam	2 (0.1)	1 (0.1)		7 (0.5)	6 (0.4)	
Other Asia	3 (0.2)	7 (0.5)		1 (0.1)	2 (0.1)	
Australia/New Zealand	1 (0.1)	2 (0.1)		44 (2.9)	53 (3.4)	
Poland	18 (1.2)	20 (1.3)		4 (0.3)	3 (0.2)	
Nigeria	3 (0.2)	2 (0.1)		11 (0.7)	17 (1.1)	
Other	13 (0.9)	12 (0.8)		0 (0)	0 (0)	
Household tenure	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
Rented	684 (45.6)	726 (48.6)		617 (40.6)	729 (47.2)	
Owned	801 (53.4)	756 (50.6)		892 (58.6)	799 (51.7)	
Living with parents	16 (1.1)	13 (0.9)		12 (0.8)	16 (1.0)	
p	0.241		0.106	0.001**		0.70
Type of family	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
Original family (both biological or adoptive parents present)	1230 (81.9)	1237 (82.7)		1249 (82.1)	1192 (77.2)	
Step family (two parents, one being a step parent)	53 (3.5)	38 (2.5)		20 (1.3)	21 (1.4)	
Sole parent family	207 (13.8)	212 (14.2)		241 (15.8)	307 (19.9)	
Other (*please describe*)	11 (0.7)	8 (0.5)		11 (0.7)	24 (1.6)	
p	0.390		0.032	0.003**		0.067
Medical card	**Intervention Time 1 n (%)**	**Comparison Time 1 n (%)**	**Phi or Cramer's V, Time 1**	**Intervention Time 2 n (%)**	**Comparison Time 2 n (%)**	**Phi or Cramer's V, Time 2**
Yes	722 (48.4)	800 (53.8)		645 (42.4)	730 (47.3)	
No	770 (51.6)	686 (46.2)		860 (56.5)	726 (47)	
p	0.003*		-0.054	0.000***		0.147

Urban/ Rural	Intervention Time 1 n (%)	Comparison Time 1 n (%)	Phi or Cramer's V, Time 1	Intervention Time 2 n (%)	Comparison Time 2 n (%)	Phi or Cramer's V, Time 2
Rural	763 (54.2)	810 (49.6)		546 (35.9)	417 (27)	
Urban	645 (45.8)	578 (47.3)		975 (64.1)	1127 (73)	
p	0.026*		0.0452	0.000***		0.096

§ Calculated from date of birth of reporting parent.

Verbatim occupation classified according to Central Statistics Office, 2006 categories.

* p<.05

** p<.01

*** p<.001

p = Pearson's chi-square test comparing intervention and comparison samples.

Effect size: Where statistically significant differences were found (p<.05), effect sizes are reported as Phi (2x2 tables) or Cramer's V.

Urban: Resides in an electoral district with a population size of population density of 150 or more per sq km;
Rural: Resides in an electoral districts with population density less than 150 per sq km (*see* OECD: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Urban-rural_typology).

Appendix B.4: Sample SDQ means, standard deviations, frequency distributions and weighted percentages

Table B.4a: Means and standard deviations for SDQ scales by sample and gender, Time 1 – Population Study

INTERVENTION SAMPLE						
Child's gender	**Male n=790**		**Female n=711**		**Total for intervention sample**	
SDQ Scale	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Total Difficulties Scale	8.8	5.7	8.1	5.2	8.5	5.5
Emotional Symptoms Sub-scale	1.8	1.8	1.9	1.9	1.8	1.9
Conduct Problem Sub-scale	1.9	1.8	1.6	1.5	1.8	1.7
Hyperactivity Sub-scale	3.6	2.3	3.1	2	3.4	2.2
Peer Problem Sub-scale	1.6	1.6	1.4	1.6	1.5	1.6
Pro-social Sub-scale	7.7	2.1	8	1.9	7.8	2
INTERVENTION SAMPLE						
Child's gender	**Male n=766**		**Female n=729**		**Total for comparison sample**	
SDQ Scale	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Total Difficulties Scale	8.3	5.8	7.4	5.1	7.9	5.5
Emotional Symptoms Sub-scale	1.8	1.9	1.8	1.9	1.8	1.9
Conduct Problem Sub-scale	1.7	1.7	1.5	1.5	1.6	1.6
Hyperactivity Sub-scale	3.4	2.3	2.8	2	3.1	2.2
Peer Problem Sub-scale	1.3	1.6	1.3	1.5	1.3	1.5
Pro-social Sub-scale	8	2	8.5	1.7	8.3	1.9
COMBINED SAMPLE						
Child's gender	**Male n=1,556**		**Female n=1,440**		**Total for combined sample**	
SDQ Scale	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Total Difficulties Scale	8.5	5.8	7.7	5.2	8.2	5.5
Emotional Symptoms Sub-scale	1.8	1.9	1.9	1.9	1.8	1.9
Conduct Problem Sub-scale	1.8	1.7	1.5	1.5	1.7	1.6
Hyperactivity Sub-scale	3.5	2.3	3	2	3.3	2.2
Peer Problem Sub-scale	1.4	1.6	1.4	1.5	1.4	1.6
Pro-social Sub-scale	7.9	2.1	8.3	1.8	8	1.9

Table B.4b: Means and standard deviations for SDQ scales by sample and gender, Time 2 – Population Study

INTERVENTION SAMPLE						
Child's gender	**Male n=790**		**Female n=711**		**Total for intervention sample**	
SDQ Scale	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Total Difficulties Scale	7.9	6.0	8.9	8.2	7.3	5.6
Emotional Symptoms Sub-scale	1.6	2.0	2.4	3.0	1.5	1.9
Conduct Problem Sub-scale	1.6	1.7	1.9	2.4	1.4	1.6
Hyperactivity Sub-scale	3.5	2.6	3.0	2.2	3.1	2.2
Peer Problem Sub-scale	1.2	1.6	1.6	2.0	1.2	1.5
Pro-social Sub-scale	8.5	1.8	8.8	2.0	8.3	1.9
INTERVENTION SAMPLE						
Child's gender	**Male n=766**		**Female n=729**		**Total for comparison sample**	
SDQ Scale	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Total Difficulties Scale	7.9	6.0	8.6	8.2	8.4	7.3
Emotional Symptoms Sub-scale	1.6	2.0	2.4	3.0	2.0	3.6
Conduct Problem Sub-scale	1.6	1.7	1.9	2.4	1.7	2.1
Hyperactivity Sub-scale	3.5	2.6	3.0	2.2	3.3	2.4
Peer Problem Sub-scale	1.2	1.6	1.6	2.0	1.4	1.8
Pro-social Sub-scale	8.5	1.8	8.8	2.0	8.7	1.9
COMBINED SAMPLE						
Child's gender	**Male n=1,556**		**Female n=1,440**		**Total for combined sample**	
SDQ Scale	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Total Difficulties Scale	7.8	5.8	8.0	7.2	7.9	6.5
Emotional Symptoms Sub-scale	1.5	1.9	2.0	2.6	1.8	2.3
Conduct Problem Sub-scale	1.5	1.6	1.6	2.1	1.6	1.9
Hyperactivity Sub-scale	3.5	2.4	2.9	2.2	3.2	2.3
Peer Problem Sub-scale	1.4	1.5	1.4	1.8	1.3	1.7
Pro-social Sub-scale	8.3	1.8	8.6	1.9	8.5	1.0

Table B.4c: Weighted frequency distribution of the Total Difficulties scores for intervention and comparison samples, Times 1 and 2 – Population Study

SDQ Score	Intervention, Time 1		Comparison, Time 1		Intervention, Time 2		Comparison, Time 2	
	%	Cumulative %	%	Cumulative %	%	Cumulative %	%	Cumulative %
0	1.8	1.8	2.4	2.4	3.3	3.3	5.1	5.1
1	3.9	5.7	6.6	9	4	7.3	4.7	9.8
2	5.8	11.5	7.7	16.7	6.4	13.7	6.8	16.6
3	6.8	18.3	7.5	24.3	8.3	22	9.4	26
4	7.8	26.1	9	33.2	12.7	34.7	10.1	36
5	8.3	34.3	10.3	43.6	11.9	46.7	9.5	45.6
6	8.8	43.2	8.2	51.7	8.7	55.4	8.5	54.1
7	8.4	51.6	7.7	59.4	7.7	63.1	6.1	60.2
8	7.5	59.1	5.7	65.1	7.9	71	6.8	67
9	7.2	66.2	6	71.1	5.7	76.7	4.8	71.8
10	6.2	72.4	5.2	76.3	4.6	81.4	6	77.8
11	3.4	75.8	4.2	80.5	3.4	84.8	3.3	81.1
12	4.5	80.3	3.4	83.9	2.8	87.6	2.6	83.7
13	3.6	84	2.8	86.6	2.4	90	1.8	85.5
14	2.4	86.4	1.8	88.5	1.5	91.5	2.2	87.7
15	2.4	88.7	2.3	90.8	0.7	92.2	1.8	89.5
16	1.8	90.5	1.5	92.3	1.1	93.3	1.4	90.8
17	1.9	92.5	1.8	94.1	1	94.4	0.8	91.6
18	1.3	93.8	1.4	95.5	0.8	95.2	1.3	92.9
19	1.4	95.2	1	96.5	0.8	95.9	0.4	93.4
20	1.8	97	0.8	97.2	1.1	97.1	1.1	94.5
21	1	98	0.7	97.9	0.3	97.3	0.7	95.2
22	0.5	98.4	0.5	98.4	0.2	97.5	0.2	95.4
23	0.7	99.2	0.1	98.4	0.3	97.9	0.2	95.6
24	0.3	99.4	0.2	98.6	0.3	98.2	0.2	95.8
25	0.1	99.5	0	98.6	0.5	98.6	0.1	95.9
26	0	99.5	0.6	99.2	0.2	98.8	0.3	96.2
27	0.2	99.7	0.2	99.4	0.1	98.9	0.1	96.3
28	0.1	99.8	0.1	99.5	0.1	99	0.2	96.5
29	0	99.8	0.2	99.7	0.2	99.2	0.1	96.7
30	0.1	99.9	0.1	99.7	0.6	99.8	3.2	99.9
31	0.1	99.9	0.1	99.8	0.2	100	0.1	100
32	0.1	100	0.1	99.9	0.0	100	0.0	100
33	0.0	100	0.1	100	0.0	100	0.0	100

Table B.4d: Weighted frequency distribution of the Emotional Symptoms scores for intervention and comparison samples, Times 1 and 2 – Population Study

SDQ Score	Intervention, Time 1		Comparison, Time 1		Intervention, Time 2		Comparison, Time 2	
	%	Cumulative %	%	Cumulative %	%	Cumulative %	%	Cumulative %
0	31	31	33.5	33.5	39.9	39.9	37.3	37.3
1	23.9	54.9	21.7	55.3	25.1	65.1	20.3	57.5
2	15	70	15.5	70.8	14.6	79.7	16.4	74
3	13	82.9	13.3	84.1	8.3	88	9.3	83.3
4	7.7	90.7	6.3	90.4	5.7	93.7	6	89.3
5	5.1	95.8	4.8	95.2	2.7	96.4	3.9	93.2
6	2.8	98.6	2	97.2	1.2	97.6	1.8	95
7	0.7	99.3	0.9	98.1	0.9	98.5	1	96
8	0.4	99.7	1	99.1	0.3	98.8	0.5	96.6
9	0.1	99.8	0.8	99.9	0.5	99.4	0.2	96.7
10	0.2	100	0.1	100	0.6	100	3.3	100

Table B.4e: Weighted frequency distribution of the Conduct Problem scores for intervention and comparison samples, Times 1 and 2 – Population Study

SDQ Score	Intervention, Time 1		Comparison, Time 1		Intervention, Time 2		Comparison, Time 2	
	%	Cumulative %	%	Cumulative %	%	Cumulative %	%	Cumulative %
0	27.4	27.4	31.8	31.8	30.0	30.0	37.8	37.8
1	23.8	51.3	25.6	57.4	33.8	63.8	25.7	63.5
2	21.5	72.7	21.4	78.7	17.5	81.3	16.6	80.1
3	14	86.8	9.8	88.5	9.3	90.7	7.8	88
4	5.8	92.6	6.3	94.8	4.7	95.4	4.3	92.3
5	4.5	97.2	2.5	97.3	2.4	97.8	2.6	95
6	1.5	98.6	0.9	98.3	0.9	98.7	0.9	95.9
7	0.8	99.4	1.1	99.4	0.3	99.1	0.6	96.6
8	0.3	99.8	0.2	99.6	0.8	99.9	3.4	100
9	0.2	100	0.3	99.9	0.1	100	0.0	100
10	0.0	100	0.1	100	0.0	100	0.0	100

Table B.4f: Weighted frequency distribution of the hyperactivity scores for intervention and comparison samples, Times 1 and 2 – Population Study

SDQ Score	Intervention, Time 1		Comparison, Time 1		Intervention, Time 2		Comparison, Time 2	
	%	Cumulative %	%	Cumulative %	%	Cumulative %	%	Cumulative %
0	7.7	7.7	8.9	8.9	10.4	10.4	14.3	14.3
1	13.7	21.4	20.6	29.5	13.6	24	14.6	28.8
2	17.5	38.9	18.8	48.4	17.9	41.9	16.6	45.4
3	17.3	56.2	16.2	64.5	20.7	62.6	15.4	60.8
4	16	72.2	13.8	78.3	16.6	79.2	12.7	73.5
5	12.1	84.4	9.4	87.7	7.8	87	8.7	82.1
6	7.3	91.7	5.3	93	5	92	7.8	89.9
7	4.8	96.5	3.2	96.2	3.3	95.2	4.8	94.8
8	1.7	98.2	1.9	98.1	1.8	97.1	2	96.8
9	0.9	99.1	1.1	99.2	1.8	98.8	1.6	98.4
10	0.9	100	0.8	100	1.2	100	1.6	100

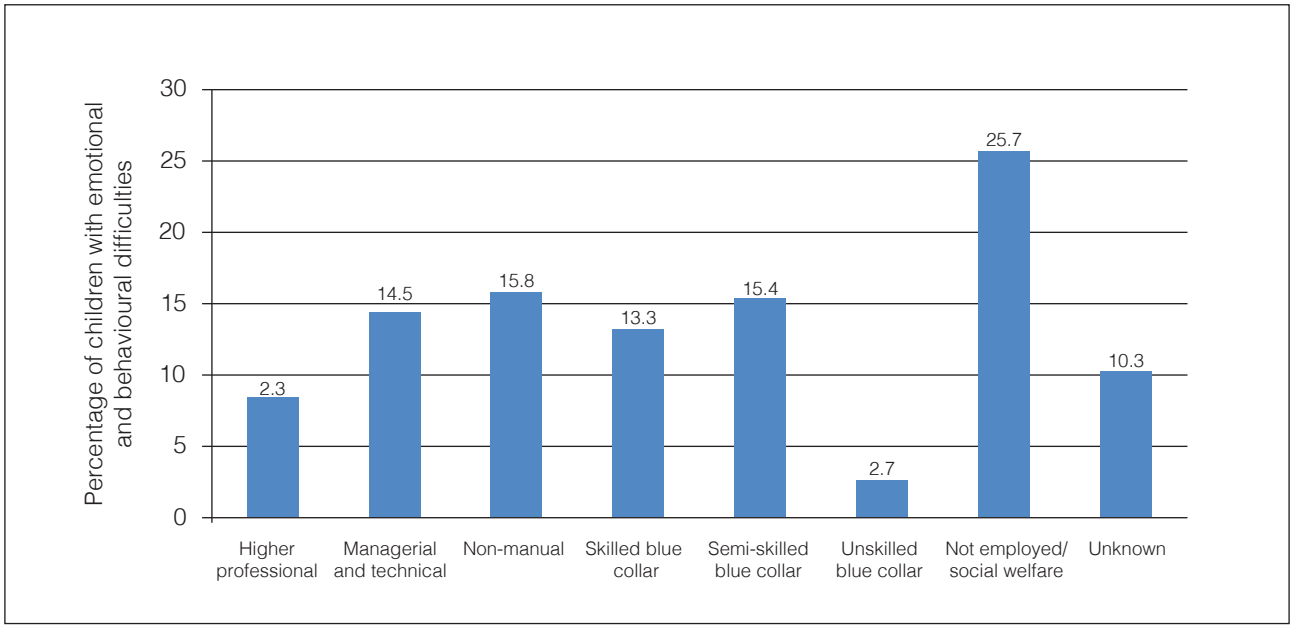
Table B.4g: Weighted frequency distribution of the peer problem scores for intervention and comparison samples, Times 1 and 2 – Population Study

SDQ Score	Intervention, Time 1		Comparison, Time 1		Intervention, Time 2		Comparison, Time 2	
	%	Cumulative %	%	Cumulative %	%	Cumulative %	%	Cumulative %
0	35.2	35.2	43.4	43.4	43.7	43.7	45.5	45.5
1	24.0	59.3	23.7	67.1	21.9	65.6	22.3	67.8
2	19.5	78.8	14.3	81.4	19.1	84.7	14.8	82.5
3	9.1	87.9	8.4	89.8	8.5	93.2	5.9	88.4
4	6.6	94.5	5.8	95.6	3.1	96.3	4.1	92.6
5	3.4	97.9	2.5	98.1	1.5	97.8	2.8	95.4
6	1.5	99.4	1.5	99.6	1.7	99.5	4.0	99.4
7	0.4	99.8	0.3	99.9	0.3	99.8	0.3	99.6
8	0.1	99.9	0.1	100	0.2	100	0.3	99.9
9	0.0	99.9	0.0	100	0.0	100	0.1	100
10	0.1	100	0.0	100	0.0	100	0.0	100

Table B.4h: Weighted frequency distribution of the pro-social scores for intervention and comparison samples, Times 1 and 2 – Population Study

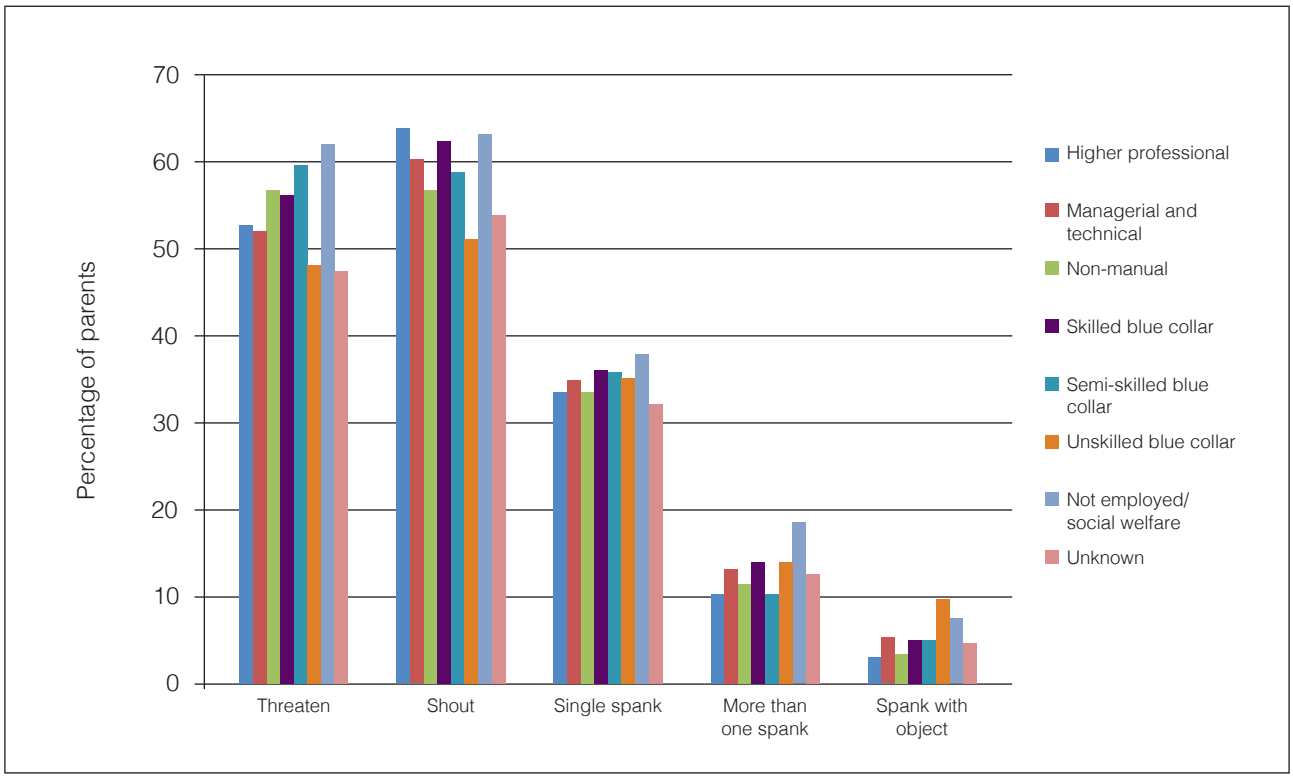
SDQ Score	Intervention, Time 1		Comparison, Time 1		Intervention, Time 2		Comparison, Time 2	
	%	Cumulative %	%	Cumulative %	%	Cumulative %	%	Cumulative %
0	0.1	0.1	0.1	0.1	0.2	0.2	0.9	0.9
1	0.1	0.2	0.1	0.1	0.2	0.3	0.2	1.1
2	0.8	1.0	0.6	0.8	0.3	0.6	0.2	1.3
3	1.0	2.0	0.5	1.3	0.8	1.4	0.6	1.9
4	4.1	6.1	1.9	3.2	2.9	4.3	1.4	3.2
5	10.4	16.5	7.0	10.2	6.1	10.4	4.1	7.3
6	11.4	27.9	9.9	20.1	7.6	18.0	3.8	11.1
7	12.6	40.5	9.1	29.2	10.2	28.2	8.6	19.8
8	14.1	54.6	14.8	44.0	16.6	44.8	13.5	33.2
9	17.4	72.0	17.9	61.9	18.3	63.2	17.9	51.1
10	28.0	100	38.1	100	36.8	100	48.9	100

Figure B.4a: Weighted§ percentage of children with emotional and behavioural difficulties across Social Class groups, at Time 1 – Population Study



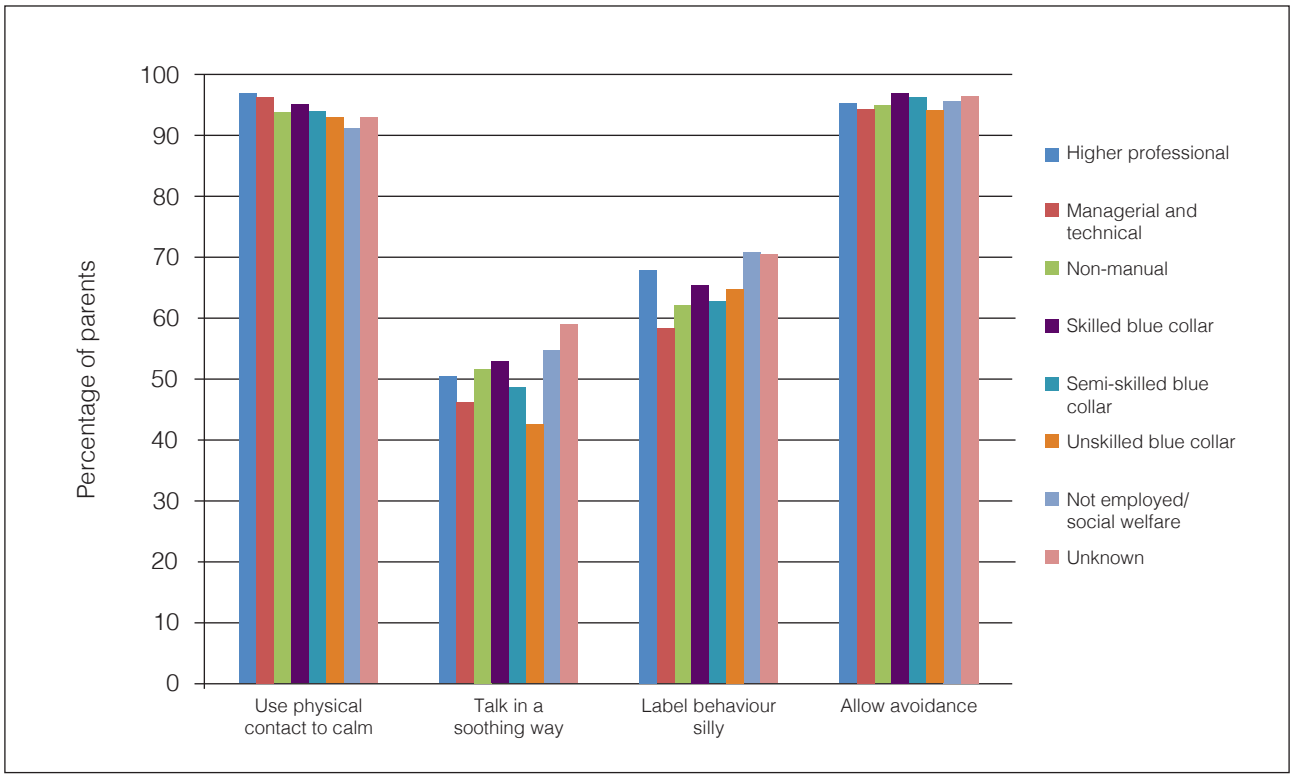
§ Weighted by age and gender of target child, social class of parents and aggregate area

Figure B.4b: Weighted§ 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

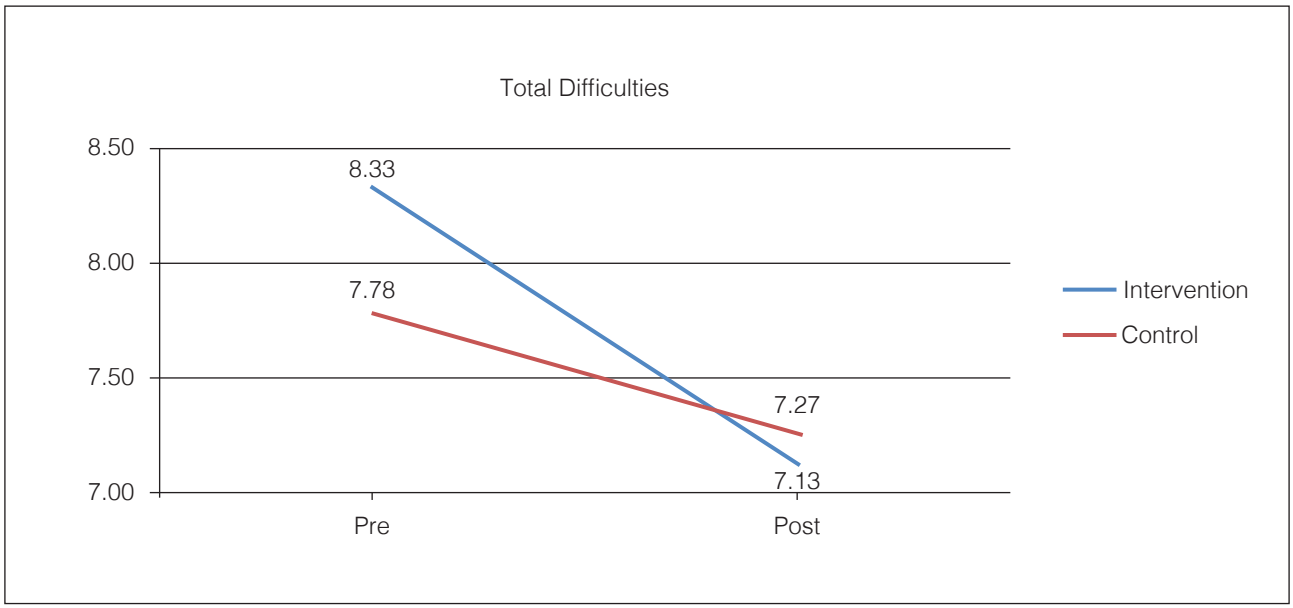
Figure B.4c: Weighted§ percentage of parent using inappropriate strategies for fearful or anxious behaviour by Social Class groups, at Time 1 – Population Study

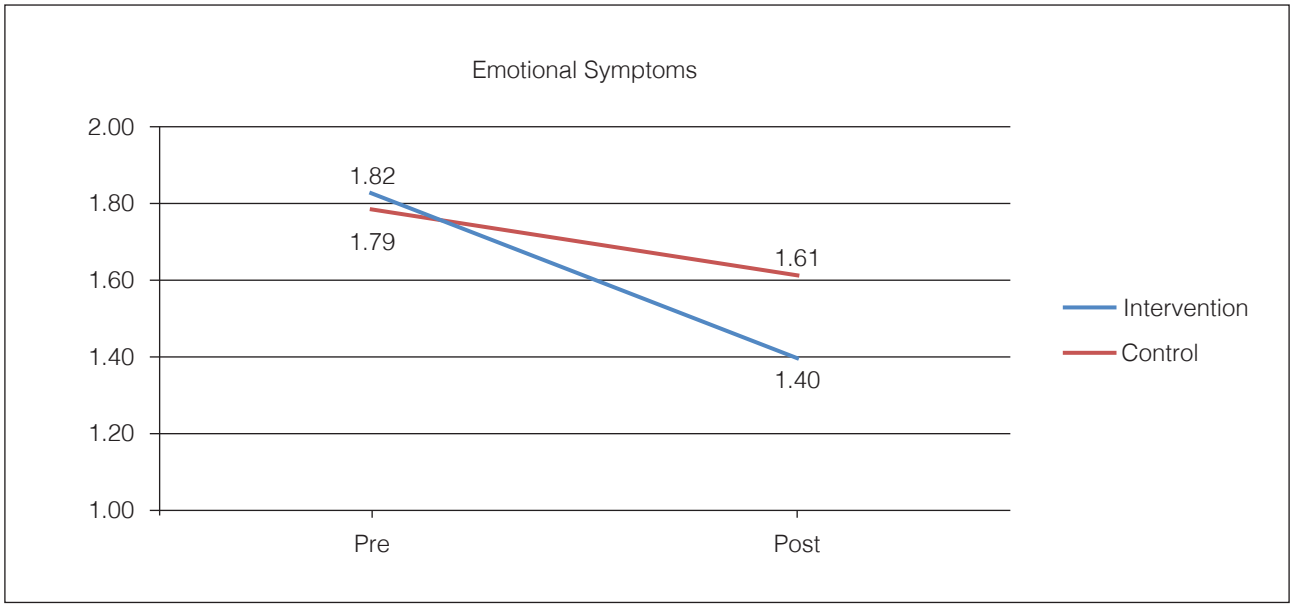


§ Weighted by age and gender of target child, social class of parents and aggregate area

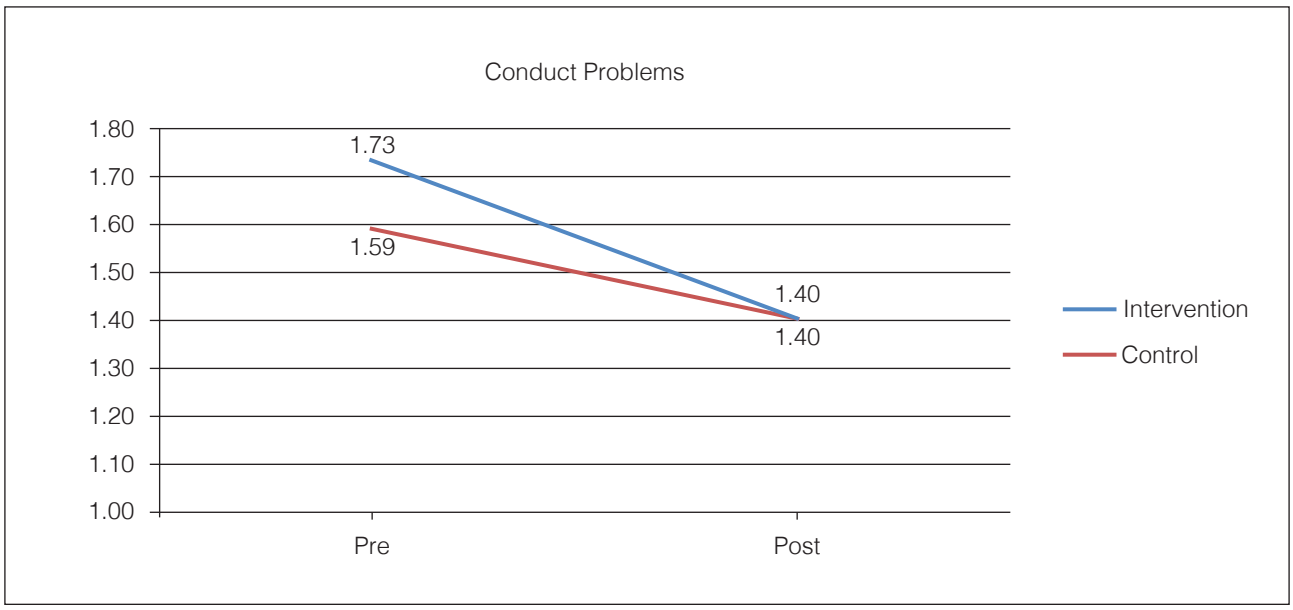
Appendix B.5: Effectiveness of Triple P at the population level

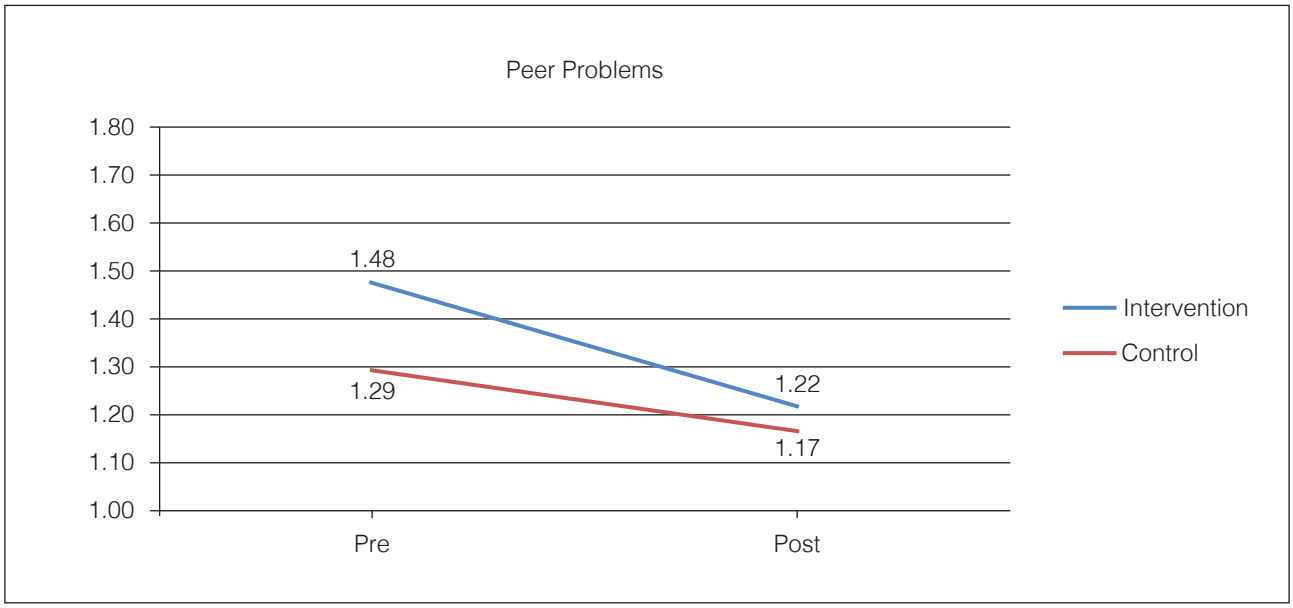
Figure B.5a: Estimated means for SDQ scales adjusted by socio-demographic variables, for intervention and comparison samples, at Time 1 (pre) and Time 2 (post) – Population Study[12]

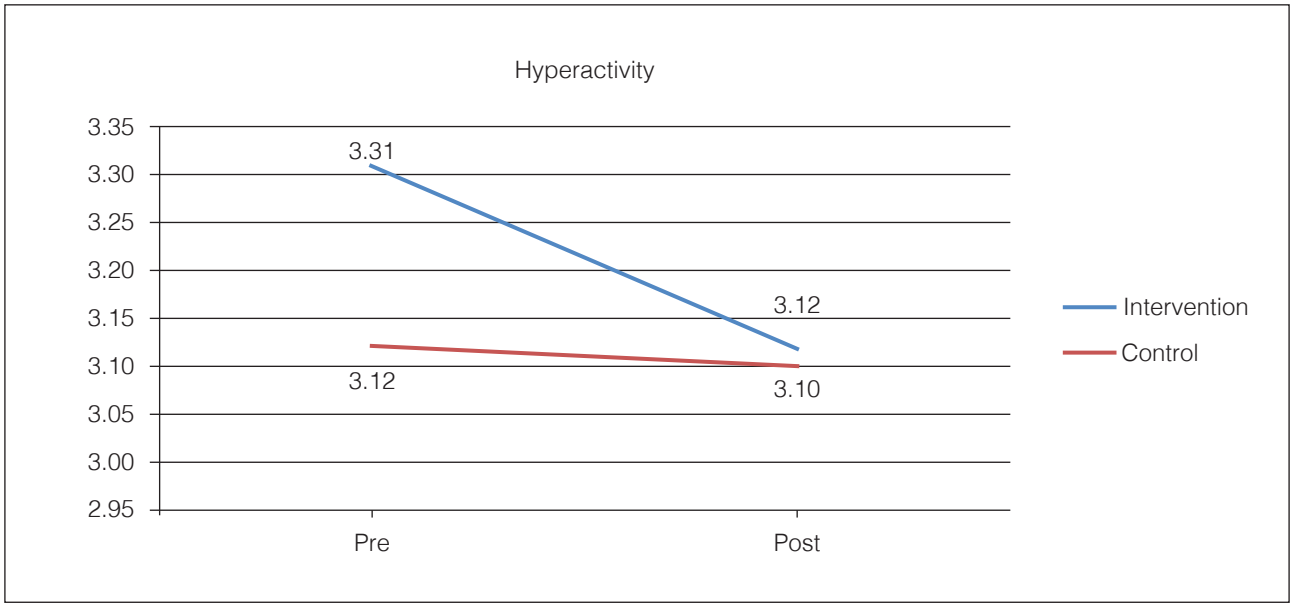




12. Derived from ANCOVA models (*see Section 7.4*).


Conduct Problems
1.80
1.70
1.60
1.50
1.40
1.30
1.20
1.10
1.00
1.73
1.59
1.40
1.40
Pre
Post
Intervention
Control


Peer Problems
1.80
1.70
1.60
1.50
1.40
1.30
1.20
1.10
1.00
1.48
1.29
1.22
1.17
Pre
Post
Intervention
Control


Hyperactivity
3.35
3.30
3.25
3.20
3.15
3.10
3.05
3.00
2.95
3.31
3.12
3.12
3.10
Pre
Post
Intervention
Control

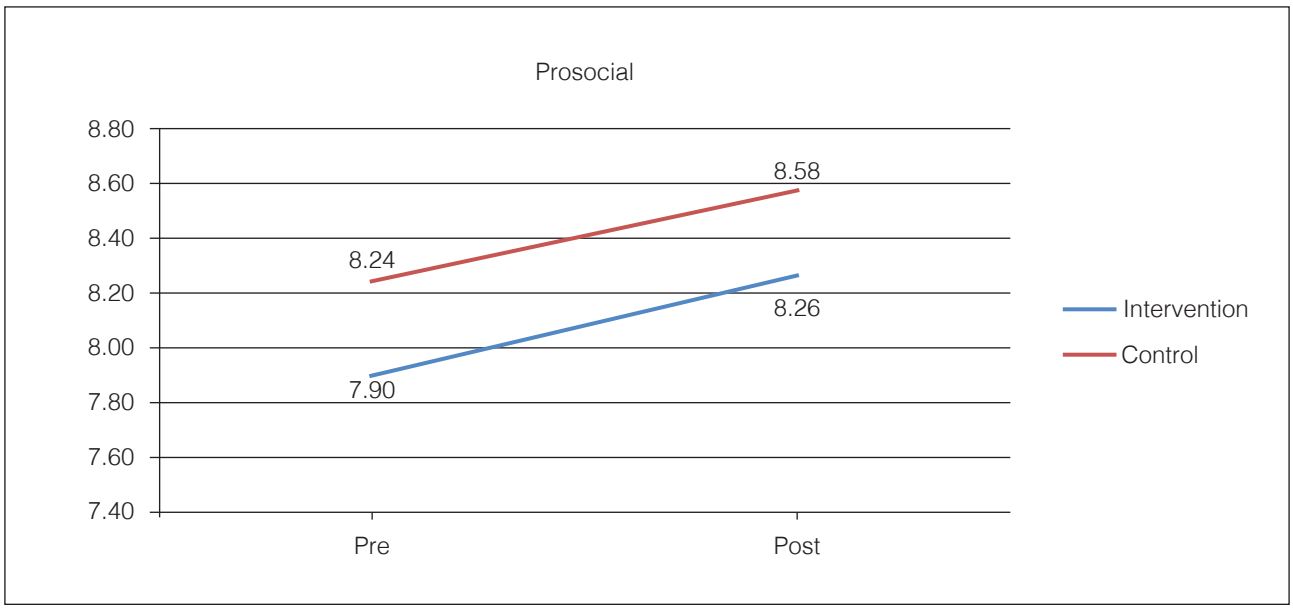
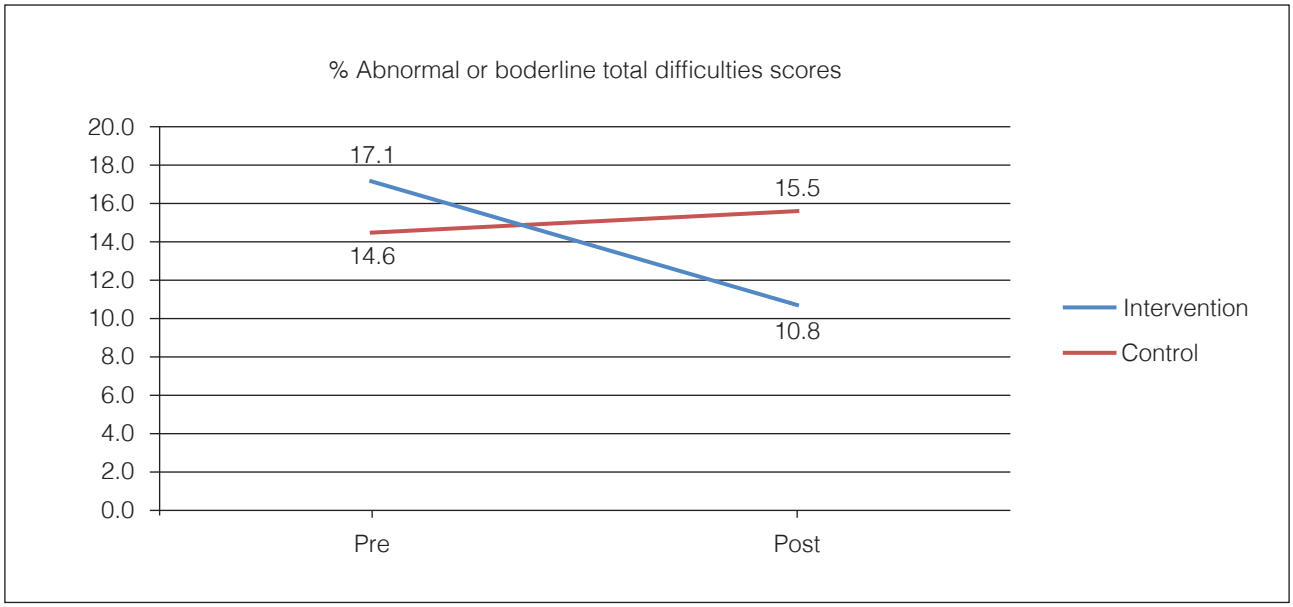
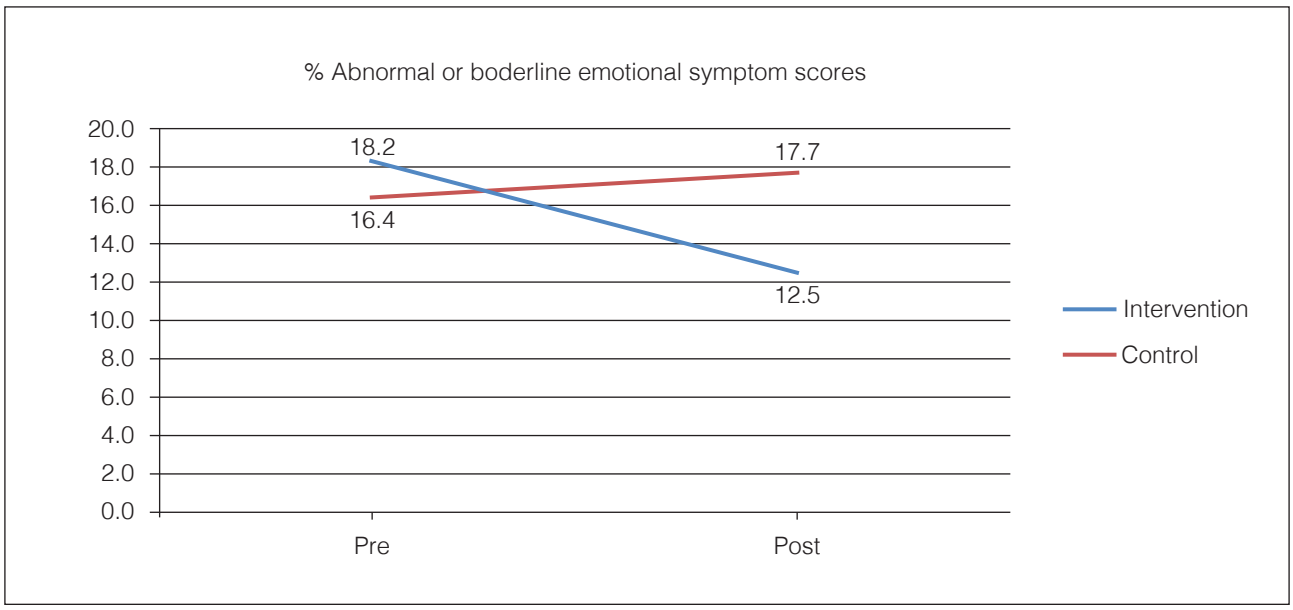
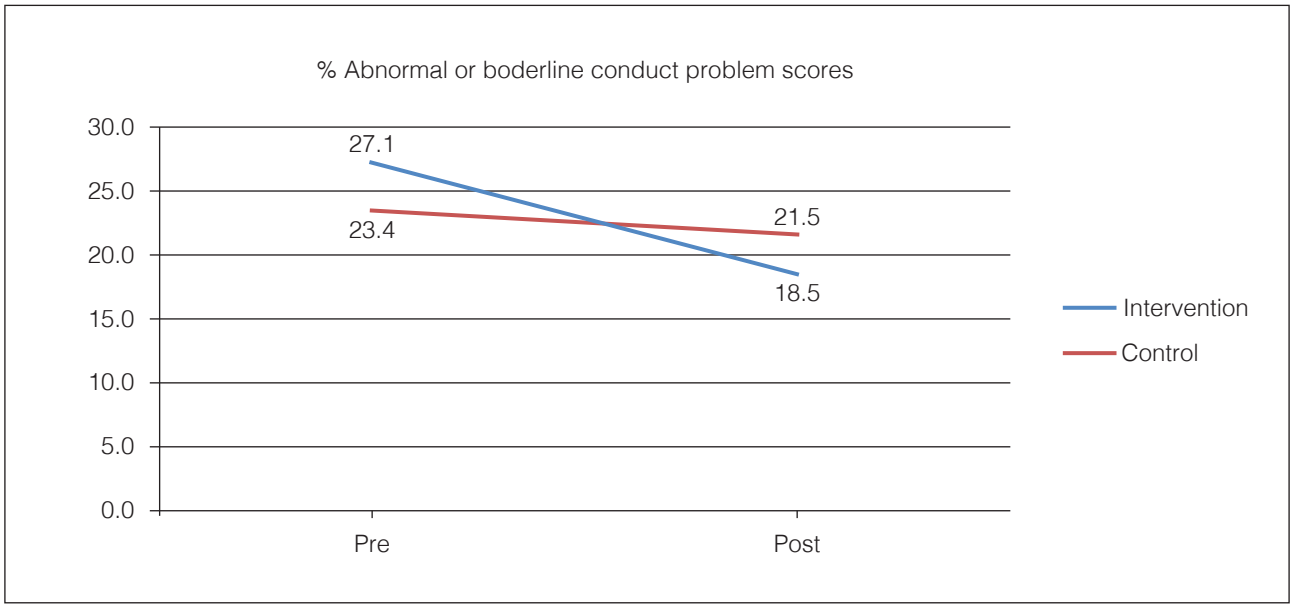


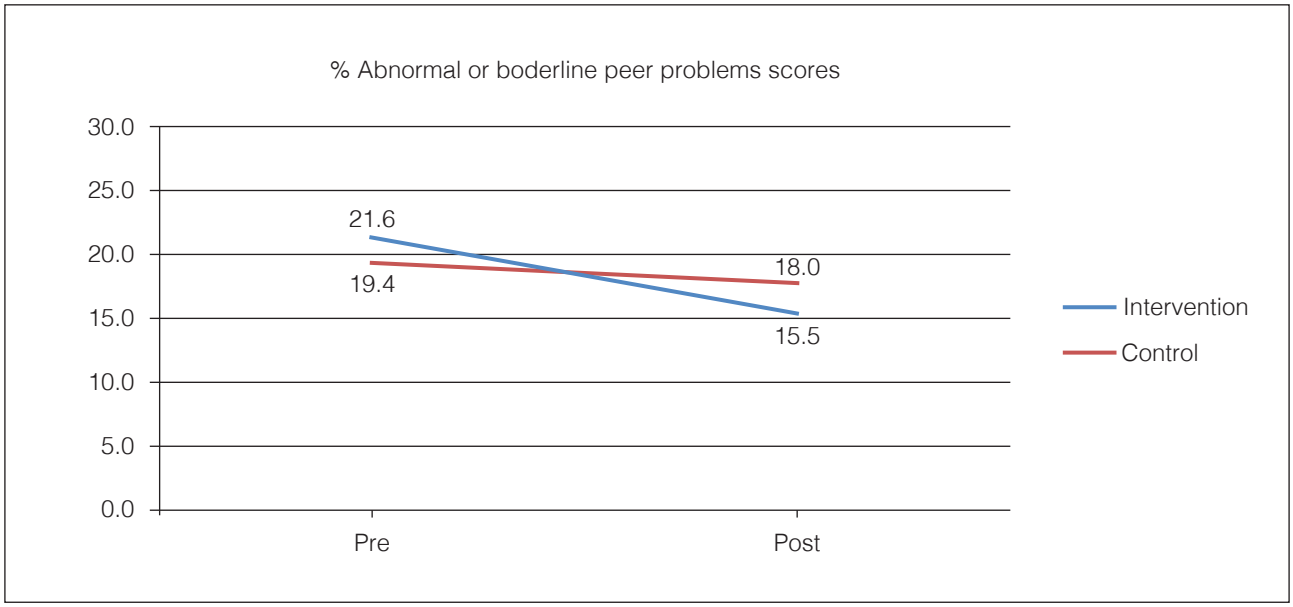
Figure B.5b: Weighted[13] percentage of respondents reporting abnormal or borderline scores for intervention and comparison samples at Time 1 (pre) and Time 2 (post) – Population Study

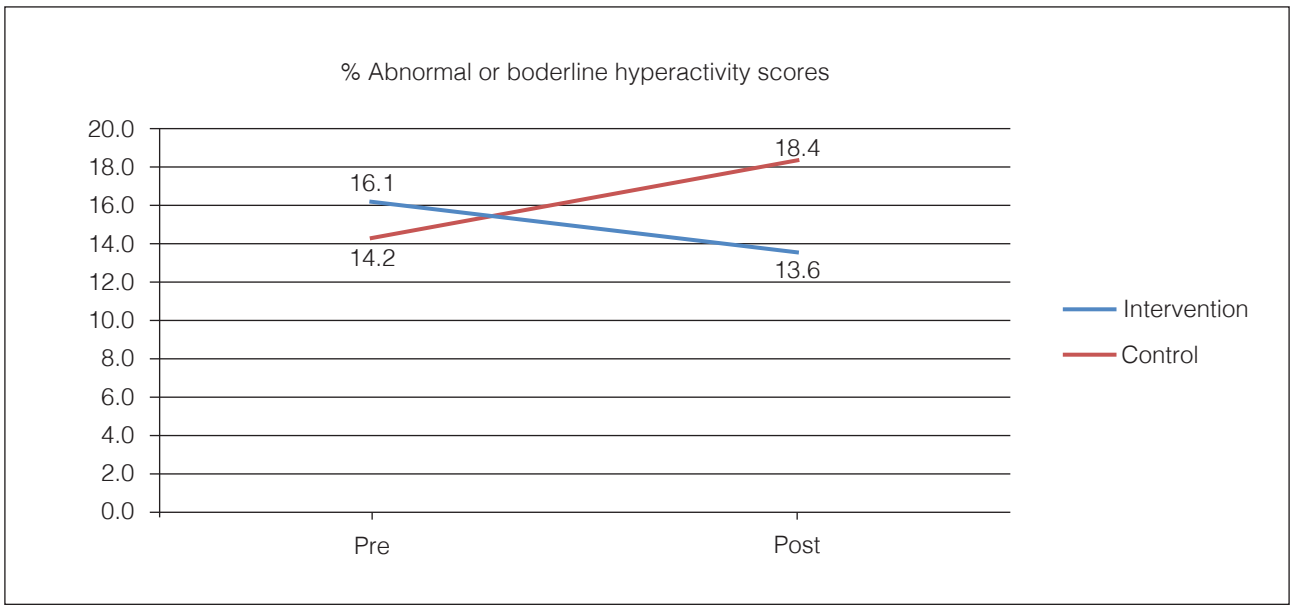


13. Weighted by age and gender of index child, socio-economic group and aggregated area.


% Abnormal or boderline emotional symptom scores
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
18.2
17.7
16.4
12.5
Pre
Post
Intervention
Control


% Abnormal or boderline conduct problem scores
30.0
25.0
20.0
15.0
10.0
5.0
0.0
27.1
23.4
21.5
18.5
Pre
Post
Intervention
Control


% Abnormal or boderline peer problems scores
30.0
25.0
20.0
15.0
10.0
5.0
0.0
21.6
19.4
18.0
15.5
Pre
Post
Intervention
Control


% Abnormal or boderline hyperactivity scores
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
16.1
18.4
14.2
13.6
Pre
Post
Intervention
Control

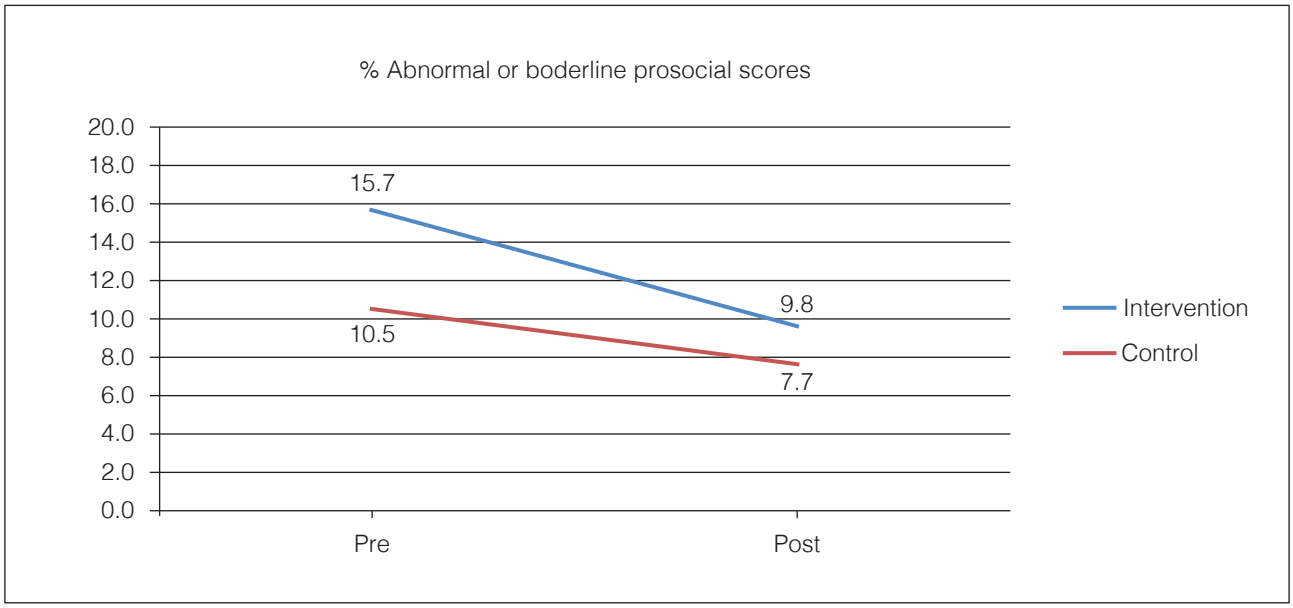

% Abnormal or boderline prosocial scores
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
15.7
9.8
10.5
7.7
Pre
Post
Intervention
Control

Table B.5a: ANCOVA outputs for the Strengths and Difficulties Questionnaire sub-scale 'Total Difficulties', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	11551.8	17	679.5	25.1	0.000	0.076	7552.8	15	503.5	19.4	0.000	0.1	4388.4	15	292.6	10.3	0.000	0.057
Intercept	1295.7	1	1295.7	47.8	0.000	0.009	835.0	1	835.0	32.2	0.000	0.012	447.1	1	447.1	15.8	0.000	0.006
Time	540.7	1	540.7	19.9	0.000	0.004	615.0	1	615.0	23.7	0.000	0.009	65.4	1	65.4	2.3	0.128	0.001
Location	36.8	1	36.8	1.4	0.244	0.000												
Time by location	116.6	1	116.6	4.3	0.038	0.001												
Age of child	6.8	1	6.8	0.2	0.618	0.000	0.1	1	0.1	0.0	0.957	0.000	10.9	1	10.9	0.4	0.534	0.000
Sex of child	1008.1	1	1008.1	37.2	0.000	0.007	484.3	1	484.3	18.7	0.000	0.007	525.2	1	525.2	18.6	0.000	0.007
Relationship to child	4.1	1	4.1	0.2	0.696	0.000	0.0	1	0.0	0.0	0.994	0.000	9.9	1	9.9	0.4	0.554	0.000
Age of respondent	162.9	1	162.9	6.0	0.014	0.001	40.4	1	40.4	1.6	0.212	0.001	121.5	1	121.5	4.3	0.038	0.002
Sex of respondent	1.4	1	1.4	0.1	0.821	0.000	0.4	1	0.4	0.0	0.903	0.000	3.1	1	3.1	0.1	0.74	0.000
Marital status	635.8	1	635.8	23.5	0.000	0.005	279.3	1	279.3	10.8	0.001	0.004	369.9	1	369.9	13.1	0.000	0.005
Educational status	798.5	1	798.5	29.5	0.000	0.006	392.1	1	392.1	15.1	0.000	0.006	397.1	1	397.1	14.0	0.000	0.005
Employment status	12.7	1	12.7	0.5	0.493	0.000	27.6	1	27.6	1.1	0.302	0.000	0.0	1	0.0	0.0	0.972	0.000
Social Class	137.5	1	137.5	5.1	0.024	0.001	92.7	1	92.7	3.6	0.059	0.001	34.4	1	34.4	1.2	0.27	0.000
Medical card status	481.2	1	481.2	17.8	0.000	0.003	380.4	1	380.4	14.7	0.000	0.006	135.5	1	135.5	4.8	0.029	0.002
Rurality	47.2	1	47.2	1.7	0.187	0.000	149.3	1	149.3	5.8	0.017	0.002	3.1	1	3.1	0.1	0.742	0.000
No. in household	21.9	1	21.9	0.8	0.369	0.000	6.5	1	6.5	0.2	0.618	0.000	16.5	1	16.5	0.6	0.444	0.000
Household tenure	519.7	1	519.7	19.2	0.000	0.004	484.3	1	484.3	18.7	0.000	0.007	104.6	1	104.6	3.7	0.054	0.001
Aggregated area	0.0	1	0.0	0.0	0.988	0.000	30.5	1	30.5	1.2	0.278	0.000	0.9	1	0.9	0.0	0.86	0.000
Error	140576.3	5186	27.1				67695.4	2609	25.9				72462.2	2563	28.3			
Total	451460.0	5204					229218.0	2625					222242.0	2579				
Corrected Total	152128.1	5203					75248.2	2624					76850.6	2578				
	R Squared = .076 (Adjusted R Squared = .073)						R Squared = .100 (Adjusted R Squared = .095)						R Squared = .057 (Adjusted R Squared = .052)					

Table B.5b: ANCOVA outputs for the Strengths and Difficulties Questionnaire sub-scale 'Emotional Symptoms', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	637.3	17	37.5	11.7	0.000	0.037	490.8	15	32.7	10.9	0.000	0.059	220.2	15	14.7	4.3	0.000	0.025
Intercept	57.0	1	57.0	17.8	0.000	0.003	16.3	1	16.3	5.4	0.02	0.002	60.7	1	60.7	17.9	0.000	0.007
Time	84.2	1	84.2	26.3	0.000	0.005	90.2	1	90.2	29.9	0.000	0.011	13.8	1	13.8	4.1	0.044	0.002
Location	2.9	1	2.9	0.9	0.346	0.000												
Time by location	15.6	1	15.6	4.9	0.028	0.001												
Age of child	7.8	1	7.8	2.4	0.118	0.000	1.1	1	1.1	0.4	0.554	0.000	9.1	1	9.1	2.7	0.101	0.001
Sex of child	9.2	1	9.2	2.9	0.09	0.001	6.3	1	6.3	2.1	0.147	0.001	3.3	1	3.3	1.0	0.321	0.000
Relationship to child	0.6	1	0.6	0.2	0.661	0.000	5.2	1	5.2	1.7	0.188	0.001	18.9	1	18.9	5.6	0.018	0.002
Age of respondent	4.3	1	4.3	1.4	0.245	0.000	0.4	1	0.4	0.1	0.713	0.000	7.5	1	7.5	2.2	0.136	0.001
Sex of respondent	0.5	1	0.5	0.2	0.698	0.000	3.2	1	3.2	1.1	0.302	0.000	15.5	1	15.5	4.6	0.032	0.002
Marital status	71.8	1	71.8	22.4	0	0.004	23.5	1	23.5	7.8	0.005	0.003	51.5	1	51.5	15.2	0.000	0.006
Educational status	24.1	1	24.1	7.5	0.006	0.001	27.2	1	27.2	9.0	0.003	0.003	3.4	1	3.4	1.0	0.317	0.000
Employment status	0.0	1	0.0	0.0	0.986	0.000	0.7	1	0.7	0.2	0.642	0.000	0.3	1	0.3	0.1	0.757	0.000
Social Class	18.9	1	18.9	5.9	0.015	0.001	7.6	1	7.6	2.5	0.112	0.001	8.0	1	8.0	2.3	0.125	0.001
Medical card status	30.0	1	30.0	9.4	0.002	0.002	36.6	1	36.6	12.2	0.000	0.005	3.0	1	3.0	0.9	0.347	0.000
Rurality	0.5	1	0.5	0.1	0.708	0.000	0.7	1	0.7	0.2	0.631	0.000	0.0	1	0.0	0.0	0.966	0.000
No. in household	0.3	1	0.3	0.1	0.747	0.000	1.6	1	1.6	0.5	0.47	0.000	0.1	1	0.1	0.0	0.879	0.000
Household tenure	6.1	1	6.1	1.9	0.167	0.000	10.3	1	10.3	3.4	0.064	0.001	0.0	1	0.0	0.0	0.991	0.000
Aggregated area	0.9	1	0.9	0.3	0.595	0.000	2.0	1	2.0	0.7	0.415	0.000	3.5	1	3.5	1.0	0.309	0.000
Error	16626.2	5186	3.2				7861.8	2609	3.0				8675.7	2563	3.4			
Total	31183.0	5204					14923.0	2625					16260.0	2579				
Corrected Total	17263.5	5203					8352.6	2624					8895.8	2578				
	R Squared = .037 (Adjusted R Squared = .034)						R Squared = .059 (Adjusted R Squared = .053)						R Squared = .025 (Adjusted R Squared = .019)					

Table B.5c: ANCOVA outputs for the Strengths and Difficulties Questionnaire sub-scale 'Conduct Problems', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	725.6	17	42.7	18.1	0.000	0.056	468.9	15	31.3	13.8	0.000	0.073	286.7	15	19.1	7.8	0.000	0.044
Intercept	79.5	1	79.5	33.7	0.000	0.006	63.6	1	63.6	28.0	0.000	0.011	16.0	1	16.0	6.5	0.011	0.003
Time	54.3	1	54.3	23.0	0.000	0.004	48.1	1	48.1	21.2	0.000	0.008	10.7	1	10.7	4.4	0.037	0.002
Location	2.9	1	2.9	1.2	0.265	0.000												
Time by location	4.3	1	4.3	1.8	0.176	0.000												
Age of child	0.2	1	0.2	0.1	0.774	0.000	0.1	1	0.1	0.0	0.861	0.000	1.2	1	1.2	0.5	0.484	0.000
Sex of child	88.6	1	88.6	37.6	0.000	0.007	48.6	1	48.6	21.4	0.000	0.008	41.7	1	41.7	17.0	0.000	0.007
Relationship to child	4.7	1	4.7	2.0	0.158	0.000	5.6	1	5.6	2.5	0.115	0.001	0.1	1	0.1	0.0	0.838	0.000
Age of respondent	0.5	1	0.5	0.2	0.643	0.000	0.9	1	0.9	0.4	0.53	0.000	2.8	1	2.8	1.1	0.288	0.000
Sex of respondent	1.4	1	1.4	0.6	0.44	0.000	3.5	1	3.5	1.5	0.215	0.001	0.2	1	0.2	0.1	0.777	0.000
Marital status	17.5	1	17.5	7.4	0.006	0.001	17.4	1	17.4	7.7	0.006	0.003	3.9	1	3.9	1.6	0.206	0.001
Educational status	118.9	1	118.9	50.4	0.000	0.01	53.6	1	53.6	23.6	0.000	0.009	64.7	1	64.7	26.4	0.000	0.01
Employment status	0.1	1	0.1	0.0	0.854	0.000	0.6	1	0.6	0.3	0.608	0.000	1.4	1	1.4	0.6	0.448	0.000
Social Class	7.6	1	7.6	3.2	0.073	0.001	6.0	1	6.0	2.6	0.104	0.001	1.4	1	1.4	0.6	0.455	0.000
Medical card status	23.8	1	23.8	10.1	0.001	0.002	16.3	1	16.3	7.2	0.007	0.003	7.5	1	7.5	3.1	0.08	0.001
Rurality	0.4	1	0.4	0.2	0.682	0.000	8.2	1	8.2	3.6	0.058	0.001	2.1	1	2.1	0.9	0.355	0.000
No. in household	1.9	1	1.9	0.8	0.364	0.000	0.8	1	0.8	0.4	0.542	0.000	1.0	1	1.0	0.4	0.523	0.000
Household tenure	16.6	1	16.6	7.0	0.008	0.001	17.6	1	17.6	7.8	0.005	0.003	3.1	1	3.1	1.3	0.259	0.000
Aggregated area	0.0	1	0.0	0.0	0.964	0.000	2.6	1	2.6	1.1	0.289	0.000	0.0	1	0.0	0.0	0.89	0.000
Error	12238.3	5186	2.4				5924.3	2609	2.3				6279.5	2563	2.5			
Total	24902.0	5204					12648.0	2625					12254.0	2579				
Corrected Total	12963.9	5203					6393.3	2624					6566.2	2578				
	R Squared = .056 (Adjusted R Squared = .053)						R Squared = .073 (Adjusted R Squared = .068)						R Squared = .044 (Adjusted R Squared = .038)					

Table B.5d: ANCOVA outputs for the Strengths and Difficulties Questionnaire sub-scale 'Peer Problems', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	611.4	17	36.0	16.2	0.000	0.05	417.0	15	27.8	12.8	0.000	0.069	243.0	15	16.2	7.2	0.000	0.04
Intercept	38.7	1	38.7	17.5	0.000	0.003	29.4	1	29.4	13.6	0.000	0.005	9.4	1	9.4	4.2	0.042	0.002
Time	39.0	1	39.0	17.6	0.000	0.003	38.0	1	38.0	17.5	0.000	0.007	5.6	1	5.6	2.5	0.116	0.001
Location	10.2	1	10.2	4.6	0.032	0.001												
Time by location	4.1	1	4.1	1.9	0.174	0.000												
Age of child	6.0	1	6.0	2.7	0.101	0.001	0.6	1	0.6	0.3	0.598	0.000	6.7	1	6.7	3.0	0.084	0.001
Sex of child	11.7	1	11.7	5.3	0.022	0.001	15.4	1	15.4	7.1	0.008	0.003	1.2	1	1.2	0.5	0.47	0.000
Relation to child	0.0	1	0.0	0.0	0.984	0.000	0.0	1	0.0	0.0	0.917	0.000	0.3	1	0.3	0.1	0.73	0.000
Age of respondent	0.7	1	0.7	0.3	0.566	0.000	0.3	1	0.3	0.1	0.722	0.000	0.3	1	0.3	0.2	0.698	0.000
Sex of respondent	0.3	1	0.3	0.1	0.736	0.000	1.3	1	1.3	0.6	0.439	0.000	0.3	1	0.3	0.2	0.696	0.000
Marital status	34.9	1	34.9	15.8	0.000	0.003	15.2	1	15.2	7.0	0.008	0.003	22.5	1	22.5	10.0	0.002	0.004
Educational status	31.3	1	31.3	14.1	0.000	0.003	10.8	1	10.8	5.0	0.026	0.002	18.7	1	18.7	8.3	0.004	0.003
Employment status	0.0	1	0.0	0.0	0.953	0.000	0.8	1	0.8	0.4	0.533	0.000	0.4	1	0.4	0.2	0.674	0.000
Social Class	5.8	1	5.8	2.6	0.106	0.001	4.5	1	4.5	2.1	0.148	0.001	1.9	1	1.9	0.9	0.355	0.000
Medical card status	13.1	1	13.1	5.9	0.015	0.001	5.9	1	5.9	2.7	0.1	0.001	6.5	1	6.5	2.9	0.089	0.001
Rurality	22.8	1	22.8	10.3	0.001	0.002	30.4	1	30.4	14.0	0.000	0.005	0.0	1	0.0	0.0	0.91	0.000
No. in household	3.4	1	3.4	1.6	0.213	0.000	0.3	1	0.3	0.2	0.689	0.000	9.5	1	9.5	4.2	0.041	0.002
Household tenure	88.5	1	88.5	39.9	0.000	0.008	68.2	1	68.2	31.4	0.000	0.012	25.5	1	25.5	11.3	0.001	0.004
Aggregated area	0.1	1	0.1	0.1	0.799	0.000	0.2	1	0.2	0.1	0.746	0.000	1.7	1	1.7	0.8	0.382	0.000
Error	11499.7	5186	2.2				5658.3	2609	2.2				5778.0	2563	2.3			
Total	20614.0	5204					10726.0	2625					9888.0	2579				
Corrected Total	12111.1	5203					6075.3	2624					6021.0	2578				
	R Squared = .050 (Adjusted R Squared = .047)						R Squared = .069 (Adjusted R Squared = .063)						R Squared = .040 (Adjusted R Squared = .035)					

Table B.5e: ANCOVA outputs for the Strengths and Difficulties Questionnaire sub-scale 'Hyperactivity', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	1601.6	17	94.2	19.7	0.000	0.061	883.5	15	58.9	13.1	0.000	0.07	771.6	15	51.4	10.1	0.000	0.056
Intercept	177.2	1	177.2	37.0	0.000	0.007	131.4	1	131.4	29.3	0.000	0.011	39.6	1	39.6	7.7	0.005	0.003
Time	0.2	1	0.2	0.0	0.832	0.000	4.8	1	4.8	1.1	0.299	0.000	1.6	1	1.6	0.3	0.577	0.000
Location	8.2	1	8.2	1.7	0.192	0.000												
Time by location	7.6	1	7.6	1.6	0.209	0.000												
Age of child	4.9	1	4.9	1.0	0.314	0.000	5.5	1	5.5	1.2	0.269	0.000	1.5	1	1.5	0.3	0.592	0.000
Sex of child	481.9	1	481.9	100.6	0.000	0.019	185.6	1	185.6	41.4	0.000	0.016	295.9	1	295.9	57.9	0.000	0.022
Relation to child	0.8	1	0.8	0.2	0.683	0.000	0.0	1	0.0	0.0	0.922	0.000	1.0	1	1.0	0.2	0.659	0.000
Age of respondent	83.0	1	83.0	17.3	0.000	0.003	37.7	1	37.7	8.4	0.004	0.003	36.4	1	36.4	7.1	0.008	0.003
Sex of respondent	1.5	1	1.5	0.3	0.581	0.000	0.4	1	0.4	0.1	0.778	0.000	1.3	1	1.3	0.3	0.613	0.000
Marital status	44.2	1	44.2	9.2	0.002	0.002	14.5	1	14.5	3.2	0.072	0.001	28.4	1	28.4	5.6	0.018	0.002
Educational status	46.9	1	46.9	9.8	0.002	0.002	15.9	1	15.9	3.5	0.06	0.001	32.7	1	32.7	6.4	0.012	0.002
Employment status	13.9	1	13.9	2.9	0.088	0.001	7.6	1	7.6	1.7	0.193	0.001	6.6	1	6.6	1.3	0.254	0.001
Social Class	4.9	1	4.9	1.0	0.313	0.000	5.2	1	5.2	1.2	0.281	0.000	0.2	1	0.2	0.0	0.83	0.000
Medical card status	63.2	1	63.2	13.2	0.000	0.003	48.9	1	48.9	10.9	0.001	0.004	21.3	1	21.3	4.2	0.041	0.002
Rurality	0.6	1	0.6	0.1	0.717	0.000	21.8	1	21.8	4.9	0.027	0.002	0.3	1	0.3	0.1	0.809	0.000
No. in household	13.3	1	13.3	2.8	0.096	0.001	7.8	1	7.8	1.7	0.187	0.001	5.2	1	5.2	1.0	0.315	0.000
Household tenure	46.8	1	46.8	9.8	0.002	0.002	40.2	1	40.2	9.0	0.003	0.003	11.8	1	11.8	2.3	0.129	0.001
Aggregated area	0.3	1	0.3	0.1	0.79	0.000	23.7	1	23.7	5.3	0.022	0.002	15.2	1	15.2	3.0	0.084	0.001
Error	24851.0	5186	4.8				11697.5	2609	4.5				13088.8	2563	5.1			
Total	78281.0	5204					39493.0	2625					38788.0	2579				
Corrected Total	26452.6	5203					12581.0	2624					13860.4	2578				
	R Squared = .061 (Adjusted R Squared = .057)						R Squared = .070 (Adjusted R Squared = .065)						R Squared = .056 (Adjusted R Squared = .050)					

Table B.5f: ANCOVA outputs for the Strengths and Difficulties Questionnaire sub-scale 'Pro-social', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	1162.9	17	68.4	19.3	0.000	0.06	713.7	15	47.6	13.7	0.000	0.073	464.2	15	30.9	8.6	0.000	0.048
Intercept	188.2	1	188.2	53.1	0.000	0.01	144.2	1	144.2	41.6	0.000	0.016	46.6	1	46.6	13.0	0.000	0.005
Time	128.0	1	128.0	36.1	0.000	0.007	68.7	1	68.7	19.8	0.000	0.008	54.0	1	54.0	15.1	0.000	0.006
Location	5.1	1	5.1	1.4	0.229	0.000												
Time by location	0.0	1	0.0	0.0	0.942	0.000												
Age of child	81.2	1	81.2	22.9	0.000	0.004	90.7	1	90.7	26.1	0.000	0.01	11.0	1	11.0	3.1	0.08	0.001
Sex of child	105.6	1	105.6	29.8	0.000	0.006	61.2	1	61.2	17.6	0.000	0.007	47.6	1	47.6	13.3	0.000	0.005
Relation to child	0.6	1	0.6	0.2	0.683	0.000	0.0	1	0.0	0.0	0.944	0.000	0.9	1	0.9	0.2	0.626	0.000
Age of respondent	0.1	1	0.1	0.0	0.867	0.000	1.9	1	1.9	0.5	0.464	0.000	3.7	1	3.7	1.0	0.31	0.000
Sex of respondent	0.8	1	0.8	0.2	0.631	0.000	0.6	1	0.6	0.2	0.667	0.000	0.4	1	0.4	0.1	0.739	0.000
Marital status	63.6	1	63.6	18.0	0.000	0.003	20.3	1	20.3	5.9	0.016	0.002	46.0	1	46.0	12.9	0.000	0.005
Educational status	110.4	1	110.4	31.2	0.000	0.006	32.3	1	32.3	9.3	0.002	0.004	73.2	1	73.2	20.4	0.000	0.008
Employment status	9.0	1	9.0	2.5	0.111	0.000	0.1	1	0.1	0.0	0.901	0.000	13.4	1	13.4	3.7	0.054	0.001
Social Class	0.1	1	0.1	0.0	0.868	0.000	2.2	1	2.2	0.6	0.425	0.000	3.0	1	3.0	0.8	0.359	0.000
Medical card status	0.5	1	0.5	0.1	0.709	0.000	0.2	1	0.2	0.0	0.833	0.000	0.3	1	0.3	0.1	0.79	0.000
Rurality	364.1	1	364.1	102.7	0.000	0.019	209.1	1	209.1	60.2	0.000	0.023	95.0	1	95.0	26.5	0.000	0.01
No. in household	6.3	1	6.3	1.8	0.182	0.000	0.5	1	0.5	0.1	0.711	0.000	15.1	1	15.1	4.2	0.04	0.002
Household tenure	55.1	1	55.1	15.5	0.000	0.003	48.9	1	48.9	14.1	0.000	0.005	11.1	1	11.1	3.1	0.078	0.001
Aggregated area	101.3	1	101.3	28.6	0.000	0.005	41.7	1	41.7	12.0	0.001	0.005	96.0	1	96.0	26.8	0.000	0.01
Error	18380.8	5186	3.5				9055.3	2609	3.5				9176.8	2563	3.6			
Total	374616.0	5204					182052.0	2625					192564.0	2579				
Corrected Total	19543.7	5203					9769.0	2624					9641.0	2578				
	R Squared = .060 (Adjusted R Squared = .056)						R Squared = .073 (Adjusted R Squared = .068)						R Squared = .048 (Adjusted R Squared = .043)					

Table B.5g: ANCOVA outputs for 'Confident Parenting', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	7063.9	17	415.5	11.7	0.000	0.037	2587.0	15	172.5	5.2	0.000	0.029	5488.0	15	365.9	9.711	0.000	0.054
Intercept	5410.5	1	5410.5	151.8	0.000	0.028	3794.2	1	3794.2	113.5	0.000	0.042	1652.5	1	1652.5	43.861	0.000	0.017
Time	55.3	1	55.3	1.6	0.213	0.000	6.2	1	6.2	0.2	0.667	0.000	166.1	1	166.1	4.409	0.036	0.002
Location	20.7	1	20.7	0.6	0.447	0.000												
Time by location	112.2	1	112.2	3.1	0.076	0.001												
Age of child	2.0	1	2.0	0.1	0.812	0.000	38.4	1	38.4	1.2	0.284	0.000	63.9	1	63.9	1.697	0.193	0.001
Sex of child	4.5	1	4.5	0.1	0.721	0.000	36.1	1	36.1	1.1	0.299	0.000	13.0	1	13.0	0.346	0.557	0.000
Relation to child	6.8	1	6.8	0.2	0.662	0.000	0.7	1	0.7	0.0	0.889	0.000	4.3	1	4.3	0.113	0.737	0.000
Age of respondent	341.3	1	341.3	9.6	0.002	0.002	6.0	1	6.0	0.2	0.673	0.000	435.2	1	435.2	11.552	0.001	0.004
Sex of respondent	0.2	1	0.2	0.0	0.934	0.000	1.0	1	1.0	0.0	0.86	0.000	0.0	1	0.0	0	0.994	0.000
Marital status	1480.7	1	1480.7	41.5	0.000	0.008	470.1	1	470.1	14.1	0.000	0.005	1003.9	1	1003.9	26.647	0.000	0.01
Educational status	1552.4	1	1552.4	43.6	0.000	0.008	283.6	1	283.6	8.5	0.004	0.003	1443.9	1	1443.9	38.325	0.000	0.015
Employment status	335.9	1	335.9	9.4	0.002	0.002	50.8	1	50.8	1.5	0.218	0.001	287.7	1	287.7	7.636	0.006	0.003
Social Class	76.0	1	76.0	2.1	0.144	0.000	70.8	1	70.8	2.1	0.146	0.001	30.3	1	30.3	0.805	0.37	0.000
Medical card status	29.9	1	29.9	0.8	0.359	0.000	68.2	1	68.2	2.0	0.153	0.001	233.5	1	233.5	6.198	0.013	0.002
Rurality	1792.8	1	1792.8	50.3	0.000	0.01	332.6	1	332.6	9.9	0.002	0.004	1248.9	1	1248.9	33.149	0.000	0.013
No. in household	107.0	1	107.0	3.0	0.083	0.001	6.7	1	6.7	0.2	0.655	0.000	252.1	1	252.1	6.691	0.01	0.003
Household tenure	460.3	1	460.3	12.9	0.000	0.002	131.2	1	131.2	3.9	0.048	0.002	329.6	1	329.6	8.749	0.003	0.003
Aggregated area	134.8	1	134.8	3.8	0.052	0.001	9.7	1	9.7	0.3	0.591	0.000	59.7	1	59.7	1.585	0.208	0.001
Error	184844.6	5186	35.6				87234.5	2609	33.4				96561.4	2563	37.7			
Total	6979345.0	5204					3497584.0	2625					3481761.0	2579				
Corrected Total	191908.5	5203					89821.6	2624					102049.4	2578				
	R Squared = .037 (Adjusted R Squared = .034)						R Squared = .029 (Adjusted R Squared = .023)						R Squared = .054 (Adjusted R Squared = .048)					

Table B.5h: ANCOVA outputs for 'Good Experience of Parenting', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	2869.9	17	168.8	23.6	0.000	0.072	1956.4	15	130.4	19.5	0.000	0.101	1160.8	15	77.4	10.3	0.000	0.057
Intercept	1416.5	1	1416.5	198.3	0.000	0.037	1120.0	1	1120.0	167.6	0.000	0.06	348.9	1	348.9	46.3	0.000	0.018
Time	546.5	1	546.5	76.5	0.000	0.015	371.7	1	371.7	55.6	0.000	0.021	216.5	1	216.5	28.7	0.000	0.011
Location	6.5	1	6.5	0.9	0.341	0.000												
Time by location	13.5	1	13.5	1.9	0.169	0.000												
Age of child	2.4	1	2.4	0.3	0.565	0.000	0.5	1	0.5	0.1	0.786	0.000	0.3	1	0.3	0.0	0.836	0.000
Sex of child	11.8	1	11.8	1.7	0.199	0.000	5.2	1	5.2	0.8	0.378	0.000	3.6	1	3.6	0.5	0.489	0.000
Relation to child	5.3	1	5.3	0.7	0.391	0.000	0.0	1	0.0	0.0	0.948	0.000	17.5	1	17.5	2.3	0.128	0.001
Age of respondent	46.9	1	46.9	6.6	0.01	0.001	26.6	1	26.6	4.0	0.046	0.002	23.1	1	23.1	3.1	0.080	0.001
Sex of respondent	0.7	1	0.7	0.1	0.747	0.000	4.4	1	4.4	0.7	0.417	0.000	4.7	1	4.7	0.6	0.427	0.000
Marital status	127.5	1	127.5	17.8	0.000	0.003	18.5	1	18.5	2.8	0.096	0.001	126.0	1	126.0	16.7	0.000	0.006
Educational status	175.4	1	175.4	24.6	0.000	0.005	87.5	1	87.5	13.1	0.000	0.005	86.5	1	86.5	11.5	0.001	0.004
Employment status	0.3	1	0.3	0.0	0.833	0.000	8.6	1	8.6	1.3	0.256	0.000	12.7	1	12.7	1.7	0.194	0.001
Social Class	13.9	1	13.9	1.9	0.164	0.000	1.2	1	1.2	0.2	0.668	0.000	9.6	1	9.6	1.3	0.259	0.000
Medical card status	221.1	1	221.1	30.9	0.000	0.006	201.1	1	201.1	30.1	0.000	0.011	66.4	1	66.4	8.8	0.003	0.003
Rurality	3.6	1	3.6	0.5	0.476	0.000	40.5	1	40.5	6.1	0.014	0.002	7.9	1	7.9	1.1	0.305	0.000
No. in household	94.5	1	94.5	13.2	0.000	0.003	102.4	1	102.4	15.3	0.000	0.006	12.8	1	12.8	1.7	0.193	0.001
Household tenure	24.8	1	24.8	3.5	0.062	0.001	35.4	1	35.4	5.3	0.021	0.002	1.0	1	1.0	0.1	0.711	0.000
Aggregated area	0.1	1	0.1	0.0	0.906	0.000	104.3	1	104.3	15.6	0.000	0.006	54.4	1	54.4	7.2	0.007	0.003
Error	37050.4	5186	7.1				17437.1	2609	6.7				19302.8	2563	7.5			
Total	1930744.0	5204					984119.0	2625					946625.0	2579				
Corrected Total	39920.3	5203					19393.5	2624					20463.6	2578				
	R Squared = .072 (Adjusted R Squared = .069)						R Squared = .101 (Adjusted R Squared = .096)						R Squared = .057 (Adjusted R Squared = .051)					

Table B.5i: ANCOVA outputs for 'Parental Psychological Distress', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	12775.9	17	751.5	27.5	0.000	0.083	4087.8	15	272.5	12.0	0.000	0.064	9704.4	15	647.0	20.5	0.000	0.107
Intercept	1378.0	1	1378.0	50.4	0.000	0.01	727.3	1	727.3	31.9	0.000	0.012	451.6	1	451.6	14.3	0.000	0.006
Time	105.2	1	105.2	3.9	0.05	0.001	373.3	1	373.3	16.4	0.000	0.006	8.7	1	8.7	0.3	0.6	0.000
Location	1217.1	1	1217.1	44.5	0.000	0.009												
Time by location	263.6	1	263.6	9.6	0.002	0.002												
Age of child	5.6	1	5.6	0.2	0.65	0.000	0.5	1	0.5	0.0	0.885	0.000	4.3	1	4.3	0.1	0.711	0.000
Sex of child	214.1	1	214.1	7.8	0.005	0.002	0.2	1	0.2	0.0	0.921	0.000	514.0	1	514.0	16.3	0.000	0.006
Relation to child	0.6	1	0.6	0.0	0.883	0.000	0.6	1	0.6	0.0	0.87	0.000	0.6	1	0.6	0.0	0.892	0.000
Age of respondent	1555.6	1	1555.6	56.9	0.000	0.011	424.2	1	424.2	18.6	0.000	0.007	1107.0	1	1107.0	35.1	0.000	0.014
Sex of respondent	45.0	1	45.0	1.6	0.2	0.000	19.3	1	19.3	0.8	0.357	0.000	26.2	1	26.2	0.8	0.362	0.000
Marital status	1833.6	1	1833.6	67.1	0.000	0.013	249.0	1	249.0	10.9	0.001	0.004	1848.6	1	1848.6	58.6	0.000	0.022
Educational status	1439.2	1	1439.2	52.6	0.000	0.01	191.8	1	191.8	8.4	0.004	0.003	1497.6	1	1497.6	47.5	0.000	0.018
Employment status	239.8	1	239.8	8.8	0.003	0.002	3.0	1	3.0	0.1	0.716	0.000	333.5	1	333.5	10.6	0.001	0.004
Social Class	23.1	1	23.1	0.8	0.359	0.000	0.7	1	0.7	0.0	0.865	0.000	54.8	1	54.8	1.7	0.188	0.001
Medical card status	673.2	1	673.2	24.6	0.000	0.005	416.1	1	416.1	18.3	0.000	0.007	298.4	1	298.4	9.5	0.002	0.004
Rurality	350.1	1	350.1	12.8	0.000	0.002	76.3	1	76.3	3.4	0.067	0.001	309.1	1	309.1	9.8	0.002	0.004
No. in household	247.3	1	247.3	9.0	0.003	0.002	2.4	1	2.4	0.1	0.747	0.000	374.5	1	374.5	11.9	0.001	0.005
Household tenure	452.8	1	452.8	16.6	0.000	0.003	213.7	1	213.7	9.4	0.002	0.004	190.3	1	190.3	6.0	0.014	0.002
Aggregated area	1114.7	1	1114.7	40.8	0.000	0.008	335.6	1	335.6	14.7	0.000	0.006	496.5	1	496.5	15.7	0.000	0.006
Error	141768.7	5186	27.3				59437.3	2609	22.8				80869.9	2563	31.6			
Total	1031085.0	5204					486137.0	2625					544948.0	2579				
Corrected Total	154544.5	5203					63525.1	2624					90574.3	2578				
	R Squared = .083 (Adjusted R Squared = .080)						R Squared = .064 (Adjusted R Squared = .059)						R Squared = .107 (Adjusted R Squared = .102)					

Table B.5j: ANCOVA outputs for 'Positive Family Climate', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	4239.3	17	249.4	17.5	0.000	0.055	3233.0	15	215.5	16.1	0.000	0.086	1512.3	15	100.8	6.8	0.000	0.038
Intercept	1490.7	1	1490.7	104.8	0.000	0.02	917.7	1	917.7	68.5	0.000	0.026	485.3	1	485.3	32.5	0.000	0.013
Time	632.6	1	632.6	44.5	0.000	0.009	430.8	1	430.8	32.2	0.000	0.012	199.0	1	199.0	13.3	0.000	0.005
Location	1.0	1	1.0	0.1	0.788	0.000												
Time by location	7.8	1	7.8	0.5	0.46	0.000												
Age of child	0.2	1	0.2	0.0	0.915	0.000	3.2	1	3.2	0.2	0.625	0.000	1.8	1	1.8	0.1	0.726	0.000
Sex of child	11.4	1	11.4	0.8	0.371	0.000	11.1	1	11.1	0.8	0.362	0.000	60.3	1	60.3	4.0	0.045	0.002
Relation to child	112.5	1	112.5	7.9	0.005	0.002	82.5	1	82.5	6.2	0.013	0.002	27.0	1	27.0	1.8	0.179	0.001
Age of respondent	412.6	1	412.6	29.0	0.000	0.006	486.6	1	486.6	36.3	0.000	0.014	36.7	1	36.7	2.5	0.117	0.001
Sex of respondent	59.6	1	59.6	4.2	0.041	0.001	50.9	1	50.9	3.8	0.051	0.001	11.0	1	11.0	0.7	0.392	0.000
Marital status	626.3	1	626.3	44.0	0.000	0.009	287.1	1	287.1	21.4	0.000	0.008	384.3	1	384.3	25.7	0.000	0.01
Educational status	642.3	1	642.3	45.2	0.000	0.009	431.4	1	431.4	32.2	0.000	0.012	236.1	1	236.1	15.8	0.000	0.006
Employment status	9.5	1	9.5	0.7	0.414	0.000	9.6	1	9.6	0.7	0.397	0.000	1.1	1	1.1	0.1	0.782	0.000
Social Class	55.7	1	55.7	3.9	0.048	0.001	56.2	1	56.2	4.2	0.041	0.002	5.7	1	5.7	0.4	0.538	0.000
Medical card status	80.5	1	80.5	5.7	0.017	0.001	113.9	1	113.9	8.5	0.004	0.003	0.4	1	0.4	0.0	0.867	0.000
Rurality	130.2	1	130.2	9.2	0.002	0.002	11.3	1	11.3	0.8	0.357	0.000	57.7	1	57.7	3.9	0.049	0.002
No. in household	75.2	1	75.2	5.3	0.022	0.001	45.9	1	45.9	3.4	0.064	0.001	35.5	1	35.5	2.4	0.123	0.001
Household tenure	102.2	1	102.2	7.2	0.007	0.001	148.8	1	148.8	11.1	0.001	0.004	5.2	1	5.2	0.4	0.553	0.000
Aggregated area	2.9	1	2.9	0.2	0.654	0.000	23.3	1	23.3	1.7	0.187	0.001	41.0	1	41.0	2.7	0.098	0.001
Error	72470.5	5096	14.2				34192.6	2552	13.4				37771.9	2530	14.9			
Total	2850990.0	5114					1430244.0	2568					1420746.0	2546				
Corrected Total	76709.9	5113					37425.6	2567					39284.2	2545				
	R Squared = .055 (Adjusted R Squared = .052)						R Squared = .086 (Adjusted R Squared = .081)						R Squared = .038 (Adjusted R Squared = .033)					

Table B.5k: ANCOVA outputs for 'Good Relationship with Child', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	1664.2	17	97.9	16.9	0.000	0.053	1200.0	15	80.0	15.0	0.000	0.079	567.4	15	37.8	6.1	0.000	0.034
Intercept	1342.8	1	1342.8	232.4	0.000	0.043	882.6	1	882.6	165.7	0.000	0.06	453.3	1	453.3	72.8	0.000	0.028
Time	208.1	1	208.1	36.0	0.000	0.007	371.8	1	371.8	69.8	0.000	0.026	1.3	1	1.3	0.2	0.646	0.000
Location	44.8	1	44.8	7.8	0.005	0.001												
Time by location	166.5	1	166.5	28.8	0.000	0.006												
Age of child	2.6	1	2.6	0.5	0.502	0.000	5.2	1	5.2	1.0	0.321	0.000	0.0	1	0.0	0.0	0.987	0.000
Sex of child	0.1	1	0.1	0.0	0.891	0.000	0.6	1	0.6	0.1	0.74	0.000	1.7	1	1.7	0.3	0.602	0.000
Relation to child	0.3	1	0.3	0.1	0.81	0.000	0.2	1	0.2	0.0	0.848	0.000	0.2	1	0.2	0.0	0.862	0.000
Age of respondent	77.8	1	77.8	13.5	0.000	0.003	38.5	1	38.5	7.2	0.007	0.003	33.5	1	33.5	5.4	0.02	0.002
Sex of respondent	0.0	1	0.0	0.0	0.97	0.000	1.3	1	1.3	0.3	0.617	0.000	2.0	1	2.0	0.3	0.568	0.000
Marital status	35.3	1	35.3	6.1	0.013	0.001	19.4	1	19.4	3.7	0.056	0.001	16.2	1	16.2	2.6	0.107	0.001
Educational status	420.6	1	420.6	72.8	0.000	0.014	198.8	1	198.8	37.3	0.000	0.014	221.9	1	221.9	35.6	0.000	0.014
Employment status	35.0	1	35.0	6.1	0.014	0.001	2.4	1	2.4	0.5	0.5	0.000	42.5	1	42.5	6.8	0.009	0.003
Social Class	2.0	1	2.0	0.3	0.558	0.000	6.4	1	6.4	1.2	0.272	0.000	1.5	1	1.5	0.2	0.628	0.000
Medical card status	64.0	1	64.0	11.1	0.001	0.002	56.0	1	56.0	10.5	0.001	0.004	12.4	1	12.4	2.0	0.159	0.001
Rurality	78.3	1	78.3	13.5	0.000	0.003	8.8	1	8.8	1.7	0.199	0.001	49.4	1	49.4	7.9	0.005	0.003
No. in household	52.2	1	52.2	9.0	0.003	0.002	21.4	1	21.4	4.0	0.045	0.002	28.0	1	28.0	4.5	0.034	0.002
Household tenure	76.5	1	76.5	13.2	0.000	0.003	48.6	1	48.6	9.1	0.003	0.003	27.4	1	27.4	4.4	0.036	0.002
Aggregated area	70.5	1	70.5	12.2	0.000	0.002	4.1	1	4.1	0.8	0.383	0.000	56.8	1	56.8	9.1	0.003	0.004
Error	29966.4	5186	5.8				13894.1	2609	5.3				15962.5	2563	6.2			
Total	1804126.0	5204					912631.0	2625					891495.0	2579				
Corrected Total	31630.7	5203					15094.0	2624					16529.9	2578				
	R Squared = .053 (Adjusted R Squared = .050)						R Squared = .079 (Adjusted R Squared = .074)						R Squared = .034 (Adjusted R Squared = .029)					

Table B.5l: ANCOVA outputs for 'Positive Parenting', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	864.2	17	50.8	10.9	0.000	0.034	255.2	15	17.0	3.7	0.000	0.021	667.6	15	44.5	9.3	0.000	0.052
Intercept	765.1	1	765.1	163.8	0.000	0.031	527.0	1	527.0	115.8	0.000	0.043	221.6	1	221.6	46.4	0.000	0.018
Time	12.4	1	12.4	2.7	0.103	0.001	1.2	1	1.2	0.3	0.603	0.000	40.5	1	40.5	8.5	0.004	0.003
Location	19.9	1	19.9	4.3	0.039	0.001												
Time by location	27.3	1	27.3	5.8	0.016	0.001												
Age of child	0.2	1	0.2	0.0	0.856	0.000	2.8	1	2.8	0.6	0.433	0.000	2.0	1	2.0	0.4	0.522	0.000
Sex of child	15.3	1	15.3	3.3	0.07	0.001	1.8	1	1.8	0.4	0.53	0.000	15.6	1	15.6	3.3	0.071	0.001
Relation to child	0.7	1	0.7	0.2	0.691	0.000	0.1	1	0.1	0.0	0.875	0.000	1.1	1	1.1	0.2	0.633	0.000
Age of respondent	142.0	1	142.0	30.4	0.000	0.006	40.4	1	40.4	8.9	0.003	0.003	93.5	1	93.5	19.6	0.000	0.008
Sex of respondent	5.1	1	5.1	1.1	0.297	0.000	3.2	1	3.2	0.7	0.401	0.000	1.5	1	1.5	0.3	0.579	0.000
Marital status	39.4	1	39.4	8.4	0.004	0.002	29.9	1	29.9	6.6	0.01	0.003	12.5	1	12.5	2.6	0.106	0.001
Educational status	101.3	1	101.3	21.7	0.000	0.004	14.9	1	14.9	3.3	0.07	0.001	102.6	1	102.6	21.5	0.000	0.008
Employment status	24.3	1	24.3	5.2	0.023	0.001	1.9	1	1.9	0.4	0.515	0.000	23.8	1	23.8	5.0	0.026	0.002
Social Class	4.9	1	4.9	1.0	0.307	0.000	3.1	1	3.1	0.7	0.409	0.000	3.1	1	3.1	0.7	0.419	0.000
Medical card status	2.1	1	2.1	0.5	0.501	0.000	2.3	1	2.3	0.5	0.481	0.000	14.3	1	14.3	3.0	0.084	0.001
Rurality	273.7	1	273.7	58.6	0.000	0.011	36.7	1	36.7	8.1	0.005	0.003	150.9	1	150.9	31.6	0.000	0.012
No. in household	69.8	1	69.8	14.9	0.000	0.003	27.1	1	27.1	5.9	0.015	0.002	38.8	1	38.8	8.1	0.004	0.003
Household tenure	23.5	1	23.5	5.0	0.025	0.001	11.8	1	11.8	2.6	0.108	0.001	9.6	1	9.6	2.0	0.157	0.001
Aggregated area	109.6	1	109.6	23.5	0.000	0.005	0.7	1	0.7	0.2	0.695	0.000	133.1	1	133.1	27.9	0.000	0.011
Error	24218.5	5186	4.7				11870.6	2609	4.6				12227.4	2563	4.8			
Total	905677.0	5204					448965.0	2625					456712.0	2579				
Corrected Total	25082.6	5203					12125.9	2624					12894.9	2578				
	R Squared = .034 (Adjusted R Squared = .031)						R Squared = .021 (Adjusted R Squared = .015)						R Squared = .052 (Adjusted R Squared = .046)					

Table B.5m: ANCOVA outputs for 'Taking on Parenting Responsibilities', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	39330.5	17	2313.6	241.1	0.000	0.453	19378.4	15	1291.9	154.4	0.000	0.482	20398.7	15	1359.9	126.9	0.000	0.437
Intercept	1950.7	1	1950.7	203.3	0.000	0.039	1446.4	1	1446.4	172.8	0.000	0.065	549.0	1	549.0	51.2	0.000	0.02
Time	574.8	1	574.8	59.9	0.000	0.012	312.8	1	312.8	37.4	0.000	0.015	267.6	1	267.6	25.0	0.000	0.01
Location	199.9	1	199.9	20.8	0.000	0.004												
Time by location	0.4	1	0.4	0.0	0.834	0.000												
Age of child	0.5	1	0.5	0.1	0.823	0.000	6.1	1	6.1	0.7	0.393	0.000	0.9	1	0.9	0.1	0.778	0.000
Sex of child	116.6	1	116.6	12.1	0.000	0.002	27.1	1	27.1	3.2	0.072	0.001	107.6	1	107.6	10.0	0.002	0.004
Relation to child	199.0	1	199.0	20.7	0.000	0.004	122.5	1	122.5	14.6	0.000	0.006	74.7	1	74.7	7.0	0.008	0.003
Age of respondent	329.3	1	329.3	34.3	0.000	0.007	21.6	1	21.6	2.6	0.109	0.001	378.1	1	378.1	35.3	0.000	0.014
Sex of respondent	465.6	1	465.6	48.5	0.000	0.01	351.5	1	351.5	42.0	0.000	0.017	113.1	1	113.1	10.6	0.001	0.004
Marital status	1830.3	1	1830.3	190.7	0.000	0.037	1106.4	1	1106.4	132.2	0.000	0.05	792.5	1	792.5	74.0	0.000	0.029
Educational status	250.2	1	250.2	26.1	0.000	0.005	2.8	1	2.8	0.3	0.562	0.000	376.3	1	376.3	35.1	0.000	0.014
Employment status	1835.4	1	1835.4	191.3	0.000	0.037	661.4	1	661.4	79.0	0.000	0.031	1151.4	1	1151.4	107.5	0.000	0.042
Social Class	5.2	1	5.2	0.5	0.462	0.000	28.8	1	28.8	3.4	0.064	0.001	1.2	1	1.2	0.1	0.736	0.000
Medical card status	2.3	1	2.3	0.2	0.628	0.000	23.4	1	23.4	2.8	0.095	0.001	7.6	1	7.6	0.7	0.4	0.000
Rurality	114.1	1	114.1	11.9	0.001	0.002	2.0	1	2.0	0.2	0.627	0.000	82.3	1	82.3	7.7	0.006	0.003
No. in household	333.6	1	333.6	34.8	0.000	0.007	54.7	1	54.7	6.5	0.011	0.003	303.1	1	303.1	28.3	0.000	0.011
Household tenure	12.1	1	12.1	1.3	0.261	0.000	12.2	1	12.2	1.5	0.227	0.001	4.8	1	4.8	0.5	0.502	0.000
Aggregated area	181.6	1	181.6	18.9	0.000	0.004	1.9	1	1.9	0.2	0.634	0.000	183.2	1	183.2	17.1	0.000	0.007
Error	47546.5	4955	9.6				20846.6	2491	8.4				26246.1	2450	10.7			
Total	2292546.0	4973					1156126.0	2507					1136420.0	2466				
Corrected Total	86877.0	4972					40225.1	2506					46644.8	2465				
	R Squared = .453 (Adjusted R Squared = .451)						R Squared = .482 (Adjusted R Squared = .479)						R Squared = .437 (Adjusted R Squared = .434)					

Table B.5n: ANCOVA outputs for 'Parenting Consistency', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	34.6	17	2.0	3.5	0.000	0.011	23.9	15	1.6	2.6	0.001	0.015	21.4	15	1.4	2.6	0.001	0.015
Intercept	90.2	1	90.2	156.3	0.000	0.029	52.2	1	52.2	85.5	0.000	0.032	35.2	1	35.2	65.2	0.000	0.025
Time	1.2	1	1.2	2.1	0.148	0.000	0.0	1	0.0	0.1	0.795	0.000	1.8	1	1.8	3.4	0.065	0.001
Location	0.7	1	0.7	1.3	0.256	0.000												
Time by location	0.6	1	0.6	1.0	0.32	0.000												
Age of child	3.0	1	3.0	5.3	0.022	0.001	1.3	1	1.3	2.1	0.148	0.001	1.9	1	1.9	3.6	0.058	0.001
Sex of child	4.4	1	4.4	7.6	0.006	0.001	1.9	1	1.9	3.1	0.078	0.001	2.5	1	2.5	4.7	0.031	0.002
Relation to child	0.8	1	0.8	1.3	0.245	0.000	0.2	1	0.2	0.3	0.572	0.000	0.8	1	0.8	1.5	0.224	0.001
Age of respondent	0.3	1	0.3	0.5	0.497	0.000	0.9	1	0.9	1.5	0.221	0.001	2.2	1	2.2	4.1	0.042	0.002
Sex of respondent	1.0	1	1.0	1.7	0.192	0.000	0.2	1	0.2	0.4	0.546	0.000	1.0	1	1.0	1.9	0.172	0.001
Marital status	5.6	1	5.6	9.6	0.002	0.002	5.2	1	5.2	8.5	0.004	0.003	1.4	1	1.4	2.5	0.112	0.001
Educational status	0.5	1	0.5	0.9	0.35	0.000	1.9	1	1.9	3.1	0.079	0.001	0.0	1	0.0	0.1	0.767	0.000
Employment status	0.0	1	0.0	0.0	0.906	0.000	0.0	1	0.0	0.0	0.944	0.000	0.0	1	0.0	0.0	0.892	0.000
Social Class	0.3	1	0.3	0.5	0.468	0.000	0.1	1	0.1	0.1	0.77	0.000	1.5	1	1.5	2.8	0.096	0.001
Medical card status	0.2	1	0.2	0.3	0.602	0.000	0.0	1	0.0	0.0	0.944	0.000	0.4	1	0.4	0.7	0.397	0.000
Rurality	0.2	1	0.2	0.4	0.537	0.000	0.0	1	0.0	0.0	0.924	0.000	0.1	1	0.1	0.3	0.616	0.000
No. in household	0.1	1	0.1	0.2	0.675	0.000	0.8	1	0.8	1.4	0.245	0.001	1.6	1	1.6	3.0	0.086	0.001
Household tenure	1.8	1	1.8	3.1	0.08	0.001	3.2	1	3.2	5.2	0.022	0.002	0.0	1	0.0	0.1	0.806	0.000
Aggregated area	3.4	1	3.4	6.0	0.015	0.001	0.6	1	0.6	1.0	0.33	0.000	2.8	1	2.8	5.3	0.022	0.002
Error	2975.0	5156	0.6				1583.3	2592	0.6				1377.8	2550	0.5			
Total	93727.0	5174					47868.0	2608					45859.0	2566				
Corrected Total	3009.5	5173					1607.2	2607					1399.2	2565				
	R Squared = .011 (Adjusted R Squared = .008)						R Squared = .015 (Adjusted R Squared = .009)						R Squared = .015 (Adjusted R Squared = .010)					

Table B.5o: ANCOVA outputs for 'Likely to use Appropriate Discipline', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	1969.9	17	115.9	9.5	0.000	0.03	780.6	15	52.0	4.3	0.000	0.024	1596.4	15	106.4	8.7	0.000	0.049
Intercept	2281.9	1	2281.9	186.6	0.000	0.035	1279.6	1	1279.6	105.5	0.000	0.039	1110.6	1	1110.6	91.0	0.000	0.034
Time	79.3	1	79.3	6.5	0.011	0.001	229.5	1	229.5	18.9	0.000	0.007	3.3	1	3.3	0.3	0.604	0.000
Location	83.2	1	83.2	6.8	0.009	0.001												
Time by location	202.7	1	202.7	16.6	0.000	0.003												
Age of child	14.7	1	14.7	1.2	0.273	0.000	2.7	1	2.7	0.2	0.64	0.000	42.8	1	42.8	3.5	0.061	0.001
Sex of child	306.4	1	306.4	25.1	0.000	0.005	20.8	1	20.8	1.7	0.191	0.001	430.2	1	430.2	35.2	0.000	0.014
Relation to child	2.6	1	2.6	0.2	0.645	0.000	1.4	1	1.4	0.1	0.734	0.000	40.4	1	40.4	3.3	0.069	0.001
Age of respondent	416.7	1	416.7	34.1	0.000	0.007	88.7	1	88.7	7.3	0.007	0.003	365.3	1	365.3	29.9	0.000	0.012
Sex of respondent	0.6	1	0.6	0.0	0.826	0.000	18.7	1	18.7	1.5	0.215	0.001	33.8	1	33.8	2.8	0.096	0.001
Marital status	4.4	1	4.4	0.4	0.548	0.000	4.4	1	4.4	0.4	0.549	0.000	19.9	1	19.9	1.6	0.201	0.001
Educational status	243.0	1	243.0	19.9	0.000	0.004	54.4	1	54.4	4.5	0.034	0.002	207.0	1	207.0	17.0	0.000	0.007
Employment status	101.3	1	101.3	8.3	0.004	0.002	24.6	1	24.6	2.0	0.155	0.001	67.4	1	67.4	5.5	0.019	0.002
Social Class	9.7	1	9.7	0.8	0.373	0.000	10.1	1	10.1	0.8	0.362	0.000	1.1	1	1.1	0.1	0.764	0.000
Medical card status	22.5	1	22.5	1.8	0.175	0.000	63.1	1	63.1	5.2	0.023	0.002	0.6	1	0.6	0.0	0.831	0.000
Rurality	37.8	1	37.8	3.1	0.079	0.001	2.6	1	2.6	0.2	0.647	0.000	73.0	1	73.0	6.0	0.015	0.002
No. in household	128.6	1	128.6	10.5	0.001	0.002	43.8	1	43.8	3.6	0.057	0.001	74.9	1	74.9	6.1	0.013	0.002
Household tenure	85.2	1	85.2	7.0	0.008	0.001	0.0	1	0.0	0.0	0.993	0.000	155.4	1	155.4	12.7	0.000	0.005
Aggregated area	53.8	1	53.8	4.4	0.036	0.001	25.1	1	25.1	2.1	0.151	0.001	6.9	1	6.9	0.6	0.451	0.000
Error	63432.2	5186	12.2				31644.8	2609	12.1				31294.7	2563	12.2			
Total	2418522.0	5204					1233629.0	2625					1184893.0	2579				
Corrected Total	65402.2	5203					32425.4	2624					32891.0	2578				
	R Squared = .030 (Adjusted R Squared = .027)						R Squared = .024 (Adjusted R Squared = .018)						R Squared = .049 (Adjusted R Squared = .043)					

Table B.5p: ANCOVA outputs for 'Unlikely to use Inappropriate Discipline', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	4892.5	17	287.8	29.5	0.000	0.091	2975.7	15	198.4	19.1	0.000	0.104	2470.4	15	164.7	18.3	0.000	0.099
Intercept	805.3	1	805.3	82.4	0.000	0.016	621.9	1	621.9	60.0	0.000	0.024	238.9	1	238.9	26.5	0.000	0.01
Time	2994.9	1	2994.9	306.5	0.000	0.058	1638.6	1	1638.6	158.1	0.000	0.06	1239.8	1	1239.8	137.7	0.000	0.052
Location	18.1	1	18.1	1.9	0.173	0.000												
Time by location	3.5	1	3.5	0.4	0.55	0.000												
Age of child	2.2	1	2.2	0.2	0.638	0.000	6.7	1	6.7	0.6	0.423	0.000	0.2	1	0.2	0.0	0.895	0.000
Sex of child	210.2	1	210.2	21.5	0.000	0.004	79.5	1	79.5	7.7	0.006	0.003	152.9	1	152.9	17.0	0.000	0.007
Relation to child	10.8	1	10.8	1.1	0.293	0.000	18.7	1	18.7	1.8	0.18	0.001	0.8	1	0.8	0.1	0.769	0.000
Age of respondent	7.2	1	7.2	0.7	0.391	0.000	0.1	1	0.1	0.0	0.936	0.000	20.8	1	20.8	2.3	0.129	0.001
Sex of respondent	11.6	1	11.6	1.2	0.277	0.000	22.8	1	22.8	2.2	0.138	0.001	1.1	1	1.1	0.1	0.726	0.000
Marital status	0.6	1	0.6	0.1	0.8	0.000	2.6	1	2.6	0.3	0.616	0.000	4.1	1	4.1	0.5	0.501	0.000
Educational status	278.1	1	278.1	28.5	0.000	0.006	312.2	1	312.2	30.1	0.000	0.012	37.7	1	37.7	4.2	0.041	0.002
Employment status	10.1	1	10.1	1.0	0.31	0.000	1.2	1	1.2	0.1	0.732	0.000	31.2	1	31.2	3.5	0.063	0.001
Social Class	0.8	1	0.8	0.1	0.777	0.000	0.4	1	0.4	0.0	0.839	0.000	3.8	1	3.8	0.4	0.518	0.000
Medical card status	127.5	1	127.5	13.0	0.000	0.003	82.0	1	82.0	7.9	0.005	0.003	27.6	1	27.6	3.1	0.08	0.001
Rurality	27.0	1	27.0	2.8	0.097	0.001	0.1	1	0.1	0.0	0.944	0.000	1.2	1	1.2	0.1	0.71	0.000
No. in household	35.7	1	35.7	3.7	0.056	0.001	3.7	1	3.7	0.4	0.552	0.000	38.8	1	38.8	4.3	0.038	0.002
Household tenure	4.6	1	4.6	0.5	0.492	0.000	73.6	1	73.6	7.1	0.008	0.003	25.6	1	25.6	2.8	0.092	0.001
Aggregated area	89.9	1	89.9	9.2	0.002	0.002	22.9	1	22.9	2.2	0.137	0.001	324.0	1	324.0	36.0	0.000	0.014
Error	48920.9	5007	9.8				25727.6	2482	10.4				22606.2	2511	9.0			
Total	543358.0	5025					276129.0	2498					267229.0	2527				
Corrected Total	53813.4	5024					28703.3	2497					25076.6	2526				
	R Squared = .091 (Adjusted R Squared = .088)						R Squared = .104 (Adjusted R Squared = .098)						R Squared = .099 (Adjusted R Squared = .093)					

Table B.5q: ANCOVA outputs for 'Unlikely to use Inappropriate Discipline for Anxious or Fearful Behaviour', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	1164.3	17	68.5	12.3	0.000	0.042	818.6	15	54.6	9.7	0.000	0.057	378.5	15	25.2	4.5	0.000	0.028
Intercept	678.6	1	678.6	121.8	0.000	0.025	361.9	1	361.9	64.6	0.000	0.026	339.6	1	339.6	61.2	0.000	0.025
Time	218.8	1	218.8	39.3	0.000	0.008	275.6	1	275.6	49.2	0.000	0.02	17.8	1	17.8	3.2	0.073	0.001
Location	42.0	1	42.0	7.5	0.006	0.002												
Time by location	76.8	1	76.8	13.8	0.000	0.003												
Age of child	10.0	1	10.0	1.8	0.18	0.000	5.1	1	5.1	0.9	0.338	0.000	5.0	1	5.0	0.9	0.34	0.000
Sex of child	8.4	1	8.4	1.5	0.22	0.000	9.2	1	9.2	1.6	0.2	0.001	0.9	1	0.9	0.2	0.685	0.000
Relation to child	18.2	1	18.2	3.3	0.07	0.001	33.8	1	33.8	6.0	0.014	0.003	1.0	1	1.0	0.2	0.67	0.000
Age of respondent	5.8	1	5.8	1.0	0.31	0.000	4.2	1	4.2	0.8	0.386	0.000	1.9	1	1.9	0.4	0.554	0.000
Sex of respondent	38.6	1	38.6	6.9	0.01	0.001	60.8	1	60.8	10.8	0.001	0.005	0.0	1	0.0	0.0	0.951	0.000
Marital status	0.1	1	0.1	0.0	0.90	0.000	0.2	1	0.2	0.0	0.856	0.000	0.0	1	0.0	0.0	0.973	0.000
Educational status	91.6	1	91.6	16.5	0.00	0.003	30.7	1	30.7	5.5	0.019	0.002	59.9	1	59.9	10.8	0.001	0.005
Employment status	50.4	1	50.4	9.1	0.00	0.002	6.4	1	6.4	1.1	0.286	0.000	52.7	1	52.7	9.5	0.002	0.004
Social Class	14.3	1	14.3	2.6	0.11	0.001	7.5	1	7.5	1.3	0.249	0.001	6.2	1	6.2	1.1	0.291	0.000
Medical card status	29.9	1	29.9	5.4	0.02	0.001	21.3	1	21.3	3.8	0.052	0.002	9.2	1	9.2	1.7	0.199	0.001
Rurality	1.6	1	1.6	0.3	0.60	0.000	0.4	1	0.4	0.1	0.778	0.000	0.4	1	0.4	0.1	0.789	0.000
No. in household	14.3	1	14.3	2.6	0.11	0.001	6.7	1	6.7	1.2	0.273	0.001	6.3	1	6.3	1.1	0.286	0.000
Household tenure	85.5	1	85.5	15.3	0.00	0.003	52.0	1	52.0	9.3	0.002	0.004	35.9	1	35.9	6.5	0.011	0.003
Aggregated area	49.3	1	49.3	8.8	0.00	0.002	10.5	1	10.5	1.9	0.172	0.001	36.3	1	36.3	6.5	0.011	0.003
Error	26481.2	4754	5.6				13437.9	2397	5.6				12996.5	2343	5.5			
Total	1748514.0	4772					889344.0	2413					859170.0	2359				
Corrected Total	27645.5	4771					14256.4	2412					13375.1	2358				
	R Squared = .042 (Adjusted R Squared = .039)						R Squared = .057 (Adjusted R Squared = .052)						R Squared = .028 (Adjusted R Squared = .022)					

Table B.5r: ANCOVA outputs for 'Inappropriate Opinions on Parenting', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	5798.7	17	341.1	18.5	0.000	0.057	2630.6	15	175.4	10.0	0.000	0.054	3624.8	15	241.7	12.6	0.000	0.069
Intercept	1489.7	1	1489.7	80.9	0.000	0.015	970.4	1	970.4	55.3	0.000	0.021	516.0	1	516.0	26.8	0.000	0.01
Time	63.3	1	63.3	3.4	0.064	0.001	118.1	1	118.1	6.7	0.009	0.003	0.2	1	0.2	0.0	0.917	0.000
Location	163.6	1	163.6	8.9	0.003	0.002												
Time by location	26.6	1	26.6	1.4	0.229	0.000												
Age of child	38.4	1	38.4	2.1	0.149	0.000	26.9	1	26.9	1.5	0.216	0.001	18.1	1	18.1	0.9	0.332	0.000
Sex of child	13.2	1	13.2	0.7	0.397	0.000	6.4	1	6.4	0.4	0.546	0.000	62.3	1	62.3	3.2	0.072	0.001
Relation to child	20.2	1	20.2	1.1	0.295	0.000	15.2	1	15.2	0.9	0.351	0.000	1.6	1	1.6	0.1	0.776	0.000
Age of respondent	297.9	1	297.9	16.2	0.000	0.003	1.7	1	1.7	0.1	0.756	0.000	602.1	1	602.1	31.3	0.000	0.012
Sex of respondent	2.5	1	2.5	0.1	0.715	0.000	1.0	1	1.0	0.1	0.816	0.000	4.4	1	4.4	0.2	0.634	0.000
Marital status	309.0	1	309.0	16.8	0.000	0.003	74.4	1	74.4	4.2	0.039	0.002	242.3	1	242.3	12.6	0.000	0.005
Educational status	420.6	1	420.6	22.8	0.000	0.004	337.8	1	337.8	19.3	0.000	0.007	135.7	1	135.7	7.1	0.008	0.003
Employment status	191.0	1	191.0	10.4	0.001	0.002	27.4	1	27.4	1.6	0.211	0.001	180.0	1	180.0	9.4	0.002	0.004
Social Class	151.4	1	151.4	8.2	0.004	0.002	121.0	1	121.0	6.9	0.009	0.003	41.2	1	41.2	2.1	0.143	0.001
Medical card status	59.9	1	59.9	3.3	0.071	0.001	40.0	1	40.0	2.3	0.131	0.001	13.4	1	13.4	0.7	0.404	0.000
Rurality	191.9	1	191.9	10.4	0.001	0.002	5.8	1	5.8	0.3	0.565	0.000	136.8	1	136.8	7.1	0.008	0.003
No. in household	204.8	1	204.8	11.1	0.001	0.002	34.4	1	34.4	2.0	0.161	0.001	168.3	1	168.3	8.8	0.003	0.003
Household tenure	394.7	1	394.7	21.4	0.000	0.004	248.9	1	248.9	14.2	0.000	0.005	169.7	1	169.7	8.8	0.003	0.003
Aggregated area	80.9	1	80.9	4.4	0.036	0.001	1.1	1	1.1	0.1	0.799	0.000	86.5	1	86.5	4.5	0.034	0.002
Error	95549.4	5186	18.4				45745.2	2609	17.5				49256.8	2563	19.2			
Total	1253097.0	5204					639601.0	2625					613496.0	2579				
Corrected Total	101348.045	5203					48375.8	2624					52881.6	2578.0				
	R Squared = .057 (Adjusted R Squared = .054)						R Squared = .054 (Adjusted R Squared = .049)						R Squared = .069 (Adjusted R Squared = .063)					

Table B.5s: ANCOVA outputs for 'Inappropriate Opinions on Smacking', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	6229.6	17	366.4	18.5	0.000	0.057	5348.5	15	356.6	18.0	0.000	0.094	1922.6	15	128.2	6.6	0.000	0.037
Intercept	665.8	1	665.8	33.6	0.000	0.006	624.8	1	624.8	31.5	0.000	0.012	111.9	1	111.9	5.7	0.017	0.002
Time	3595.8	1	3595.8	181.4	0.000	0.034	2281.5	1	2281.5	115.1	0.000	0.042	1274.1	1	1274.1	65.3	0.000	0.025
Location	229.0	1	229.0	11.6	0.001	0.002												
Time by location	58.3	1	58.3	2.9	0.087	0.001												
Age of child	54.8	1	54.8	2.8	0.097	0.001	22.3	1	22.3	1.1	0.289	0.000	26.7	1	26.7	1.4	0.242	0.001
Sex of child	16.0	1	16.0	0.8	0.369	0.000	0.8	1	0.8	0.0	0.841	0.000	25.2	1	25.2	1.3	0.255	0.001
Relation to child	12.9	1	12.9	0.6	0.421	0.000	29.3	1	29.3	1.5	0.224	0.001	3.8	1	3.8	0.2	0.659	0.000
Age of respondent	171.1	1	171.1	8.6	0.003	0.002	43.9	1	43.9	2.2	0.137	0.001	142.1	1	142.1	7.3	0.007	0.003
Sex of respondent	8.9	1	8.9	0.5	0.502	0.000	28.6	1	28.6	1.4	0.23	0.001	6.4	1	6.4	0.3	0.567	0.000
Marital status	6.9	1	6.9	0.3	0.556	0.000	55.6	1	55.6	2.8	0.094	0.001	19.6	1	19.6	1.0	0.316	0.000
Educational status	565.0	1	565.0	28.5	0.000	0.005	611.5	1	611.5	30.8	0.000	0.012	64.5	1	64.5	3.3	0.069	0.001
Employment status	8.4	1	8.4	0.4	0.515	0.000	12.4	1	12.4	0.6	0.43	0.000	0.2	1	0.2	0.0	0.917	0.000
Social Class	0.2	1	0.2	0.0	0.925	0.000	4.8	1	4.8	0.2	0.623	0.000	3.3	1	3.3	0.2	0.682	0.000
Medical card status	188.6	1	188.6	9.5	0.002	0.002	65.6	1	65.6	3.3	0.069	0.001	114.2	1	114.2	5.9	0.016	0.002
Rurality	19.3	1	19.3	1.0	0.324	0.000	38.3	1	38.3	1.9	0.165	0.001	43.0	1	43.0	2.2	0.138	0.001
No. in household	21.3	1	21.3	1.1	0.3	0.000	34.3	1	34.3	1.7	0.189	0.001	2.2	1	2.2	0.1	0.739	0.000
Household tenure	185.9	1	185.9	9.4	0.002	0.002	457.3	1	457.3	23.1	0.000	0.009	3.6	1	3.6	0.2	0.667	0.000
Aggregated area	115.2	1	115.2	5.8	0.016	0.001	87.5	1	87.5	4.4	0.036	0.002	0.8	1	0.8	0.0	0.836	0.000
Error	102808.9	5186	19.8				51720.4	2609	19.8				49986.9	2563	19.5			
Total	579631.0	5204					299796.0	2625					279835.0	2579				
Corrected Total	109038.5	5203					57068.9	2624					51909.4	2578				
	R Squared = .057 (Adjusted R Squared = .054)						R Squared = .094 (Adjusted R Squared = .089)						R Squared = .037 (Adjusted R Squared = .031)					

Table B.5t: ANCOVA outputs for 'Satisfied with Parenting Information available in Locality', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	423.6	17	24.9	19.0	0.000	0.059	225.3	15	15.0	11.1	0.000	0.06	154.9	15	10.3	8.3	0.000	0.046
Intercept	53.5	1	53.5	40.7	0.000	0.008	45.4	1	45.4	33.5	0.000	0.013	12.0	1	12.0	9.6	0.002	0.004
Time	50.5	1	50.5	38.5	0.000	0.007	165.7	1	165.7	122.2	0.000	0.045	4.4	1	4.4	3.5	0.061	0.001
Location	143.1	1	143.1	108.9	0.000	0.021												
Time by location	132.0	1	132.0	100.5	0.000	0.019												
Age of child	0.9	1	0.9	0.7	0.396	0.000	0.9	1	0.9	0.7	0.419	0.000	0.1	1	0.1	0.1	0.799	0.000
Sex of child	1.7	1	1.7	1.3	0.261	0.000	0.1	1	0.1	0.0	0.847	0.000	6.3	1	6.3	5.0	0.025	0.002
Relation to child	0.7	1	0.7	0.6	0.458	0.000	2.2	1	2.2	1.6	0.2	0.001	0.4	1	0.4	0.3	0.555	0.000
Age of respondent	12.6	1	12.6	9.6	0.002	0.002	5.0	1	5.0	3.7	0.055	0.001	6.3	1	6.3	5.1	0.025	0.002
Sex of respondent	1.4	1	1.4	1.0	0.308	0.000	2.0	1	2.0	1.5	0.22	0.001	0.1	1	0.1	0.1	0.821	0.000
Marital status	8.0	1	8.0	6.1	0.014	0.001	0.7	1	0.7	0.5	0.47	0.000	8.5	1	8.5	6.8	0.009	0.003
Educational status	0.0	1	0.0	0.0	0.975	0.000	0.9	1	0.9	0.7	0.408	0.000	1.8	1	1.8	1.5	0.224	0.001
Employment status	0.4	1	0.4	0.3	0.566	0.000	0.0	1	0.0	0.0	0.94	0.000	0.7	1	0.7	0.5	0.465	0.000
Social Class	1.8	1	1.8	1.3	0.247	0.000	1.5	1	1.5	1.1	0.301	0.000	1.7	1	1.7	1.4	0.239	0.001
Medical card status	0.2	1	0.2	0.1	0.727	0.000	2.4	1	2.4	1.7	0.188	0.001	0.4	1	0.4	0.3	0.559	0.000
Rurality	43.2	1	43.2	32.9	0.000	0.006	1.6	1	1.6	1.2	0.278	0.000	74.2	1	74.2	59.4	0.000	0.023
No. in household	0.4	1	0.4	0.3	0.573	0.000	0.2	1	0.2	0.1	0.713	0.000	1.4	1	1.4	1.1	0.292	0.000
Household tenure	3.4	1	3.4	2.6	0.11	0.000	0.2	1	0.2	0.1	0.723	0.000	6.0	1	6.0	4.8	0.029	0.002
Aggregated area	72.6	1	72.6	55.3	0.000	0.011	23.7	1	23.7	17.5	0.000	0.007	12.9	1	12.9	10.3	0.001	0.004
Error	6811.4	5186	1.3				3537.3	2609	1.4				3199.1	2563	1.2			
Total	45033.0	5204					25003.0	2625					20030.0	2579				
Corrected Total	7235.0	5203					3762.6	2624					3354.0	2578				
	R Squared = .059 (Adjusted R Squared = .055)						R Squared = .060 (Adjusted R Squared = .054)						R Squared = .046 (Adjusted R Squared = .041)					

Table B.5u: ANCOVA outputs for 'Satisfied with Parenting Services available in Locality', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	397.6	17	23.4	17.6	0.000	0.055	232.7	15	15.5	11.6	0.000	0.062	168.2	15	11.2	8.7	0.000	0.049
Intercept	51.9	1	51.9	39.0	0.000	0.007	37.1	1	37.1	27.8	0.000	0.011	15.9	1	15.9	12.4	0.000	0.005
Time	79.7	1	79.7	59.9	0.000	0.011	157.7	1	157.7	117.8	0.000	0.043	0.5	1	0.5	0.4	0.515	0.000
Location	131.6	1	131.6	99.0	0.000	0.019												
Time by location	90.8	1	90.8	68.3	0.000	0.013												
Age of child	0.5	1	0.5	0.4	0.529	0.000	1.5	1	1.5	1.2	0.282	0.000	0.1	1	0.1	0.1	0.744	0.000
Sex of child	1.2	1	1.2	0.9	0.335	0.000	0.2	1	0.2	0.1	0.709	0.000	6.4	1	6.4	4.9	0.026	0.002
Relation to child	0.2	1	0.2	0.2	0.677	0.000	0.7	1	0.7	0.6	0.456	0.000	0.2	1	0.2	0.2	0.688	0.000
Age of respondent	20.4	1	20.4	15.3	0.000	0.003	6.4	1	6.4	4.8	0.028	0.002	11.6	1	11.6	9.0	0.003	0.004
Sex of respondent	1.2	1	1.2	0.9	0.347	0.000	1.3	1	1.3	0.9	0.332	0.000	0.0	1	0.0	0.0	0.977	0.000
Marital status	6.9	1	6.9	5.2	0.023	0.001	1.0	1	1.0	0.7	0.398	0.000	6.3	1	6.3	4.9	0.027	0.002
Educational status	0.0	1	0.0	0.0	0.854	0.000	0.0	1	0.0	0.0	0.981	0.000	0.5	1	0.5	0.4	0.514	0.000
Employment status	0.8	1	0.8	0.6	0.45	0.000	0.1	1	0.1	0.1	0.772	0.000	0.6	1	0.6	0.4	0.506	0.000
Social Class	0.3	1	0.3	0.2	0.637	0.000	0.5	1	0.5	0.4	0.554	0.000	0.8	1	0.8	0.6	0.425	0.000
Medical card status	0.0	1	0.0	0.0	0.921	0.000	3.7	1	3.7	2.8	0.096	0.001	3.3	1	3.3	2.5	0.111	0.001
Rurality	45.4	1	45.4	34.2	0.000	0.007	0.5	1	0.5	0.4	0.539	0.000	89.3	1	89.3	69.5	0.000	0.026
No. in household	0.6	1	0.6	0.4	0.511	0.000	2.8	1	2.8	2.1	0.149	0.001	6.1	1	6.1	4.7	0.03	0.002
Household tenure	0.6	1	0.6	0.4	0.52	0.000	0.1	1	0.1	0.1	0.765	0.000	0.9	1	0.9	0.7	0.413	0.000
Aggregated area	67.2	1	67.2	50.6	0.000	0.01	21.4	1	21.4	16.0	0.000	0.006	7.8	1	7.8	6.1	0.014	0.002
Error	6896.4	5186	1.3				3492.0	2609	1.3				3293.9	2563	1.3			
Total	45481.0	5204					25062.0	2625					20419.0	2579				
Corrected Total	7294.0	5203.0					3724.8	2624					3462.1	2578				
	R Squared = .055 (Adjusted R Squared = .051)						R Squared = .062 (Adjusted R Squared = .057)						R Squared = .049 (Adjusted R Squared = .043)					

Table B.5v: ANCOVA outputs for 'Likely to engage with future Parenting Programmes', overall and by location – Population Study

	Overall						Intervention Counties						Comparison Counties					
Source	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**	**Sum of Squares**	**DF**	**Mean Square**	**F**	**p**	**Partial H^2**
Corrected	1920.0	17	112.9	13.2	0.000	0.042	1413.3	15	94.2	11.3	0.000	0.061	747.2	15	49.8	5.7	0.000	0.032
Intercept	73.8	1	73.8	8.6	0.003	0.002	26.1	1	26.1	3.1	0.077	0.001	56.6	1	56.6	6.5	0.011	0.003
Time	73.1	1	73.1	8.6	0.003	0.002	1.8	1	1.8	0.2	0.642	0.000	190.7	1	190.7	21.8	0.000	0.008
Location	43.1	1	43.1	5.0	0.025	0.001												
Time by location	94.1	1	94.1	11.0	0.001	0.002												
Age of child	2.9	1	2.9	0.3	0.562	0.000	14.2	1	14.2	1.7	0.191	0.001	1.0	1	1.0	0.1	0.731	0.000
Sex of child	6.6	1	6.6	0.8	0.381	0.000	19.8	1	19.8	2.4	0.123	0.001	1.4	1	1.4	0.2	0.69	0.000
Relation to child	17.8	1	17.8	2.1	0.149	0.000	8.3	1	8.3	1.0	0.319	0.000	25.1	1	25.1	2.9	0.09	0.001
Age of respondent	6.5	1	6.5	0.8	0.384	0.000	9.9	1	9.9	1.2	0.275	0.000	0.1	1	0.1	0.0	0.909	0.000
Sex of respondent	16.1	1	16.1	1.9	0.17	0.000	39.4	1	39.4	4.7	0.029	0.002	3.9	1	3.9	0.4	0.506	0.000
Marital status	7.2	1	7.2	0.8	0.358	0.000	0.8	1	0.8	0.1	0.753	0.000	17.2	1	17.2	2.0	0.16	0.001
Educational status	32.9	1	32.9	3.9	0.05	0.001	13.9	1	13.9	1.7	0.196	0.001	22.5	1	22.5	2.6	0.108	0.001
Employment status	36.5	1	36.5	4.3	0.039	0.001	13.0	1	13.0	1.6	0.212	0.001	20.3	1	20.3	2.3	0.128	0.001
Social Class	7.4	1	7.4	0.9	0.353	0.000	1.0	1	1.0	0.1	0.731	0.000	6.5	1	6.5	0.7	0.387	0.000
Medical card status	7.7	1	7.7	0.9	0.343	0.000	0.2	1	0.2	0.0	0.864	0.000	20.4	1	20.4	2.3	0.126	0.001
Rurality	183.5	1	183.5	21.5	0.000	0.004	110.2	1	110.2	13.3	0.000	0.005	127.1	1	127.1	14.6	0.000	0.006
No. in household	6.5	1	6.5	0.8	0.384	0.000	9.5	1	9.5	1.1	0.286	0.000	0.7	1	0.7	0.1	0.783	0.000
Household tenure	24.6	1	24.6	2.9	0.09	0.001	18.2	1	18.2	2.2	0.139	0.001	7.8	1	7.8	0.9	0.344	0.000
Aggregated area	102.2	1	102.2	12.0	0.001	0.002	121.0	1	121.0	14.6	0.000	0.006	10.5	1	10.5	1.2	0.272	0.000
Error	44316.1	5186	8.5				21684.1	2609	8.3				22367.8	2563	8.7			
Total	147712.0	5204					75845.0	2625					71867.0	2579				
Corrected Total	46236.1	5203					23097.5	2624					23115.0	2578				
	R Squared = .042 (Adjusted R Squared = .038)						R Squared = .061 (Adjusted R Squared = .056)						R Squared = .032 (Adjusted R Squared = .027					

Table B.5w: Summary of population level impact of Triple P programme: Child and parent outcomes

	Intervention counties				Comparison counties				Population effect (p) §	What happened
	Means (SE)§		Effect size◆	Direction and significance (p)Δ	Means (SE)§		Effect size◆	Direction and significance (p)Δ		
	Pre	Post			Pre	Post				
Child outcomes										
SDQ Total Difficulties	8.27 (0.20)	7.31 (0.19)	-0.18	↓ <0.001***	7.63 (0.20)	7.26 (0.20)	-0.07	ns	<0.05*	Intervention counties went down, but no change in comparison counties
SDQ Emotional Symptoms	1.79 (0.07)	1.42 (0.06)	-0.21	↓ <0.001***	1.77 (0.07)	1.62 (0.07)	-0.08	↓ <0.05*	<0.05*	Intervention counties went down more than comparison counties
SDQ Conduct Problems	1.71 (0.06)	1.44 (0.06)	-0.17	↓ <0.001***	1.55 (0.06)	1.4 (0.06)	-0.10	↓ <0.05*	ns	Both intervention and comparison counties went down
SDQ Peer Problems	1.5 (0.06)	1.26 (0.05)	-0.16	↓ <0.001***	1.26 (0.06)	1.14 (0.06)	-0.08	ns	ns	Intervention counties went down, but no change in comparison counties
SDQ Hyperactivity	3.28 (0.09)	3.19 (0.08)	-0.04	ns	3.04 (0.08)	3.11 (0.08)	0.03	ns	ns	No change in either intervention or comparison counties
SDQ Pro-social	8.15 (0.07)	8.47 (0.07)	0.17	↑ <0.001***	8.02 (0.07)	8.34 (0.07)	0.17	↑ <0.001***	ns	Both intervention and comparison counties went up
Parenting outcomes										
Confident parenting	36.28 (0.23)	36.19 (0.21)	-0.01	ns	35.72 (0.23)	36.23 (0.22)	0.08	↑ <0.05*	ns	No change in intervention county, but comparison counties went up
Good experience of parenting	18.71 (0.10)	19.49 (0.10)	0.29	↑ <0.001***	18.67 (0.10)	19.24 (0.10)	0.20	↑ <0.001***	ns	Both intervention and comparison counties went up
Parental psychological distress	12.39 (0.20)	11.64 (0.19)	-0.15	↓ <0.001***	13.92 (0.2)	14.08 (0.20)	0.03	ns	<0.01**	Intervention counties went down, but no change in comparison counties
Positive family climate	22.82 (0.15)	23.63 (0.14)	0.21	↑ <0.001***	22.96 (0.14)	23.61 (0.14)	0.17	↑ <0.001***	<0.001***	Both intervention and comparison counties went up
Good relationship with child	18.23 (0.09)	19.01 (0.09)	0.33	↑ <0.001***	18.21 (0.09)	18.27 (0.09)	0.02	ns	<0.001***	Intervention counties went up, but no change in comparison counties
Engage in positive parenting	13.12 (0.08)	13.16 (0.08)	0.02	ns	13.01 (0.08)	12.76 (0.08)	-0.11	↓ <0.01**	<0.05*	No change in intervention counties, but comparison counties went down
Engage in parental responsibilities	21.86 (0.12)	21.14 (0.11)	-0.18	↓ <0.001***	21.02 (0.12)	20.34 (0.12)	-0.16	↓ <0.001***	ns	Both intervention and comparison counties went down
Parenting consistency	4.17 (0.03)	4.16 (0.03)	-0.01	ns	4.24 (0.03)	4.19 (0.03)	-0.07	ns	ns	No change in either intervention or comparison counties
Likely to use appropriate discipline	21.18 (0.14)	21.83 (0.13)	0.19	↑ <0.001***	21.06 (0.13)	20.91 (0.13)	-0.04	ns	<0.001***	Intervention counties went up, but no change in comparison counties
Unlikely to use inappropriate discipline	19.35 (0.13)	21 (0.11)	0.50	↑ <0.001***	19.15 (0.12)	20.7 (0.12)	0.51	↑ <0.001***		Both intervention and comparison counties went up

Unlikely to use inappropriate parenting for anxious behaviour	18.8 (0.10)	19.5 (0.09)	0.29	↑ <0.001***	18.67 (0.09)	18.86 (0.09)	0.08		<0.001***	Intervention counties went up, but no change in comparison counties
Inappropriate opinions on parenting	15.44 (0.17)	15.06 (0.15)	-0.09		14.56 (0.16)	14.48 (0.16)	-0.02			No change in either intervention or comparison counties
Inappropriate opinions on smacking	10.99 (0.17)	9.06 (0.16)	-0.42	↓ <0.001***	9.91 (0.17)	8.41 (0.17)	-0.34	↓ <0.001***		Both intervention and comparison counties went down
Satisfied with available parenting services	2.76 (0.05)	3.28 (0.04)	0.45	↑ <0.001***	2.37 (0.04)	2.36 (0.04)	-0.01		<0.001***	Intervention counties went up, but no change in comparison counties
Satisfied with available parenting information	2.76 (0.05)	3.28 (0.04)	0.45	↑ <0.001***	2.4 (0.04)	2.28 (0.04)	-0.10		<0.001***	Intervention counties went up, but no change in comparison counties
Likelihood of participating in future parenting programmes	4.23 (0.11)	4.25 (0.10)	0.01		4.87 (0.11)	4.36 (0.11)	-0.17	↓ <0.001***	<0.001***	No change in intervention counties, but comparison counties went down

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

SE = Standard error of covariate adjusted means.

◆ Effect size was calculated as Cohen's d to standardise the difference between covariate adjusted means pre- and post-intervention (numerator) using unadjusted pooled standard deviations (denominator) for each outcome measure (Lipsey and Wilson, 2001).

Δ p values are presented for significant differences in outcomes over time.

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

The arrows indicate the direction of the relationships identified: ↑ indicates that respondents at Time 2 had higher values on the outcome than respondents at Time 1, while ↓ indicates that respondents reported lower values at Time 2.

§ p values are presented for significant time by location interactions.

Appendix C – PARTNERSHIP STUDY

Appendix C.1: Roles and responsibilities within LWPP

Three key roles within the Longford Westmeath Parenting Partnership (LWPP) include the Chair, the Treasurer and the Project Director. The **Project Director** has wide-ranging responsibilities, including the following: regularly inform LWPP about the status and developments of the Triple P project; report to the Archways Board on the overall performance of the Collaborative Initiative; lead the development and manage the implementation of the project plan; lead the design and completion of all research components of the project; act as the chief communicator/figurehead for the Collaborative Initiative; present and communicate research findings in formats suitable for diverse purposes and audiences; represent the Collaborative Initiative at key events; liaise and advocate with relevant organisations in Ireland to promote the use of evidence-based programmes and partnership approaches to service delivery; provide direction, support and guidance to other members of the Core Team and Panel 1 through the provision of clinical supervision; ensure that the fidelity requirements of the programme are adhered to; provide regular update reports to the Expert Advisory Group; and manage the relationship between the Collaborative Initiative and Triple P/The Atlantic Philanthropies/Centre for Effective Services/DCYA (Grant Proposal, p. 71).

A further key role is the **Partnership Manager** whose roles and responsibilities include the following: work in partnership with the LWPP to maximise opportunities for interagency collaboration; serve as the primary link between the project and Archways; monitor and report on performance against the project plan/budget; manage resources efficiently and effectively on a day-to-day basis; provide regular update reports to the LWPP; present and communicate learning from the partnership experience in a format suitable for diverse purposes and audiences; represent the Collaborative Initiative at key events; liaise and advocate with relevant organisations in Ireland to promote the use of evidence-based programmes and partnership approaches to service delivery; liaise with HSE service managers/planners on a continuous basis regarding progress to date and emerging programme opportunities; actively target and pursue the recruitment of new partners; and manage the relationship between the Collaborative Initiative and Triple P/The Atlantic Philanthropies (Grant Proposal, p. 71).

The roles and responsibilities of the **Office Administrator/Clerical Officer** include: manage day-to-day office operations, including IT, supplies, etc.; serve as the primary point of contact for incoming communications; respond to project queries from other organisations and interested parents; support the financial management of the Core Team office; facilitate the management of all events, presentations, conferences, etc.; support the Project Director and Partnership Manager with the scheduling of training and delivery programme components (Grant Proposal, p. 71).

Appendix C.2: Partnership Interview Schedules

Partnership Interview Schedule, May 2011 (Time 1)

You and your organisation

1. What is your role in your organisation?
2. What type of organisation do you work in?
    - Health
    - Childcare/crèche
    - School
    - Other education service/body
    - Community organisation
    - An Garda Síochána
    - Other

Partnership working

3. What does the term partnership mean to you?
4. Have you delivered a service as part of a partnership organisation before?
5. If yes, give details
6. Have you been involved in any training on partnership working?
7. Is there a history of partnership working in the area covered by Triple P?
8. How would you describe that history?

Getting involved with LWPP

9. Were you involved with LWPP before the application for Triple P was made?
10. Describe that involvement if so.
11. What prior knowledge, if any, did you have about the Triple P parenting programme?
12. What are its strengths and weaknesses in your opinion?
13. Were you and your organisation involved in the setting up of the Triple P?
14. How? Give details.
15. What are your impressions (strengths and weaknesses) of the development process?
16. To what extent did you feel you and your organisation were able to play a full part?
17. Is there a formal agreement between your organisation and Triple P?
18. What does this cover? Funding, places on training, numbers of service users?
19. How could the development process have been improved upon?
20. Describe the factors which you consider has supported the development of the Triple P Partnership?
21. Describe the obstacles?
22. What are the factors supporting your organisation's involvement in Triple P?
23. What are the obstacles?

Impact at this stage

24. What impact has it had at this stage on the work of your organisation? Specify- any outcomes you can point to?
25. What impact has it had at this stage on your own work?

Any other comments

Partnership Interview Schedule, November 2011 (Time 2)

Background and involvement in LWPP

1. Tell me about your organisation and your role within it?
2. Tell me about your involvement in LWPP

MoU and PARTNERSHIP WORKING

The MoU is key to LWPP:

3. Is the Memorandum of Understanding working?
   - Is it useful? Do the aims still hold? Do the principles/values still hold?
   - In your opinion is LWPP operating in accordance with the MoU?
   - Is your organisation happy with its involvement as a partner in LWPP?
4. How effective has the partnership been in ensuring the delivery of Triple P as expressed under the points 'Within the scope of the LWPP' in the MoU
5. Do you see LWPP as part of your organisation's core business?
6. Is LWPP activity officially part of your organisation's work plan?
7. Has the partnership had any impact at this stage on the work of your organisation (specific examples)?
8. Has it had any impact on your own specific area of work (specific examples)?
9. Has partnership working improved across organisations involved in LWPP?
10. Has the LWPP partnership impacted on partnership working in other areas of your work/of your organisation's work?
11. At this point in the development of the partnership, how does it compare to other partnerships that you have been involved in? (Positively/Negatively)

LWPP commitments and expectations

12. Tell me about your organisation's initial commitments to LWPP.
13. Have you been able to deliver on these?
14. Have there been changes in the level of commitment that you/other LWPP partners have given since the inception of the partnership?
15. Are more demands being made of the partners (making more requests of partners)? If so, can you deliver on these demands?
16. Has your organisation been affected by changes in the wider funding environment? If so, have such changes affected your capacity to be a partner in LWPP?

PPP and Evidence-based programmes

17. Has the adoption of Triple P changed attitudes towards evidence-based programmes in your organisation?
    - (Prevention and early intervention)
18. Outside of the regular formal updating that you receive as a partner, have you received other feedback on programme implementation/value? If so, what has that been?

Other comments

19. Have you any other comments that you would like to make?

Partnership Interview Schedule, September 2012 (Time 3)

Implementation of the partnership

1. What is your organisation's role in the partnership?
2. What different types of contribution does your organisation make?
3. Has this changed since the start of your organisation's involvement?

Motivations

4. What were the initial reasons for joining the partnership?
5. Do those reasons still hold?

Memorandum of Understanding (MoU)

6. In your opinion is LWPP operating in accordance with the MoU?
7. What difficult issues have arisen and were they addressed in accordance with the MoU?

The partnership itself

8. In your opinion what other organisations should be in the partnership?
9. Are there any organisations that should not be in the partnership?

Expansion of programme delivery

10. Does there need to be a partnership for the delivery of this type of programme? (connects with replication of project)
11. What are your views on proposals to expand the delivery of Triple P?

Other comments

12. At this point in the partnership and programme delivery are there any other specific issues that you think are important and that we have not covered?

Partnership Interview Schedule, May 2013 (Time 4)

1. Was a partnership approach necessary for successful implementation of Triple P as a population intervention?
2. The MoU, its implementation, and review
3. How would you characterise your contribution as a partner under the following headings:
   Attendance at partnership meetings and influence on decision making
   Delivery of Triple P programme
   Recruitment of parents to the programme
   Promotion of the programme
4. What are your views on the roll-out of the programme?
5. What is the current status of the partnership given that the catchment area has been extended?
6. In what way could the partnership be improved?

Appendix C.3: Person Specification for Laois Offaly Practitioners

Relevant qualifications

Qualification	Essential	Desirable
Relevant health/social work/childcare/community qualification	E	
Demonstrate commitment to personal and professional development		D

Relevant experience

Qualification	Essential	Desirable
Experience of working with parents/families	E	
Research and Evaluation experience		D
Relevance to current work role	E	
Have you delivered a parenting programme previously		
IT experience and access to IT equipment		D
PR and Marketing skills		D
Ability to plan and work as part if a team across a range of organisations and disciplines		D

Knowledge of parenting issues

Qualification	Essential	Desirable
Your understanding of Triple P		
Your understanding of key issues for parents of children 0 – 7 yrs		D
Access to parents in current role	E	

Facilitation skills

Qualification	Essential	Desirable
Ability to lead a group, creating a friendly and participative environment for parents		D
Previous experience of training/delivery in your work		D
Interpersonal and communication skills	E	
Willing to learn and willing to change if needed		
Ability to see programme through and to follow up on issues where necessary	E	
To be able to listen, to have empathy and be non-judgemental	E	
To be able to be flexible and solve problems on own initiative	E	
To commit to delivering Triple P and fidelity to the programme	E	
Ability to plan, work and deliver in a collaborative manner	E	

Job description for practitioners delivering 100 hours Triple P per annum

Training and accreditation

- Commitment to participating in training and accreditation and delivery of Triple P programmes over next 2 years
- To participate in co-delivery, supervision and mentoring relating to the programme.
- To participate in research and evaluation processes where necessary.

Recruitment of parents

- To be able to build and develop working relationships with parents, colleagues and wider community in supporting parents to access Triple P programmes
- To promote parental and community involvement in the rollout of Triple P across Laois Offaly
- Enthusiasm and commitment to promote Triple P Programme in Laois Offaly.

Delivery

- Ability to plan, work with and as part of a team rolling out delivery of Triple P across Laois Offaly
- To deliver in a flexible manner for example evening work may be required depending on parents needs.
- To be in a position with management support to prioritise Triple P delivery within current work role.

Fidelity, supervision and support

- To deliver Triple P in partnership with core team members ensuring and maintaining fidelity to the programme
- Maintain records and input data as required by Triple P programme
- Maintain links and contacts with Athlone Office re submitting and recording data for Triple P delivery.
- To update and improve own knowledge and skills when reflecting on own work practices
- To take part in recorded sessions for peer review as part of fidelity work.

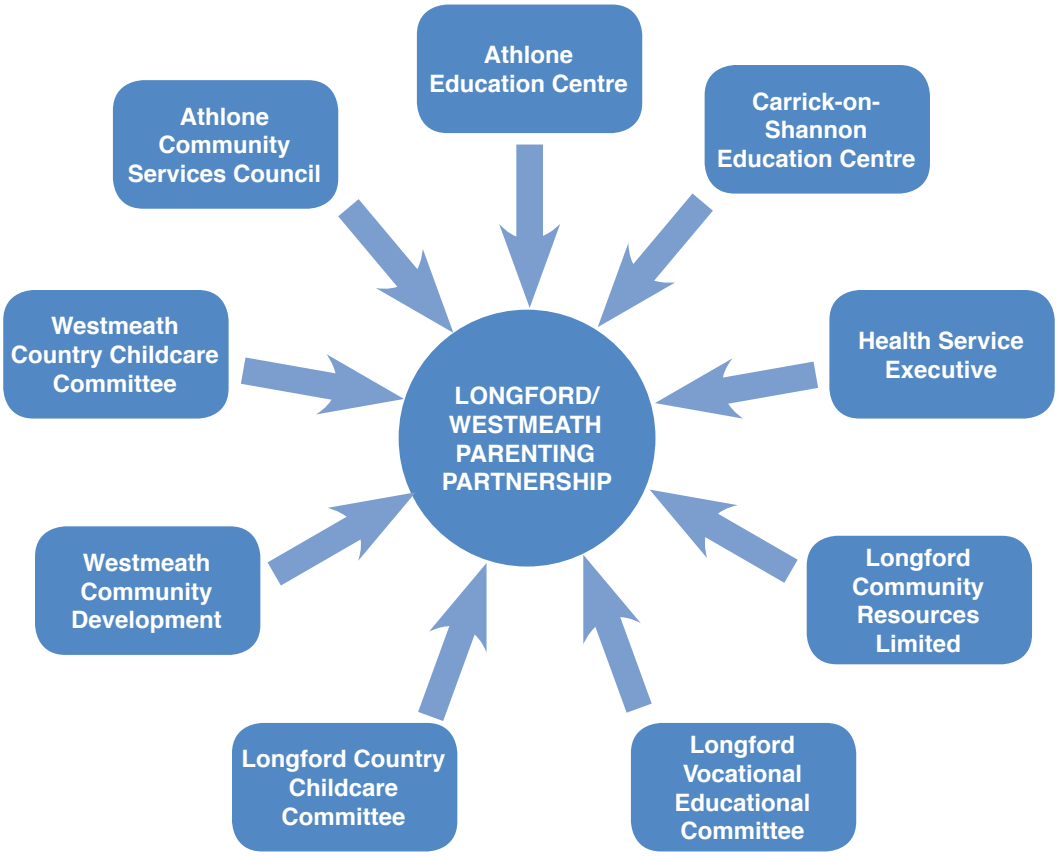
Appendix C.4: Memorandum of Understanding

LONGFORD WESTMEATH PARENTING PARTNERSHIP MEMORANDUM OF UNDERSTANDING – A Shared Commitment to Partnership

1. Purpose of this Memorandum of Understanding

This Memorandum of Understanding (MoU) reflects the formal commitment of the constituent partners[14] of the Longford Westmeath Parenting Partnership (LWPP) to collaborate in the planning, organisation and delivery of proven evidence-based programmes to benefit parents and children in the counties of Longford and Westmeath. This is a wide-scale strategic process and the partner organisations recognise that the proper functioning of the Partnership – including clarity on its operational arrangements and commitment to the principles of good governance and management – is likely to positively influence the quality and sustainability of the programme's delivery.

This MoU sets out the basis for the collaboration towards which the organisations will proceed in good faith, with a view to progressing implementation of the Partnership. It outlines the development, vision and goals of the process, indicates its scope and parameters, and sets out the ways in which the collaboration will be operationalised, including the structures and supporting mechanisms that will be used to implement it.



14. 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.

2. Vision

To provide positive parenting strategies and skills to families with children that will result in real social and emotional gains for children, parents and the wider community.

3. Mission Statement

The mission of the Longford/Westmeath Parenting Partnership (LWPP) is to deliver evidence-based parenting knowledge and skills to the population of Longford/Westmeath.

4. Goal

To improve outcomes for children by strengthening collaborative relationships and referral pathways for children, their parents and significant others in Longford-Westmeath.

5. Purpose of Longford Westmeath Parenting Partnership

a. To implement a community-based intervention focused on reducing childhood emotional and behavioural problems amongst children in Longford-Westmeath.

b. To implement community-based interventions focused on supporting the specific needs of the parents and families of children with emotional and behavioural problems.

c. To strengthen collaborative relationships and pathways between associated service providers (primary healthcare professionals, school teachers, etc).

d. To promote and deliver professional training in relation to mental health promotion and the detection of, and early intervention in, childhood emotional and behavioural problems.

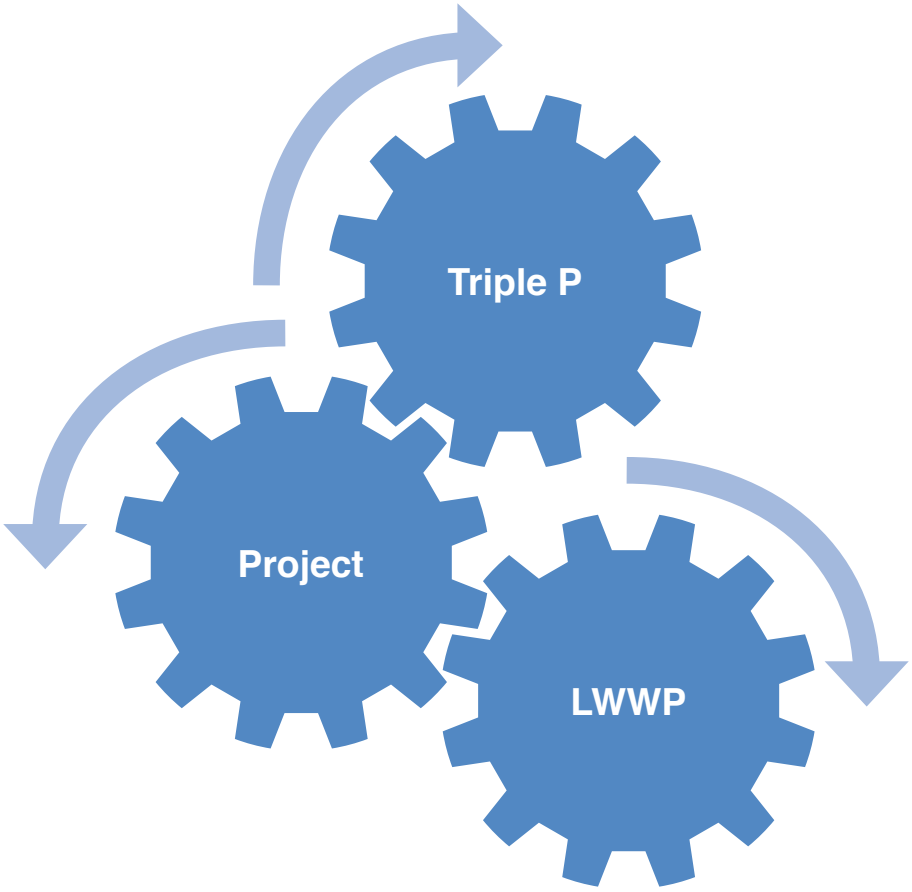
e. To promote and support the delivery of evidence-based parenting knowledge and skills to the population of Longford and Westmeath.

6. Differentiating the Partnership, Programme and Project

a. Partnership – The **Partnership** refers to the shared conviction of LWPP's constituent organisations that a partnership approach will facilitate greater access to the range of supports that parents need. LWPP have formed this partnership to enhance the interests of parents and children (of all ages) in the two counties with a particular focus on facilitating child well-being, social inclusion and parent education. As they embark on the delivery of the first programme the partners remain open to the prospect that LWPP may adopt and deliver other evidence-based programmes in the future.

b. Project – The **Project** refers to the initiative undertaken by the partnership to prioritise the roll-out and evaluation of the Triple P Programme, taking a universal population approach across counties Longford and Westmeath. The project involves a consistent and integrated multi-agency approach to addressing the needs of parents of children aged 3 to 7 years in Longford/Westmeath in relation to skills and information. The aim of the current initiative is to build on established partnerships to maximise the use of the Triple P programme. It is recognised that this may require the creation of new and extended partnerships in order to provide a comprehensive intervention approach.

c. Programme – The **Programme** refers to the internationally renowned and evidence-based Triple P Programme which LWPP has adopted as its first delivery initiative across counties Longford and Westmeath. The partners remain open to the prospect that LWPP will adopt and deliver other relevant programmes in the future. The Triple P – Positive Parenting Program™ is a multi-level, parenting and family support strategy. Triple P aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. The system was developed by Professor Matt Sanders and colleagues from the Parenting and Family Support Centre in the School of Psychology at The University of Queensland.



7. High Level Aims of the Partnership

a. To establish (i) the prevalence of parent reported emotional/behavioural problems for their children and (ii) parenting confidence levels

b. To implement community-based interventions focused on reducing childhood emotional and behavioural problems

c. To implement community-based interventions focused on supporting parents and families and preventing or decreasing levels of parental anxiety and depression

d. To co-ordinate a media and information campaign focused on promoting positive parenting and healthy family relationships in target areas, including enhanced awareness of childhood social and emotional problems

e. To develop an interagency approach to implement evidence-based programmes using a population approach, and to evaluate the effectiveness of this approach.

f. To influence national policy and achieve sustainability within Longford/Westmeath by demonstrating the effectiveness of its programmes, and of the partnership approach.

8. Principles

a. The needs of children, young people and parents are paramount;

b. All partners commit to working to achieve agreed joint targets and priorities and to being collectively accountable for their achievement;

c. While it is recognised that the constituent organisations of LWPP are diverse in terms of their scale and resources; missions and mandate; and their power and public accountability responsibilities – nevertheless LWPP operates on the principle that all partners are equal and their respective contributions to the Partnership have parity of esteem;

d. In particular, the power differential represented by the scale and the statutory responsibilities of the Health Service Executive (HSE) are recognised by the combined group of partners. For its part, the HSE undertakes to participate within LWPP as an equal partner and to manage its particular status with sensitivity and proportionality, subject only to its statutory and public accountability obligations;

e. LWPP adheres to the principle of subsidiarity i.e. decisions will be made at the lowest level consistent with efficiency and achievement of outcomes while the partnership does not assume authority or responsibility for roles, responsibilities, or activities that rest elsewhere.

f. LWPP cannot interfere with or override decisions of its constituent organisations nor, in particular, can it require them to act in any way that is contrary to their mission or statutory responsibility.

9. Scope and Parameters

Within the scope of LWPP:

a. To plan and coordinate the delivery of an evidence-based approach to parenting skills and information to parents of children in counties Longford and Westmeath;

b. To maintain fidelity in the implementation of proven programmes for children and parents;

c. To create consistent and effective structures and processes to optimise the participation of partners within LWPP and to facilitate the flow of information and coordination of activities;

d. To cooperate in demonstrating the added value of collaboration in the delivery of evidence-based parenting programmes

e. To consider and plan for the sustainability of LWPP beyond the current funding cycle.

Outside the scope of LWPP

It is not the responsibility of LWPP –

a. To ensure that personnel of the constituent organisations are fully informed and briefed on the development of the programme – this remains the responsibility of the respective representatives;

b. To investigate or sanction inappropriate or inadequate performance in the delivery of the programme by any constituent organisation – rather existing mechanisms (e.g. for the reporting of child protection concerns, or for meeting accountability standards to funders) will continue to be the appropriate channels for dealing with such matters[15];

c. To provide financial or other resources (other than support related to the programme) to constituent organisations.

10. Relationships to Other Significant Organisations or Partnerships

LWPP is committed to maintaining constructive relationships, and to working collaboratively, with other organisations that are aligned with its mission including:

- Children's Services Committee[16]
- OMCYA

15. Notwithstanding this, the Partnership will, as necessary, take appropriate steps to protect its reputation and the credibility of its programme(s).
16. LWPP considers that the Children's Services Committee (CSC) will have particular significance for the Partnership, particularly since they will both share common goals and significant duality of membership. However, as the CSC is itself in an early stage of development, the precise nature of this relationship has yet to be defined, although it is possible that LWPP may evolve into a sub-committee of the Children's Services Committee.

- Atlantic Philanthropies
- Archways
- Aontacht Phobail Teoranta (APT)
- Centre for Effective Services
- Triple P

11. LWPP Values

LWPP is committed to the highest professional standards as evidenced by

- Fidelity to proven programmes
- Integrity
- Active engagement and participation
- Mutual Respect
- Honest communication

12. Accountability

Accountability operates at four levels:

a. The accountability of partner representatives to LWPP as expressed by their attendance and active participation at LWPP meetings, by honouring their commitment to the goals and ideals of the Partnership and more generally to assist, promote and support it in the achievement of its mission;

b. For its part, LWPP is accountable to its constituent organisations for its performance, the appropriate and efficient use of resources and to provide a reasonable return for their investment, and it undertakes not to undermine or discredit them in any way;

c. LWPP owes particular accountability to its funders and commits to adhere to the conditions of its grants including timely and comprehensive reporting, that includes both successes and challenges, and to act with integrity at all times;

d. LWPP is accountable to the population of Longford Westmeath to deliver evidence based programmes and communicate findings.

13. Operations

a. Representation
Other than the organisation providing the Chair, each constituent organisation will be represented on the Partnership by one nominated representative of sufficient seniority to act with discretion and reasonable autonomy, and to exercise decision-making in contributing meaningfully to Partnership meetings on behalf of their organisation. Each representative will have a named alternate who is also of sufficient seniority and is adequately briefed to enable him or her to participate effectively when required. With regard to the HSE, in recognition of the relevance of several disciplines and departments, it is accepted that relevant personnel may attend meetings of the Partnership at the discretion of the combined partners, but only the nominated HSE representative may vote.

b. Membership
Currently the Partnership consists of nine member – or, partner – organisations. It is anticipated that the membership of the partnership may change over time with, perhaps, some partners withdrawing and new organisations joining. The current partners recognise the importance of remaining open to new members and to facilitating their rapid integration through an effective induction policy and process, which will be developed as part of the work plan.

c. Key Roles and Responsibilities

i. **Chair**

- To impartially lead the Partnership and represent it externally
- To chair meetings of the Partnership, ensuring that arrangements and documentation for meetings facilitate the participation of partners
- To periodically consult partner organisations on their experience of, and level of satisfaction with, the functioning of the Partnership

ii. **Treasurer** – The Treasurer has responsibility for overseeing the management of the Partnership's resources and expenditure in consultation with the Project Director and the Chair, and for providing regular financial reports to the members. S/he also signs off on financial reports.

iii. **Project Director** – The Project Director has responsibility for the following:

- Regularly inform LWPP about status and developments of Triple-P project.
- Report to the Archways Board on the overall performance of the Collaborative Initiative.
- Lead the development and manage the implementation of the project plan.
- Lead the design and completion of all research components of the project.
- Act as the chief communicator/figurehead for the Collaborative Initiative.
- Present and communicate research findings in formats suitable for diverse purposes and audiences.
- Represent the Collaborative Initiative at key events.
- Liaise and advocate with relevant organisations in Ireland to promote the use of evidence-based programmes and partnership approaches to service delivery.
- Provide direction, support and guidance to other members of the Core Team and Panel 1 through the provision of clinical supervision.
- Ensure that the fidelity requirements of the programme are adhered to.
- Provide regular update reports to the Expert Advisory Group.
- Manage the relationship between the Collaborative Initiative and Triple P/The Atlantic Philanthropies/Centre for Effective Services/OMCYA.

The Project Director is entitled to attend and to vote at LWPP meetings while it remains a Partnership. If the Partnership proceeds to become a limited company, the Project Director will not be a Director of the Company and therefore will no longer have a vote.

iv. **Members** – The members are jointly responsible for the proper functioning and management of the Partnership and for ensuring its compliance with both legal requirements and the conditions under which it accepts funding. All members are also required to respect the confidentiality of LWPP discussions and to declare any conflicts of interest or potential conflicts of interest.

d. Conduct of Business

- Meetings of the Partnership will normally be held at least four times each year.
- Agendas will be prepared and circulated in advance.
- All partners may request that an item be included on the agenda of a forthcoming meeting.

- Minutes will be taken of all formal meetings of the Partnership and circulated e.g. within 10 working days.
- The quorum for meetings of the Partnership will be 5 voting members present.

e. Decision-making

All formal business will be transacted through regular meetings of all partners (unless it is decided to establish sub-committees, e.g. Officer group, audit committee, etc).

- Each partner is of equal value to the Partnership.
- Each partner has equal voting rights.
- The ethos of the Partnership is to strive to reach all decisions by consensus.
- Where it is not possible to reach a consensus, decisions at Partnership level will be by way of a simple majority vote. Where a vote is tied, the Chair may determine the appropriate decision by exercising a casting vote.
- HOWEVER, exceptionally, where a partner organisation declares an issue to be of fundamental importance to that organisation, a decision will be required to carry the support of at least two-thirds of the member organisations present and voting.

f. Principles of Financial Management[17]

i. Longford/Westmeath Parenting Partnership shall maintain a complete audit trail in relation to all monies received.

ii. It is the responsibility of the Treasurer of LWPP to maintain all relevant books in relation to all transactions on all bank accounts held in the name of Longford/Westmeath Parenting Partnership.

iii. The following books and records shall be maintained as required: Cheque Journal, Cash Receipts Book, Petty Cash Book.

iv. It is the responsibility of the Treasurer to present budgets and to review the accounting records on a quarterly basis with the Chairperson/Treasurer.

v. All books and records are to be retained until determined by the LWPP. It is the responsibility of the Treasurer to ensure all books and records are archived and stored securely and available at all times.

g. Resolution of disputes[18]

The partners commit to addressing issues of conflict as early, and as close to the point of conflict, as possible.

The combined group of partner representatives will be the final arbiter in cases of conflict – and they are committed to taking care to ensure that they consider only issues that fall within the scope and parameters of the Partnership.

The partners have agreed the following procedure for resolving conflict:

i. In the first instance, a full discussion will be conducted on the area of conflict, allowing all partners to set out their views;

ii. In recording the discussion, the relative positions taken will be clearly recorded. If a consensus view is reached, this will also be clearly recorded;

17. These principles are taken from LWPP's Financial Procedures (November 2009).
18. This section is adapted from the governance arrangements formulated by the Children's Trust for County Durham, January 2009.

iii. If consensus is not reached after a reasonable period of debate, a formal objection to the matter for decision should be made to the Chair of the relevant group;

iv. The matter will then be deferred to a second meeting, which must be at least seven days later. A special meeting can be convened in the event of an extended period between scheduled meetings or if further delay is problematic. During this intervening period, attempts will be made (facilitated by the Chair) to reach a compromise acceptable to all parties.

v. Should compromise not be possible, the matter will be discussed again at the second meeting. If conflict still prevails then, having had a further full and open debate by all partners, the matter will be put to a vote.

vi. The Chair has a casting vote in the event of a tie.

The dispute resolution process seeks to provide a method for reaching and recording a consensus decision, it does not detract from the principles that:

- Decisions of LWPP cannot override those of a partner organisation, in particular it cannot require any partner to act in a way contrary to their mission or statutory responsibility.
- The needs of children, young people and their families, including the need for safeguarding, are paramount.

h. External relations

LWPP will seek to build positive relations with other relevant organisations working to progress common goals including, for example, parent associations, boards of management, parenting groups, probation service, etc.

i. Public relations

LWPP will seek to build positive relationships with relevant media and to adopt an open and proactive approach to communications with its key audiences including the general public.

14. Work plan

LWPP's current agreed work plan is to progress the Triple-P.

15. Review process

The functioning of the Partnership, including the continuing relevance and functioning of the Memorandum of Understanding will be formally reviewed by the partners on an agreed basis. In the coming year (2011) it will be reviewed at six-monthly intervals; if found to be functioning satisfactorily, thereafter it will be reviewed every 12 months.

Appendix D – IMPLEMENTATION STUDY

Appendix D.1: Calculation of figures for programme delivery

Level 2

The Seminar total participant figure included all those who attended seminars. The figure was not limited to those who agreed to take part in the evaluation and completed the Client Satisfaction Questionnaire. As no unique identity numbers were assigned to participants at Level 2 and as parents were free to attend multiple seminars, it was not possible to calculate the number of unique participants and therefore double-counting may have occurred. Therefore the Seminar total participant figure represents the number of places filled on the programme and not the number of unique participants.

Levels 3 and 4

In contrast to the participant figures presented for Level 2, the figures presented for Level 3 and Level 4 represent the number of unique participants. The figures for Level 3 and Level 4 were calculated by removing all 'duplicate' data entries, i.e. individuals with more than one data entry. The rationale for doing so is that this tells us how many parents were participants, as opposed to how many programme places were taken up, with some parents participating more than once. Data from all participating parents have been included, whereas in evaluating the impact of the programme only data from parents with children in the target age range have been included. Data were included only from parents who participated in the programme, excluding all those who booked a place on the programme but never attended. Finally, Level 3 participation figures were calculated on a Workshop-by-Workshop basis since this was the way in which the impact of the programme was evaluated. While all duplicates at the level of each of the four workshops have been removed, the total Level 3 figure contains some duplicates, including as it does some parents attending more than one workshop.

Level 4: The Level 4 participation figure of 803 was calculated by removing 4 'duplicates' and 238 parents who did not attend the programme (from an original figure of 1,045).

Level 3: The Level 3 figure of 1,100 was calculated by removing 18 'duplicates' and 429 parents who never attended the programme. A further 28 were in the database, but without a Workshop title were retained, although not included in data presented on numbers attending each workshop. A further 53 parents who participated in the Primary Care version of Level 3 were included. (In the data file sent from LWPP, the total figure for delivery of Level 3 was 1,575.)

Appendix D.2: Profile of practitioners (Triple P International)

Table D.2a (taken from Triple P International) describes the practitioners who attend training at these levels.

Table D.2a: Practitioners who attend training and accreditation courses (from Triple P International)

Level	Triple P Course	Practitioners who attend this course include
1	Universal Triple P	Universal Triple P is not a training course. Rather, Universal Triple P is a communications campaign designed to raise community awareness of the importance to positive parenting. It comprises a Triple P communications strategy for major regional disseminations and a suite of communications and media materials to engage the general public.
2	Selected Seminars/ Selected Individual Support	Support workers who are engaged in an organisation offering the Triple P system within a primary healthcare setting. Practitioners employed, or acting on a volunteer basis offering ancillary support to parents who are engaged in Triple P programs with an Accredited Triple P Provider.
3	Primary Care	Those who may be involved in long-term support for the client and are only able to provide brief therapeutic interventions, including school counsellors, nurses, home visitors, family physicians, paediatricians, allied health practitioners.
4	Group	Those who are able to provide long-term regular group interventions, including school counsellors, nurses, psychologists, social workers.
4	Stepping Stones	Those who are able to provide long-term regular group interventions, including school counsellors, nurses, psychologists, social workers.
5	Enhanced	Those who are able to provide long-term regular interventions, including school counsellors, nurses, psychologists, social workers, allied health practitioners.

Table D.2b (taken from Triple P International) outlines the training and accreditation involved for each level of Triple P as well as the resources provided to each practitioner by Triple P.

Table D.2b: Content of training and accreditation courses (from Triple P International)

Selected Triple P (Seminars)	**Training** Part 1: 1 training day (maximum of 20 practitioners). Part 2: 1 accreditation workshop per practitioner. Total of 1 accreditation day. (A maximum of 10 practitioners per half day attend 2-3 months post-training).Training materials include: set readings, participant notes, questionnaires/evaluation forms for each practitioner. Access to the Triple P Provider Network for up to 20 providers.
	Resources Facilitator's Kit for Selected Triple P (includes a Facilitator's Manual and CD ROM with Seminar Series PowerPoint presentations). Triple P Tip Sheet Series – Seminar Series (includes a tip sheet from each Seminar Series).
Primary Care Triple P	**Training** Part 1: 2 training days (maximum of 20 practitioners). Part 2: 2 accreditation days undertaken 2-3 months post-training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day). Training materials include: set readings, participant notes, questionnaires/evaluation forms for each practitioner. Access to the Triple P Provider Network for up to 20 providers.
	Resources Practitioner's Kit for Primary Care Triple P (includes Practitioner's Manual, Consultation Flip Chart, and Positive Parenting wall chart). Triple P Tip Sheet Series – Sample Pack (includes the Positive Parenting Booklet and a sample of the Triple P Tip Sheet Series). Every Parent's Survival Guide [DVD].
Group Triple P	**Training** Part 1: 3 training days (maximum of 20 practitioners). Part 2: 2 accreditation days undertaken 2-3 months post-training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day). Training materials include: set readings, participant notes, questionnaires/evaluation forms for each practitioner. Access to the Triple P Provider Network for up to 20 providers.
	Resources Facilitator's Kit for Group Triple P (includes Facilitator's Manual, CD ROM with Group). Triple P PowerPoint presentations and the Every Family Group Workbook. Every Parent's Survival Guide [DVD].
Enhanced Triple P	**Training** Part 1: 2 training days (maximum of 20 practitioners). Part 2: 1 accreditation day (to be Part 2: 2 accreditation days undertaken 2-3 months post-training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day). Training materials include: set readings, participant notes, questionnaires/evaluation forms for each practitioner. Access to the Triple P Provider Network for up to 20 providers.
	Resources Practitioner's Kit for Pathways Triple P (includes Practitioner's Manual, CD ROM with Group Pathways PowerPoint presentations, Parent Workbooks). Coping with Stress [DVD].

Triple P practitioners were to be trained by Triple P International and all practitioners were to complete the Triple P accreditation process. Triple P International also completed a follow-up evaluation of the training and accreditation process to obtain feedback on practitioners' satisfaction in 2009.

Appendix D.3: Proposed Triple P Training Courses

Triple P Programme	Course overview
Level 2 Selected Seminars	Level 2 Selected Seminars Triple P Provider Training course will train practitioners to deliver 3 x 2 hour seminars to large groups of parents with a 2-12 year focus. The seminars include: The Power of Positive Parenting; Raising Confident, Competent Children; and Raising Resilient Children.
Level 3 Primary Care	Level 3 Primary Care Triple P Provider Training course will train practitioners to work with families using a brief consultation format (usually 30 minute consultations over a 3-4 week period). This programme offers support and advice to parents of children 2 to 12 years old experiencing recent onset of behavioural or emotional difficulties.
Level 4 Group	Level 4 Group Triple P Provider Training course will train practitioners to work intensively with small groups of parents of children 2 to 12 years old over an 8 week period.
Level 5 Enhanced/Pathways	Level 5 Enhanced and Pathways Triple P will train practitioners to address the needs of families presenting with additional problems such as family conflict, poor coping skills, neglect and maltreatment of children, anger management problems and other broader family issues.

Appendix D.4: Interview Schedules – Implementation Study

Schedule for Focus Groups with Parents (1st/2nd May 2012)

1. How did you hear about the programme?
   Awareness of media campaign: Tippaper, use of website
2. What motivated you to join the programme?
3. What was your experience of the programme?
   What Workshop(s) did you attend?

   Keep as open as possible, e.g. how did you feel about the following – explore clarity, usefulness etc as they come up or as prompts

   - Presentation?
   - Content?
   - Facilitation?
4. Has participation in the programme led you to change your parenting?
   Prompts
   - Specific strategies
   - General style
   - Level of confidence as a parent
5. What has worked – and why?
6. What has not worked – and why?
   What are the necessary qualities in a facilitator?
7. Have you seen any changes in your child(ren)?
8. Have you seen any changes in your family?
9. Would you recommend the programme to other parents?
10. Suggestions for changes in/additions to programme?
    Were your expectations met?

Schedule for Triple P Practitioner Focus Groups (November 2011)

1. Your own motivation: reasons for coming to and using Triple P
2. Perspectives on training
3. Adequacy of materials and equipment
4. Supports received and supports given
   a. Administrative and clinical
   b. Own organisation and LWPP
5. What worked well and what challenges arose in delivery?
   a. The sessions themselves
   b. Adaptability to each family
6. Explore any effect of Triple P on existing work/within own organisation
   a. Including proportion of time on Triple P
7. Explore perceptions of impact on families
8. Perspectives on the Triple P model: theoretical underpinning; evidence-based intervention
9. Public awareness of Triple P (and promotion of Triple P)
10. Suggestions for improvement