

3 Cheers Parenting Initiatives Study

Final Report

**Respectfully Submitted to the:
3 Cheers Parenting Initiatives Committee**

2008

by

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3 Cheers Parenting Initiatives Study

Introduction

Increasing evidence indicates that the social, emotional, intellectual and physical development of children is significantly impacted by the quality of their early experiences in life. Interventions that promote positive, caring and consistent parenting practices have repeatedly been shown to reduce the incidence of child behavioural disorders and the incidence of child maltreatment (Azar, 1997; Sanders & Cann, 2002). Supportive parent-child relationships, positive discipline methods, close monitoring and supervision, parental advocacy for their children and parental pursuit of needed information and support have been consistently shown to be buffers against the development of problem behaviours (Huizinga, Loeber & Thornberry, 1995; Bry, 1996; Alvarado & Kumpfer, 2000).

Numerous parenting education courses have been developed with the intention of improving fundamental parenting practices and reducing the potential for problem behaviours in children. Many of these courses are targeted interventions that are aimed at helping specific groups of parents - often those who have children who are at risk for developing severe behavioural problems. Others are designed to reach a broader audience of families who may be at risk for dysfunction. Parenting education cannot be simply defined; it encompasses a wide range of philosophies, programs, purposes and materials (Medway, 1989). Generally speaking, parenting education refers to the processes of imparting the parental attitudes, knowledge, and skills necessary to promote the optimal physical, cognitive and psychosocial development of children at different developmental stages (Mahoney, Kaiser & Girolametto, 1999; Winton, Sloop & Rodriguez, 1999). It also involves supporting parents in developing coping skills, communication skills, problem-solving skills, and supporting parents in their own personal development (Tsang & Leung, 2005).

Parents may benefit from parenting education and parent support groups through the development of new skills that can lead to increased confidence, insight, and self-esteem (Adams, 2001). Other benefits of parenting education include decreases in the use of negative physical/coercive discipline techniques, emotionally abusive behaviours and parental criticism (Thomas et al., 1999). Some research indicates that parents who complete parenting education exhibit an increase in parenting resourcefulness, warm/positive parent-child interactions, sense of parenting competency and satisfaction and use of community resources (Chislett & Kennett, 2006). It is critical that organizations who are accountable and responsible for supporting the health and wellbeing of communities and the public at large make concerted efforts to deliver parenting education programs that will minimize risks for, and maximize the potential benefits to families within their population.

The 3 Cheers Parenting Initiatives Committee is a multi-agency committee that was developed to support and advise the parenting strategies of 3 Cheers for the Early Years. The goal of this focus area of 3 Cheers is to enhance parental capacity for positive parenting practices. The underlying vision of 3 Cheers is that "All children in the Calgary Health Region will achieve

optimal health through the foundation years of conception to school age." The Committee is currently committed to pursuing the achievement of this vision through parenting strategies based on the Health Promotion Model, which adopts a population health perspective. Population health is a broad approach to health that aims to improve the health of the entire population, and to reduce health inequities among population groups (Public Health Agency of Canada, 2002). It recognizes, measures and analyzes the full range of social, economic and physical environmental factors, early childhood development, personal health practices, individual capacity and coping skills, human biology and health services that contribute to health (Health Canada, 2001). A population health perspective to interventions recognizes the role of the broader ecological context for human development. Multiple activities across the wide range of interventions that make up the health continuum are integrated in a population health approach; from health care to prevention, protection, health promotion and action on the broader determinants of health (Health Canada, 2001). A population health approach recognizes the importance of preventive approaches, thereby supporting the delivery of programs and services that are universally available to all individuals who seek assistance.

Goals and Background

The initial goals of this study were:

- (a) To complete a review of the literature that would identify evidence-based programs and/or strategies that, if implemented, would increase the initiative's ability to address and support improved capacity for positive parenting practices; and
- (b) To complete an environmental scan that would identify present and future factors that might influence the direction and goals of the 3 Cheers Parenting Initiative Committee's actions towards improving the capacity for positive parenting practices.

During the completion of the literature review, the researcher found that many factors interfered with the identification of "effective" programs - particularly in the case of universal programs available to all members of the population. After discussing this finding with the Committee, it was decided the focus of the study should shift to completing the environmental scan. The literature review has been revised to focus more on the available support for varying parenting approaches. It is included as an appendix in this document for some of the background information that it may provide to readers. The environmental scan was designed to draw on internal conditions and external contextual information to identify positive parenting-related practices within the Calgary region, and determine perceived limitations and/or gaps in the existing strategies and programs. Specifically, the Environmental Scan sought to answer the following questions:

- (1) What programs and strategies have been identified as best practices in parenting within other health regions in Canada?
- (2) How are effective parenting education programs in other large health regions in Canada led, structured and coordinated within the communities they serve?

Environmental Scan Findings

In this investigation, thirty two key informants from across Canada (14 from Calgary) were interviewed to determine what programs and strategies have been identified as best practices in parenting within large metropolitan centres within Canada. The information gathered revealed the following main findings:

- (a) Typically, decisions made about the types of parenting programs offered are made with knowledge of recent demographic information, but limited knowledge or consideration for the *actual* needs and desires of the population being served.
- (b) Many parenting programs appear to be offered within large cities/regions with limited service provider awareness, knowledge and understanding of the specific nature and theoretical underpinnings of those programs.
- (c) To date, few parenting programs have been formally and *rigorously* evaluated in Canada. Some large-scale evaluations are being planned and undertaken (e.g. the behaviorally based Triple P parenting program through the Parent Link Centres, and a National Evaluation of Nobody's Perfect through the Public Health Agency of Canada).
- (d) Key informants from within the Calgary region indicated that there are high quality programs available to parents; however:
 - (i) Most of the targeted programs are not universally available to any parent or caregiver wishing to access a program,
 - (ii) Some of the programs have been inconsistently provided due to funding issues - program sustainability is an issue;
 - (iii) Some parents do not wish to access parenting programs because of negative societal perceptions associated with attending such programs, primarily because most of them are targeted to specific populations;
 - (iv) The delivery format of some of the programs currently offered is not flexible enough to accommodate the varying needs of parents;
 - (v) Barriers to accessibility of parenting programs prevent many parents from benefiting from programs,
 - (vi) A more collaborative, multi-disciplinary and team approach to providing parenting programs could be practiced among service providers within the Calgary region;
 - (vii) There are differing views among key informants about the extent of need and desires of parents with respect to parenting education and support.
- (e) There is a lack of information about the actual needs and desires of parents in Canada with respect to parenting.
- (f) There is a lack of information about the actual needs and desires of parents in the Calgary region with respect to parenting.

Synthesis of Findings

The review of the literature on parenting programs (see Appendix A) was re-focused when its findings led to a major shift in the focus of the study. These valuable findings of the literature review process were as follows:

- (a) Comprehensive, inclusive literature reviews of effective, evidence-based parent training programs have not been undertaken by researchers due to the overwhelming number of parenting programs that exist;
- (b) The review of the literature on parenting programs revealed that no one parenting program can be identified as optimal, effective and cost-effective for the multitude of target populations, contexts, and outcomes that must be considered in a population health model.
- (c) Evidence-based research may serve to increase the level of confidence that decision-makers have in recommending, funding and supporting particular programs for implementation. However, even positive and robust findings across many studies cannot guarantee the success that a particular program will have on individuals, groups, and the population at large.

Many researchers who have recently examined the effectiveness of parenting education programs have arrived at conclusions similar to those of researchers writing about the evaluation of parenting programs nearly 30 years ago. The issues that were problematic then remain today, even with the multitude of studies investigating the effectiveness of parenting education that have since been completed. These issues include:

- (i) The lack of sufficient funding to conduct rigorous research by many smaller, non-commercial parenting programs.
- (ii) The bias that exists in the printed literature whereby parenting programs that are behavioural in nature lend themselves to rigorously conducted quantitative research, therefore influencing the amount of "evidence" that is available to decision-makers and parents.
- (iii) The bias towards the acceptance of and preference for quantitative findings from randomized control studies by decision-makers, and the relative unimportance of findings attained through qualitative methods. Behavioural parenting education programs lend themselves to being studied through randomized control studies as they have as their outcomes observable behaviour change, whereas reflective/relational parenting education programs often measure changes in parental attitudes and behaviours based upon self-report and focus on long term development of more abstract child outcomes such as secure attachment, internal motivation, emotional regulation and social competency.

Some qualitative studies have explored parents' views about the aspects of parenting programs that parents find important (e.g. Webster-Stratton & Spitzer, 1996; Grimshaw & McGuire, 1998; Barlow & Stewart-Brown, 2001). These studies, as

identified by Kane, Wood and Barlow (2007):

... have started to provide the information needed by providers to ensure that parenting programmes meet parents' needs and have the potential to improve engagement and the promotion of parent and child well-being" (p. 784).

In addition, the inclusion of qualitative findings increases the likelihood that user concerns are addressed, and that the assessments are comprehensive and include all outcomes (Dixon-Woods et al, 2005), including those that may be unintended and/or undesirable.

- (iv) Results of long-term follow up studies on each model and comparison studies between models and between programs of the same type remain sparse.

Comparison studies of the same program or same program types are difficult since individual parenting education leaders, parent participants, and different contexts can influence the content and delivery of the program. Meta-ethnography is an approach to synthesizing qualitative research studies that was introduced by Noblit and Hare (1988). While it is not used widely in the study of parenting programs, there has been some acceptance that such a method could reveal insights beyond those capable of a traditional narrative literature review (Kane, Wood & Barlow, 2007).

- (v) The effects of the parenting education leader as a variable remains uncontrolled for in many of the research studies.

This is despite known findings that leader training, qualifications and characteristics are important in terms of the delivery of programs and subsequently in influencing evaluation results.

- (d) Parenting is a socially constructed role and process that is influenced by a broad range of personal and contextual factors that interact in complex ways; thus, researching the process and influences on the process is difficult. The impact of one particular factor on parent or child behaviour is influenced by the presence, pattern and interaction of other elements in the environment and in individuals' personal histories of experiences (Bradley, 2002). However, little research has examined how these factors may work in combination and/or cumulatively with one another.

It is difficult to estimate the impact of a particular factor or factors on parenting and child development. Individual parent and child characteristics such as personality, resilience, socioeconomic status, secure attachment relationships with caregivers, emotional restraint, dependency on caregivers, indirect versus direct expression of feelings, temperament, goals and values, and psychological characteristics can alter the ways and extent to which children are impacted in the short term and over the long term by parenting related factors.

There is considerable consensus among theorists and researchers as to the components of effective or competent parenting. These include the development of a mutually reciprocal, nurturing, encouraging, safe, loving and stable parent-infant/child relationship characterized

by warmth and acceptance; along with sensitivity to children's basic needs and capabilities, social cues, and to what is appropriately expected for each child's developmental level; and consistent discipline with the willingness and ability to direct their children's behaviour and activities with increased demands for age-appropriate behaviour without squelching their developing independence (Grych, 2002; Smith, Perou & Lesesne, 2002; Teti & Candelaria, 2002). An analysis of National Longitudinal Survey of Children and Youth (NLSCY) data on children aged 2 to 11 years found that positive parenting practices had a variety of positive influences on children's outcomes, including levels of behaviour problems and prosocial behaviour (Chao & Willms, 2002). Harsh, negative, coercive parenting is generally regarded as having detrimental effects on children, although the degree of the negative impact varies with the age and temperament of the child (Miller, Jenkins & Keating, 2002; Teti & Candelaria, 2002).

While research indicates that social context plays a great role in the effects of individual and accumulated risk and opportunity factors on child development outcomes, additional research is needed to examine the effects of parenting styles within a given socioeconomic and cultural context (Teti & Candelaria, 2002). It has been suggested that the buffering effects of factors such as a favorable social environment, middle to high socioeconomic status of parents, and quality support services (e.g. counselling) may be much greater among children who have experienced negative parenting than among those with adequate parenting (see Lerner, Rothbaum, Boulos & Castellino, 2002).

- (e) Ineffective, negative, or incompetent parenting (often associated with the *authoritarian* and *permissive* parenting styles) exists within all demographic groups and contexts. In attempt to address this, *universal* parenting education programs are designed to inform and prepare all parents for the duties and responsibilities of parenthood, and are intended to be accessible to all parents. The approach is based on the assumption that all parents can benefit from parenting education and training.

From a public health perspective universal parenting programs may be thought of as primary prevention activities, where the intent is to provide services to the broadest group of individuals in order to prevent developmental delays, prevent a health-threatening condition from occurring, or to promote an optimal condition (Smith, Perou & Lesesne, 2002). Some examples of leading universal parenting programs that have reportedly experienced long term success over the past thirty years include: the Missouri Parents as Teachers (PAT) program, developed in 1981; the Minnesota Early Learning Design (MELD), founded in 1973 by Ellwood; and the Early Childhood Family Education Program (ECFE) program developed by the Minnesota Department of Education (Smith, Perou & Lesesne, 2002).

While the concept of a universally offered parenting program is ideal, there are numerous difficulties encountered in creating programs capable of capturing the broad vision, goals, activities, parental needs, and desired outcomes. With the rapid changes in society, it is also essential to regularly and sufficiently monitor and evaluate the achievement of program outcomes. Universal programs require considerable inputs of financial resources, and goals and outcomes must still be tailored to the specific and changing needs of the population of

interest and the communities within. A primary difficulty associated with universally accessible programs is the affordability and sustainability of such initiatives over the long term, particularly when questions persist about the effectiveness of universal approaches. While universal approaches are more likely to be sustainable with the commitment of government support and funding at the local, provincial/state and national levels, long-term investments must be established in order to recover start-up and maintenance costs. This is an especially difficult endeavor with the frequency of change in leadership at each level of government.

When considering the development of a universally offered parenting program, a valid concern is the legitimacy of prescribing how parents should raise their children. It is essential that this question be considered in the delivery of services to the Calgary region, whose population is represented by a great diversity of cultures. One problem identified with such a prescription is that it involves a judgment that some ways of parenting are better than others, and that the practices promoted as being better invariably reflect the values of the dominant culture (see Hoff, Laursen & Tardif, 2002; Pine, 1999). A related concern is that some outcomes are not universally regarded as being negative by parents of different cultures. For example, the death of a female infant may not be regarded as a highly negative outcome by some parents who originate from countries that place a much greater value on male infants. Other examples of positive values and outcomes defined by Western majority culture include success in school, avoiding public assistance, and avoiding teen pregnancy (Hoff, Laursen & Tardif, 2002).

While it is important to gather information related to the values parents hold about parenting and child rearing, there is a risk of using such information in a way that may contribute to the formation of stereotypes about certain parent groups. To guard against the judgment of parents and their child-rearing practices, (a) goals and outcomes of parenting programs should be associated with universally valued parenting outcomes such as mental health, reproductive success and successful socialization, and (b) specific information about the values, beliefs, and attitudes of parents within a population should be obtained in order to ensure that programs that are sensitive, responsive, and respectful of parents while keeping the best interests of children in mind.

A disadvantage of trying to offer targeted intervention programs universally is that it reinforces assumptions that parents who attend parenting programs must be doing something wrong that needs to be fixed. This is especially true of behavioural parenting education programs which start from the assumption that the parenting system to which the child is exposed is somehow dysfunctional, and that focuses on training parents to apply procedures and techniques to control atypical child behaviour (Medway, 1989).

- (f) Resistance and other barriers to change exist in families and the organizations responsible for the delivery of parenting programs in everyday practice. Parents differ in their levels of sensitivity and responsiveness to cues given by children, and the personality and characteristics and past experiences of each child affect the manner and degree with which children respond to parental cues. While knowledge of how children develop and effective parenting strategies are important, it must be recognized that change in knowledge about

parenting does not guarantee change in parenting behaviour and parent-child relationships (Mueller, 1996). Knowledge and understanding, however, are important first steps.

The amount of parenting education and support required by individuals, groups, and communities may vary widely. In order to provide effective parenting intervention for a population, the social and personal circumstances of parents must be known and considered in program development.

- (g) For clinicians working within the population health model, an ideal approach is to offer a variety of programs so that clinicians may select and offer the best possible interventions to families (Hensler, Wilson & Sadler, 2004). Parenting programs that have been demonstrated to be successful are generally those that are targeted interventions that have been carried out with clinical populations. Such programs have been developed with specific at-risk populations in mind (e.g. with parents whose children are manifesting serious emotional and behavioural problems) and are associated with the achievement of specific outcomes (Peters, 2007). Some of the strategies, techniques, and skills taught in such programs may be inappropriate for use with children who do not display serious problems.
- (h) Programs must be accountable to their various audiences and stakeholders, including the population(s) they serve, the agency responsible for the administration, and various funding streams (Lerner, Rothbaum, Boulos & Castellino, 2002). In program planning, it is important to determine the beliefs, needs, expectations and desires of families and communities, and to adopt a programming strategy or model focused on meeting those elements.

Needs assessment surveys are also useful in establishing community buy-in to the program, so that communities feel empowered in the development of services that will best meet their needs. Lerner, Rothbaum, Boulos and Castellino (2002) suggest that the involvement and buy-in of the community meant to be served by the program(s) is equally crucial to the creation and implementation of a program.

To ensure the targeted population's interest and continued engagement, a successful program must be founded in full collaboration and partnership with the communities and families who will be using the services. The voices of parents . . . must be included in such a partnership" (p. 338).

Yet, the present investigation has found that very little is known about Canadian parents' knowledge of relevant and key areas of parenting and child development; their attitudes, values and beliefs about parenting and child development; and the impact of personal circumstances and the context in which children are being raised in Canada.

Invest in Kids is a national, charitable organization dedicated to ensuring the healthy social, emotional and intellectual development of children from birth to age five by strengthening the parenting knowledge, skills and confidence of all those who touch the lives of young children in Canada (see www.investinkids.ca). With support from Unilever Canada

Foundation, Invest in Kids has undertaken research to identify what is known about how communities can support parents of young children; how parents feel about the tangible support (e.g., materials, services, programs, information), and intangible support (e.g., social and peer relations, community and cultural attitudes and values) they experience and desire; and how the support parents actually experience relates to their parenting skills. Invest in Kids is working on developing a parenting program which they hope can be delivered universally and on a national basis in the near future.

A survey (The National Parent Poll) carried out in Canada by Invest in Kids in 1999 of more than 1,600 parents of children less than six years of age indicated that,

... many parents surveyed reported using hostile/ineffective parenting practices, and fewer than half were knowledgeable about the importance of providing stimulating, sensitive environments to their young children. Although parents generally believed that their parenting practices had an important influence on their child's social and emotional development, they reported having little knowledge of or confidence in how to influence this development in a positive way. (Peters, 2007, p. 1).

A notable finding in the Alberta subgroup of survey participants (n=160) was that more parents in Alberta used physical punishment with their children at least occasionally (National = 51%; Alberta = 61%). Compared with the rest of Canada, fewer parents in Alberta expressed high confidence in their knowledge of how children grow socially, emotionally, intellectually and physically (National levels of high confidence in social development = 13%; Alberta = 3%). More parents in Alberta reported pressure from ethnic and religious groups to change how they parent (National = 4% Alberta = 10%), and fewer Alberta parents turned to their child's physician for advice about parenting (National = 61%; Alberta = 54%). The National Parent Poll has recently been followed up by the Community Vitality National Survey (final results to be released in early 2008) which examines parents' knowledge, expectations and feelings about parenting. The survey asks parents to identify some of their parenting behaviours and to identify particular barriers that may prevent parents from involving their children in programs and activities that may enhance child development. The Invest in Kids survey was not designed to enable the connection of information it gathers with data about the development of those parents' children, nor did it collect information specific to the population of parents living in the Calgary region.

Within Canada, no universally offered parenting programs have been sufficiently evaluated to be identified as effective parenting programs. The Triple P-Positive Parenting Program is an example of one parenting program that has a strong evidence base and is being piloted/implemented in an increasing number of Canadian communities. While some regions are choosing to promote it as a universal program, it is important to note that the evidence base supporting Triple P's effectiveness is based on its implementation as a targeted program. It is a multi-level system of parenting and family support that was designed for families of children with severe behavioural, emotional and developmental problems to enhance the knowledge, skills and confidence of parents. Consultation with organizations across Canada indicate that insufficient information regarding the effectiveness of the Triple P program in

Canada has been collected to date, although it is expected that such information should be available within the next year or two. In 2005, Healthy Child Manitoba announced provincial support of \$1.4 million to implement the Triple P program. The plan is to offer the program at five different levels of support through interested organizations and agencies across Manitoba. More information is available through the Health Child Manitoba link at <http://www.gov.mb.ca/healthychild/triplep/>.

- (i) The professionalization of parenting education has been gaining increasing attention as questions are raised (DeBord & Matta, 2002) such as:
- (a) "What qualifies one to be a parent educator?"
 - (b) "What sort of background do parent educators have?"
 - (c) "Is there a pertinent degree in parenting education that I can seek when hiring?"

As the practice of parenting education is conducted by people from a wide variety of backgrounds, disciplines and education, a framework for a common knowledge base for parenting education was introduced by DeBord et al. (2001) after a very comprehensive consultation process. The National Extension Parenting Educators' Framework (2002) was subsequently developed to attempt to gain consensus on not only "what" to teach, but "how" to do it. The NEPEF document builds on an earlier model that focused on the content of parenting education programs (six categories of priority parenting practices) to include critical skills and practices (also six categories) of parenting educators (DeBord et al, 2002).

The content areas of *priority parenting practices* were identified as:

- Guide – modeling, teaching and encouraging appropriate behaviour through limit setting, monitoring, and valuing basic human decency.
- Motivate – teaching children about themselves and the world around them, promoting learning
- Nurture – expressing affection and compassion, fostering self-respect and hope, modeling and teaching emotional regulation
- Understand – understanding typical child development and how children influence and respond to what happens around them
- Advocate – finding and using community resources, creating supportive environments and healthy communities for all children
- Care for Self – engaging in parental self-care, family self-care and positive help-seeking behaviours

The process areas of *critical parenting educator skills* include:

- Grow – attending to one's personal professional growth.

- Frame - understanding theoretical frameworks that guide the field.
- Embrace - understanding diversity of family, race and ethnicity.
- Develop – using the development process for educational programs.
- Educate - various teaching and outreach methods.
- Build - networking and partnering with others in the field of parenting education.

Recommendations [Abbreviated]

Recommendation 1

A priority of the 3 Cheers Parenting Initiatives Committee should be to clearly define the nature and types of parenting practices that meet their criteria of "positive" or "healthy" parenting.

Recommendation 2

The 3 Cheers Parenting Initiatives Committee should revisit and clarify a set of evidence-based, *key assumptions* regarding parenting education, parents and their relationships with children. These assumptions should be used to guide the Committee in fulfilling its mission, goals, and purpose.

Recommendation 3

The 3 Cheers Parenting Initiatives Committee should revisit and clarify a set of *underlying and guiding principles* that delineate the priority areas established by the Committee. These principles will form the foundation of a model (to be developed) on parenting education and positive parenting practices that should be aligned with the overall 3 Cheers Framework.

Recommendation 4

A comprehensive, population level, community-based parental needs assessment should be undertaken by the 3 Cheers Parenting Initiatives Committee to determine the specific parenting-related needs of parents residing within the Calgary region who have children aged 0 to 6 years.

Recommendation 5

The use of the Early Development Instrument (EDI) in the Calgary region should be supported by the 3 Cheers Parenting Initiatives Committee, and the results of the EDI may be used to enrich the findings and decisions made as a result of the population level needs assessment on parenting (see Recommendation 4).

Recommendation 6

The 3 Cheers Parenting Initiatives Committee should develop and/or adopt a Model of Parenting Education and Support for the Calgary Health Region. The model will serve as a framework which encompasses (a) the content that is the basis for parenting education, and (b) the processes used by parenting educators and/or those professionals within the CHR who are providing

parenting support. It is important that the resulting model be aligned with the overall 3 Cheers Framework.

Recommendation 7

The 3 Cheers Parenting Initiatives Committee should further investigate the actual curriculum and specific strategies taught within existing parenting programs within the CHR as well as parenting programs that the CHR is interested in implementing.

This will help to ensure that CHR programs or resources consistently provide parents with techniques that are consistent with the goals and philosophy of the 3 Cheers Parenting Initiatives group. Such an investigation must involve actual participation of a sample of parents and parenting educators in completing the actual parenting programs of interest.

Recommendation 8

The 3 Cheers Parenting Initiatives Committee should strengthen partnerships and collaborations with other local, provincial, national and international organizations that are focused on:

- (a) The advancement of parenting related knowledge and research.
- (b) The advancement and promotion of consistent parenting information and development of supportive programs designed to promote healthy child development.
- (c) Advocating for, initiating, and participating in research studies that will contribute to building the evidence base regarding effective parenting programs.

Recommendation 9

The 3 Cheers Parenting Initiatives Committee should investigate the potential impacts and implications of supporting the growing movement towards the professionalization of parenting education and the accreditation of parenting educators.

Recommendations [Complete]

Recommendation 1

A priority of the 3 Cheers Parenting Initiatives Committee should be to clearly define the nature and types of parenting practices that meet their criteria of "positive" or "healthy" parenting.

This recommendation is of particular importance since the primary goal of the 3 Cheers Parenting Initiatives Committee is to enhance parental capacity for positive parenting practices. This task should be completed prior to the Committee making any decisions related to the formation or approval of new parenting programs and prior to the creation of data collection instruments such as those required in a needs assessment of parents (see Recommendation 4).

Rationale

Without a clear definition of how 3 Cheers defines positive or healthy parenting, planning to create initiatives designed to support positive parenting practices cannot be undertaken. Absence of a clear definition leaves the term open to interpretation. Related to the scope of parenting education and support, it is important to clearly establish the nature and extent of the role that the Parenting Initiatives Committee has in creating a filtering or gate-keeping function about the knowledge and advice that parents receive.

Generally speaking, the term positive parenting refers to parental behaviour and child-rearing practices that produce positive child outcomes. However, beliefs and perceptions of what outcomes are positive may vary within families, communities, populations, and cultures. While the information is contained throughout the 3 Cheers resources, it needs to be formally defined.

Recommendation 2

The 3 Cheers Parenting Initiatives Committee should revisit and clarify a set of evidence-based, *key assumptions* regarding parenting education, parents and their relationships with children. These assumptions should be used to guide the Committee in fulfilling its mission, goals, and purpose.

Rationale:

For example, key assumptions could include variations of some or all of the following:

- Parents are the primary socializers of their children.
- Parenting attitudes, knowledge, skills, and behaviours can be positively influenced by parenting education efforts.
- Parenting is a learned skill that can be strengthened through study and experience.

- Parenting education is more effective when parents are active participants in and contributors to their parenting education programs.
- The parent-child relationship is nested within and influenced by multiple social and cultural systems.
- Programs should be responsive to diversity among parents.
- Effective parenting education may be accomplished by a variety of methods.
- Targeted approaches are most successful when nested within a universal approach.
- Both the parent and the child have needs that should be met.
- The goal of parenting education is strengthening parents' and caregivers' knowledge and skills, so that he or she is better able to facilitate the development of caring, competent, and healthy children.

Recommendation 3

The 3 Cheers Parenting Initiatives Committee should revisit and clarify a set of *underlying and guiding principles* that delineate the priority areas established by the Committee. These principles will form the foundation of a model (to be developed) on parenting education and positive parenting practices that should be aligned with the overall 3 Cheers Framework.

Rationale

For example, underlying and guiding principles could include variations of one or more of the following:

- Focus on what parents and other caregivers can do to enhance the overall social, emotional, and physical well-being of their children.
- Focus on core priorities that have been identified in the literature as being practices used with children aged 0 to 6 years that positively and significantly improves their well-being.
- Focus on parental strengths and empowerment versus deficits and problems.
- Reflect the diverse and fluid needs of parents by being flexible and dynamic, as opposed to rigid and static.
- Reflect the diverse cultural backgrounds of Calgary parents and children by being sensitive to the various socio-cultural backgrounds of parents and families.
- Focus on prevention, promotion of healthy development, and appropriate interventions for issues of concern.

Recommendation 4

A comprehensive, population level, community-based parental needs assessment should be undertaken by the 3 Cheers Parenting Initiatives Committee to determine the specific parenting-related needs of parents residing within the Calgary region who have children aged 0 to 6 years. The needs assessment process will collect and examine information about the current and future needs and desires of parents within the Calgary region with respect to parenting related issues, programs and services. The results will assist the Committee in understanding the ways in which parenting needs are affected by personal and contextual factors, and will provide valuable information about the values, beliefs, attitudes, opinions, and views of parents regarding parenting. The findings will be used by the Committee to make recommendations to the 3 Cheers Steering Committee with respect to the development of priority areas.

Rationale

- A. While key informants who represented a number of different departments and organizations concerned with the improvement of parenting support in the Calgary region were contacted in this investigation, it is possible that some of the individuals interviewed were expressing beliefs related to the desire for continued funding, increased funding, or support of initiatives that may have been motivated by maintaining the immediate and best interests of their own department or organization, rather than focusing on the needs of parents within the Calgary region as a whole. Particularly since the number of key informants interviewed in Calgary was small (n=14), it was not possible to establish the validity of the information overall. It is also possible that the actual insights and beliefs of the key informants have been limited by the nature of their individual roles and the limitations imposed by the nature/characteristics of clients that they or their organization are in greatest contact with. These factors suggest that information about the needs of parents must be obtained from the population of parents in the Calgary region itself.
- B. As identified in the *3 Cheers for the Early Years Strategic Plan 2006-2008* (2006, p. 3), the selection process for 3 Cheers strategies is based on sound judgment and decision making. Each proposal for funding is assessed according to a number of criteria. Results of a population level assessment of parenting needs would help to support the selection and funding of projects/strategies/social marketing campaigns by providing specific, current, and community-based information regarding:
- Potential impact to influence health outcomes or social, emotional and moral community norms.
 - Ability to measure the impact of a project against baseline data in a cost effective manner.
 - Alignment of a project with other frameworks for health outcomes identified in the population
 - Cost/benefit of a project relative to the health impact of not doing the project.
 - Ethical considerations of a project.

- The innovative approach or design of a project.
 - Identifying evidence-based practices associated with a project.
 - Identifying the level of need for a project within a given community.
 - The ability of a project to develop or strengthen connections between stakeholders or other projects and create synergy within the organization and/or community.
- C. There is currently insufficient, up-to-date information that can be used to complete the detailed environmental scan segment of this investigation. Key informant interviews of service providers, administrators of parenting related programs, and other parenting related professionals were conducted to gather perceptions of gaps and barriers related to parenting programs. Perceptions of key stakeholders varied considerably regarding current programming and the future direction of parenting programs.

Few stakeholders were in the position of providing front-line services to parents and families, and therefore were unable to clearly articulate the needs of their clients, provide estimates of the extent of the needs, and speak in detail about the specific nature of barriers to parental participation in parenting programs.

A comprehensive needs assessment can constitute a major source of up-to-date information that is relevant in identifying political, economic, social, and technological factors related to current and future parenting programs. These findings can be combined and used to identify strengths, weaknesses, opportunities and threats - all of which are useful in delineating and gaining an understanding of issues critical to the success and sustainability of existing and future programs. Such results can be used to support projects and activities (e.g. advocacy) to be carried out by the 3 Cheers Parenting Initiatives Committee and other groups aimed at serving parents and their children.

It has been well established that goals and outcomes of existing and new initiatives should be specifically tailored to the needs of the population of interest. There has not been a comprehensive population level needs assessment focused solely on parenting beliefs, attitudes, practices and needs conducted in the Calgary region. Research indicates that there are many factors that may work alone or in combination to limit the effectiveness of parenting programs. Some of the factors which may need to be identified include: ingrained parental beliefs and behaviours, insufficient program length/intensity, parental personal factors, program characteristics and adaptability, program attrition, cultural relevance, accessibility issues, insufficient quality of program delivery, and barriers to change at different ecological levels.

While evaluations of existing parenting programs have been conducted within the Calgary region, such evaluations are primarily designed to evaluate specific program outcomes based upon identified goals and objectives. Such evaluations are not designed to examine parenting needs with a broad lens and through an ecological perspective. Although other provincial and national research initiatives are currently involved in population-level surveys of parents,

such surveys are not tailored to determining needs of parents within the Calgary region.

The results of a population level needs assessment of the Calgary region will enable service providers to gain an understanding of the population's perceptions and attitudes regarding parenting. It will identify existing beliefs and messages being delivered regarding parenting. A comprehensive needs assessment would enable the 3 Cheers Parenting Initiatives Committee to ensure that the needs of specific segments of the population are recognized and addressed in existing and future parenting related initiatives.

Any assessment that is undertaken should be in concert with other assessments currently being conducted in this area (for example, the Environmental Scan of Parenting Education in Calgary conducted in 2007 by the Parenting Action Group of Calgary Children's Initiative, and the Community Parenting Evaluation Research Project if funded, as well as any other related projects).

- D. A population level assessment of parenting needs can demonstrate accountability to parents and other stakeholders. The needs assessment will convey the high level of commitment to the community through ensuring that existing and future programs and services are responsive to the specific needs identified by the population itself.

Conducting a population level assessment of parenting needs will convey the message that parents and their children are highly valued within the Calgary region, and will immediately communicate the importance of parental input and involvement in the planning of programs and services designed to provide immediate and ongoing support to parents in the overall development of children. The 1999 Invest in Kids Survey found that after the birth of their first child, 45% of parents reported that they felt they did not receive enough emotional or practical support as parents. Additionally, 58% disagreed with the statement, "I think Canada values its young children" (Peters, 2007, p. 1).

- E. Results of population level assessment of parenting needs will:

- (a) Assist the 3 Cheers Parenting Initiatives Committee in the *determination* of priority areas.
- (b) Assist the 3 Cheers Parenting Initiatives Committee in the *provision of direction and guidance* with the implementation of initiatives which address the priority areas.
- (c) Assist the 3 Cheers Parenting Initiatives Committee in identifying *strategies for parental involvement* in initiatives which address the priority areas.

- F. Conducting a population level assessment of parenting needs will provide baseline data that may be used in the future to monitor and assess changes in the overall mindset (beliefs, attitudes, knowledge, practices) and needs of parents within the Calgary population towards parenting and parenting related issues. Such information can assist in the identification of program goals and outcomes, and with planning the direction and review of program evaluation strategies and results. [See Appendix B and Appendix C]

- G. To maximize the cost-effectiveness of new initiatives, needs assessments are best conducted before selection of prevention programs and before program implementation. Conducting a population level assessment of parenting needs should be considered to be part of the due diligence process.
- H. The findings can be used to justify whether initiatives should be offered universally as strategically targeted programs or a combination of both. Findings can also identify other important elements (e.g. gaps, barriers, neighborhood specific issues) that may affect program planning, funding, implementation and sustainability.
- I. Results of a population level assessment of parenting needs can be used within the Calgary region to support, justify, build, and sustain relationships among community organizations and between parents and community organizations.
- J. Results of a population level assessment of parenting needs can be used to determine the most appropriate media for transmitting or sharing information with the population regarding parenting. The needs assessment may assist in identifying learning needs and preferences that are topic-specific and/or format specific (e.g. print materials, interactive CD-ROMs, interaction with others in a group setting).
- K. Results of a population level assessment of parenting needs may be used by the 3 Cheers Parenting Initiatives Committee to assist in planning and improving the social marketing, communication, and dissemination of specific types of information internally and externally to the CHR, and to parents and others within the Calgary region.

It may do so by assisting in the identification of priority areas to alter or correct misperceptions and misunderstandings that may be common and widespread (e.g. knowledge-related items, attitude-altering campaigns, program offerings, qualifications, fees, etc). The needs assessment can identify preferences in information delivery formats, locations to distribute information, and other related issues, such as the need to deliver information in different languages.

Recommendation 5

The use of the Early Development Instrument (EDI) in the Calgary region should be supported by the 3 Cheers Parenting Initiatives Committee, and the results of the EDI may be used to enrich the findings and decisions made as a result of the population level needs assessment on parenting (see Recommendation 4).

Rationale

The EDI is typically completed at kindergarten age to help communities plan prevention and intervention programs and track the effects of those programs on young children. Ideally, population level needs assessment results (see Recommendation 4) may be used in conjunction with the findings of the EDI to solidify and explain common or consistent findings, raise

questions and promote further inquiry regarding contradictory or contrasting findings, and provide complementary perspectives that may not be apparent with one method alone.

Consideration of data gathered through multiple methods may be considered a form of triangulation of methodology. Such a strategy may *assist* researchers and decision-makers to make judgments about the data sets and formulate relevant conclusions and recommendations, even though subjective interpretations of those findings will still occur. The strength of this approach is that it allows findings gathered through one methodological source to be interpreted through a related perspective, and within a broader ecological context.

While the EDI gathers information about children within the population (as assessed by teachers), the needs assessment will gather information about the children as well as information about the parents from parents themselves. Unlike the EDI, data from the needs assessment can be analyzed to ascertain whether there are connections between parenting beliefs, attitudes, and styles, and developmental outcomes found to exist in children. If the needs assessment is conducted at regular intervals in the future (e.g. every 3 years), it may be possible to more specifically track changes in parental beliefs, attitudes and behaviours related to parenting with the effects on young children.

Recommendation 6

The 3 Cheers Parenting Initiatives Committee should develop and/or adopt a Model of Parenting Education and Support for the Calgary Health Region. The model will serve as a framework which encompasses (a) the content that is the basis for parenting education, and (b) the processes used by parenting educators and/or those professionals within the CHR who are providing parenting support. It is important that the resulting model be aligned with the overall 3 Cheers Framework.

The Model of Parenting Education and Support should be based upon the:

- (a) Definition and principles of positive parenting practices (Recommendation 1).
- (b) Key assumptions regarding parents and their relationships with children (Recommendation 2).
- (c) Underlying and guiding principles (Recommendation 3).
- (d) Priority areas identified through findings from the community-based needs assessment (Recommendation 4).

Rationale

A model can perform the critical function of helping to ensure that there are common elements and consistency in the overall vision, goals, approaches, and expected outcomes of programs and services delivered by multiple service providers within the Calgary area. It will serve as a conceptual framework for professionals working collaboratively to create comprehensive

parenting initiatives that are responsive to the needs of parents and children at the local level, while being sensitive to regional, cultural and ethnic differences in childrearing. The model can be used to communicate and explain the vision to stakeholders by using a common set of terms and approaches. The core framework could serve as a unifying structure to guide the development and delivery of programs by multiple partners, serve as a catalyst to increase collaborative efforts, and provide a basis for the evaluation and improvement of programs.

Recommendation 7

The 3 Cheers Parenting Initiatives Committee should further investigate the actual curriculum and specific strategies taught within existing parenting programs within the CHR as well as parenting programs that the CHR is interested in implementing.

This will help to ensure that CHR programs or resources consistently provide parents with techniques that are consistent with the goals and philosophy of the 3 Cheers Parenting Initiatives group. Such an investigation must involve actual participation of a sample of parents and parenting educators in completing the actual parenting programs of interest.

Rationale

When critiquing a parenting education program, no one can be certain of what the training will involve until after they have gone through that particular program. This is discussed by Medway (1989), who points out that even if a program has been described as having specific characteristics, program delivery and success is affected by: (a) the quality and competency of the people that teach/lead the program, and (b) the characteristics of the participants (parenting skills, values and attitudes). Attempting to control the characteristics of the parents who attend parenting programs would be difficult, and in many cases unjustified. However, it is possible to work towards the standardization of program delivery through the training and accreditation of group leaders.

Recommendation 8

The 3 Cheers Parenting Initiatives Committee should strengthen partnerships and collaborations with other local, provincial, national and international organizations that are focused on:

- (a) The advancement of parenting related knowledge and research.
- (b) The advancement and promotion of consistent parenting information and development of supportive programs designed to promote healthy child development.

Developing links within the 3 Cheers parenting initiatives and with other parenting initiatives outside of 3 Cheers is one of the main functions of the Committee.

Rationale

Developing links within the 3 Cheers parenting initiatives and with other parenting initiatives outside of 3 Cheers is one of the main functions of the Committee. Numerous benefits are likely to be associated with diversifying the role of the 3 Cheers Parenting Initiatives Committee to a broader ecological context, and to expand its vision to the improvement of parenting practices and family supports at the national and international population (societal) level.

Because of the multitude of social, economic, and political conditions facing families that extend beyond the control of one service sector, there needs to be increased accountability among service providers and organizations in all sectors to define and work towards common goals related to parenting support and child development. Such public accountability can be demonstrated, in part, through participation in collaborative efforts and partnerships with other public and private organizations.

Collaboration should include initiating and participating in Canada-wide initiatives that are supported with a strong evidence base. This may include participation in such initiatives as pilot projects of parenting programs, collecting information for national parenting and child-health related databases (e.g. the Early Development Instrument, the "What We Know About Child Development" Provincial Benchmark Survey being conducted by the Alberta Centre for Child, Family and Community Research and the University of Calgary), supporting participation in national research studies (e.g. Invest in Kids), campaigns to increase parenting related awareness and knowledge, and other efforts aimed at elevating the profile of parenting in the public eye. As one of the largest publicly funded health care systems in Canada, the Calgary Health Region must continuously be involved in collaborative efforts with other organizations to ensure the continued delivery of innovative, accessible community-based care that exemplifies quality, safety and public accountability.

Worldwide, research on parenting has been extensively pursued in the last few decades. Yet, fundamental gaps continue to exist about how the parenting process can be influenced to result in positive outcomes for both children and parents. Obstacles such as historical, professional, organizational, operational, financial, and other issues seem to have interfered with depth and types of collaborative relationships necessary to pursue the kinds of comprehensive and longitudinal studies that provide consistent, meaningful, and practical results. Within Canada, the development, planning, and implementation of an effective, universal approach to parenting will require increased accountabilities and increased sharing of expertise, knowledge, and resources on local, provincial, and national levels. Supported in theory by the population health approach, such a commitment has great potential to maximize the benefits to public health while minimizing the duplication of research and waste of financial resources.

Recommendation 9

The 3 Cheers Parenting Initiatives Committee should investigate the potential impacts and implications of supporting the growing movement towards the professionalization of parenting education and the accreditation of parenting educators.

Rationale

A wide diversity of individuals are involved in the provision of parenting education, ranging from highly trained professionals from diverse fields (e.g. nursing, social work, psychology) to mothers in the neighborhood who seek to help other parents (Heath & Palm, 2006). There is increasing evidence to support the movement towards formalized training for parent educators. This is contributing to a shift towards recognizing parenting education as a professional field.

Many of the widely recognized parenting programs include sophisticated training components and present parenting education as a professional endeavor (Fine & Henry, 1989). However, many programs do not require that their parenting educators have a set of core competencies and a specialized knowledge base about parenting. Given the potential impacts that parenting educators have, the movement towards professionalization reflects efforts to improve the quality of services for parents, children and families. Consensus on critical skills for parenting educators within the Calgary Health Region should be a goal. These should form the basis of any future training.

Appendix A

Review of the Literature on Parenting Programs

Note: The contents of this document remain incomplete due to the decision of the Committee to redirect the objectives of the investigation. In particular, please note that the section outlining the details of specific parenting programs (and the identification of effective programs) is very abbreviated, and based upon information that was *not* formally verified through direct contact with program sources.

Review of the Literature on Parenting Programs

The purpose of this literature review is to provide an overview of parenting programs, discuss issues related to their effectiveness, and to identify some parenting programs that have a strong evidence base supporting their effectiveness. This includes programs which have a strong theoretical basis, are clinically grounded, empirically supported (proven effective through targeted, controlled, and rigorous evaluation studies), targeted to improving child development and family well-being, contextually and culturally appropriate and flexible, and that have been successfully implemented in population health settings. The review also identifies some parenting programs that have a strong following of parents, but do not have a strong evidence base. The reason for doing so is that many parenting programs that do not have a solid evidence base are effective in achieving positive outcomes for parents and their children. Often, parenting education is provided as one component under a comprehensive program with much broader child health and development goals (e.g. Head Start; Better Beginnings, Better Futures). Such programs are beyond the scope of this review which focuses on parenting programs for parents of children aged six and under.

In order to facilitate the reader's understanding of issues related to parenting programs and their effectiveness, the report briefly introduces topics including effective parenting, parenting styles, and attachment theory.

Introduction

Increasing evidence indicates that the social, emotional, intellectual and physical development of children is significantly impacted by the quality of their early experiences in life. Ineffective parenting has been identified as one of the most serious risks for childhood behaviour problems during a child's early years (Swick & Graves, 1993). Supportive parent-child relationships, consistent parenting, positive discipline methods, close monitoring and supervision, parental advocacy for their children and parental pursuit of needed information and support have been consistently shown to be buffers against the development of problem behaviours (Alvarado & Kumpfer, 2000; Bry, 1996; Huizinga, Loeber & Thornberry, 1995; Landy & Tam, 1998) and to reduce the incidence of child maltreatment (Azar, 1997; Sanders & Cann, 2002).

Using data from the first and second cycles of the National Longitudinal Survey of Children and Youth, Thomas (2004) found that children living in a punitive environment were more likely to demonstrate aggressive behaviour, both at 2-3 years of age and at 8-9 years of age. With a change in parenting practices from punitive in cycle one to non-punitive in cycle two, the child's aggressive behaviour in cycle one changed to non-aggressive in cycle two. Children whose parents' behaviour became punitive at cycle two went from non-aggressive in cycle one to aggressive in cycle two. Other studies have also demonstrated that a positive change in parenting practices is significantly associated with a positive change in child behaviour, school adjustment and academic achievement (Collins et al, 2000).

Numerous parenting education courses have been developed with the intention of improving fundamental parenting practices and reducing the potential for problem behaviours in children. Many of these courses are targeted interventions that are aimed at helping specific groups of parents - often those who have children who are at risk for developing severe behavioural problems. Others are designed to reach a broader audience of families who may be at risk for dysfunction. Parenting education cannot be simply defined; it encompasses a wide range of philosophies, programs, purposes and materials (Medway, 1989). Generally speaking, parenting education refers to the processes of imparting the parental attitudes, knowledge, and skills necessary to promote the optimal physical, cognitive and psychosocial development of children at different developmental stages (Mahoney, Kaiser & Girolametto, 1999; Winton, Sloop & Rodriguez, 1999). It also involves supporting parents in developing coping skills, communication skills, problem-solving skills, and supporting parents in their own personal development (Tsang & Leung, 1005). Parenting education programs often provide information and services to parents with the goals of enhancing parent-child relationships and strengthening families by reinforcing supportive behaviours of parents, and altering non-productive or harmful behaviours. They may help parents to enhance their existing skills, increase their understanding of human development, introduce and allow parents to try alternate approaches to childrearing, and learn techniques to reduce stress that can undermine parental functioning (Brown, 2001; Small, 1990; Wandersman, 1987).

Parents may benefit from parenting education and parent support groups through the development of new skills that can lead to increased confidence, insight, and self-esteem (Adams, 2001). In a review of self-efficacy in parenting, Coleman and Karraker (1997) found that high self-efficacy increases satisfaction in the parenting role and reduces paternal depression, frustration, resentment and feelings of failure. An increase in parental confidence has also been associated with an increase in knowledge about child development obtained through parenting education (Crill Russell, 2003). Other benefits of parenting education include decreases in the use of negative physical/coercive discipline techniques, emotionally abusive behaviours and parental criticism (Thomas et al., 1999). Research on parenting resourcefulness and competency conducted in Ontario found that parents who completed the Nobody's Perfect program demonstrated and maintained an increase in parenting resourcefulness, warm/positive parent-child interactions, sense of parenting competency and satisfaction and use of community resources (Chislett & Kennett, 2006).

Systematic reviews of parenting programs indicate that parenting programs can have a positive impact on a number of outcomes, including improved child behaviour, increased maternal self-esteem and relationship adjustment, improved mother-child interaction and knowledge, and decreased maternal depression and stress. Evidence-based research on parenting suggests that specific types of parental influences that are consistently practiced accumulate to produce larger, long-term and meaningful outcomes over the child and adolescent years (Bunting, 2004; Collins et al., 2000). However, there is still insufficient evidence that parenting programs can produce significant and long term effects on parental attitudes and behaviours.

While some research has identified various child and family characteristics that predict effective outcomes (e.g. severity of child behaviour, maternal mental health), few studies have examined the actual processes of change that are induced by parent training and whether there are certain

subgroups (e.g. child gender, family socioeconomic status, cultural groups) for whom parent training is more effective (McMahon, 2006). Additionally, insufficient attention has been paid to identifying the conceptual, empirical, and pragmatic issues that are involved in large-scale dissemination of parent training programs within the population health approach (McMahon, 2006).

There is limited evidence that participation in parenting programs may produce unintended consequences. Qualitative research by Mockford and Barlow (2004) revealed some of the difficulties faced by parents when they attempt to change or enhance parenting practices that are entrenched in their daily lives. The findings suggest that parenting programs have the potential to create discrepancies between mothers and fathers, thus resulting in a number of unintended consequences, including parental tension. As well, financial restrictions, time limitations and reluctance to attend parenting programs on the part of some fathers have resulted in only one parent attending a program. This can result in family tension if parents are not parenting in consistent ways.

Limitations to the Research Literature and Evidence Base

Numerous parenting programs continue to be implemented in communities worldwide without having been subject to rigorous evaluation. The results of internal and/or external evaluations of such programs may not be submitted (or accepted) for publication in research journals, nor are they often available to the public. Some reasons that implemented programs are not adequately evaluated include cost and the difficulty in conducting large scale, longitudinal research under controlled conditions. When decisions must be made regarding which type of parenting education programs to offer, comparisons of programs of different theoretical orientations are difficult because each orientation is focused on different constructs of importance. For example, while Adlerian studies typically focus on measures of parental *attitudes*, behavioural studies emphasize observable or readily reportable *behaviours* (Mooney, 1995). Also, ranking of programs being compared is often not possible because of the different goals and outcomes associated with each program (Krebs, 1986).

Organizations that sell large, highly commercialized and widely advertised parenting programs may be able to devote considerable time and money to conducting high quality, large scale research projects. This may increase the likelihood that such results are accepted for publication in research journals which serve to disseminate the findings world-wide. While other parenting programs may also be producing significant and positive results, such information may be prevented from reaching mainstream society due to the insufficient accessibility to research funds and the related limitations on information dissemination. This suggests the possibility of positive bias being created in the research literature towards parenting programs that have been widely used, marketed and that have already experienced some level of commercial success.

When making decisions related to the implementation of new programs, many organizations do not have sufficient funding available to conduct investigations as to the array of options available. Administrators often have a window of opportunity for the receipt of program funding, and may

make quick decisions based upon easily accessible information (e.g. the Internet, recommendations from other service providers, recommendations based on parent input). Unfortunately, "jumping on the bandwagon" may result in the promotion and implementation of parenting practices that are popular, but not necessarily supportive of positive child development. Another great limitation of examining the research literature on parent training and education is that those classified as behavioural approaches are more likely to have been tested under rigorous conditions than relationship focused approaches.

The population health approach recognizes the limitations involved in solely implementing programs that have been identified as effective based upon research conducted under controlled, clinical, experimental conditions. With respect to the evidence-based decision-making approach used in population health, it is important to integrate formal and informal qualitative and quantitative evidence along with good reasoning to justify interventions or address health issues (Health Canada, 2001). Qualitative evidence obtained through methods such as key informant interviews with stakeholders and case studies and consultations with experts in population-based disciplines may provide access to insights and real-life implementation issues that are not typically identified or captured through traditional quantitative research methods.

Delivery of Parenting Programs in Canada

In Canada, many programs aimed at improving health and developmental outcomes for children receive funding from and are delivered through multiple ministries. While no single, overall strategy for the delivery of parenting programs have been defined nationally or provincially; there are increased efforts to improve the integration of services to reduce gaps and ensure a continuum of services. Provinces recognize the need for regional planning and service coordination and delivery. In some provinces, such as Ontario, this is accomplished through community health centres. Community health centres work with individuals, families and communities to provide education on advice on helping families to access the resources they need from other community agencies. Their health promotion activities for parents include the provision of parenting education, parenting skill training, parent-child resource rooms and drop-in programs, and programs for teen moms. Community health centres are not-for-profit, community governed organizations that deliver integrated primary care and community health services throughout the province. They integrate health and social services and emphasize prevention, health promotion, occupational health services, and other personal services, delivered at one location.

Parenting programs in Alberta are accessible in each of the health regions operating under Alberta Health and Wellness. Two province-wide services that can help parents access support are Health Link Alberta and the Parent Link Program. Health Link Alberta is a 24 hour a day, 7 day a week nurse telephone advice and health information service. Health Link can assist parents in finding appropriate services and health information, including information on where and how to access appropriate parenting programs. Alberta Children's Services established the Parent Link Program after research they conducted identified a need for comprehensive, high quality, community-based programs to help parents provide their children with the best possible start in life. Parent Link Centres provide supports to parents to help their children develop and arrive at

school ready to learn. Parents can access information about community services, obtain referrals, meet other parents and families, and take part in quality learning activities with their children (see Alberta Children's Services website: <http://child.alberta.ca>). Both these services can help parents connect with the many community agencies that offer parenting programs throughout the province.

Role of Parenting Programs in Prevention and Early Intervention

For many years now, researchers and clinicians have advocated the importance of prevention and early intervention in the development of widespread services designed to avoid or reduce the negative effects of poor parenting practices and produce improvements in the health and adjustment of children and youth (Barlow, 1999; Barlow & Coren, 2000; Patterson et al., 1993). The rationale for parenting programs arises from evidence linking dysfunctional parenting practices with an increased risk of children developing behavioural and emotional problems (Sanders & Ralph, 2004). Families themselves must be functioning well to provide a good social, emotional, interpersonal, economic and cultural contexts for healthy child development, moral development and socialization. Children who are raised by parents without sufficient capabilities, knowledge or competencies related to parenting are denied the experiences and opportunities that will enable their optimal development. This is a primary reason that increasing attention is being given to the importance of better preparing parents to understand their role and responsibilities in raising children, and that public policy supports attempts to improve parenting in contexts known to pose developmental challenges and risks to children (Garbarino, Vorrassi & Kostelny, 2002).

The increasing demand for parenting programs that have been initiated by parents suggests that parents themselves are interested in obtaining more information about parenting (Patterson et al., 2002b; Smith, 1997). Publicly funded organizations play an important role in setting the parameters for parental responsibilities and behaviours through the types of parenting programs they offer. Universal preventive approaches to parenting programs are aimed at providing all parents of infants or young children with opportunities to increase parenting related knowledge, skill development and social support. Such approaches represent active efforts in the early intervention and prevention of behavioural and developmental problems in children. However, research regarding the long term effectiveness of universal parenting programs remains inadequate and inconsistent. Peters, Petrunka and Arnold (2003) suggest that in reviews of early childhood prevention programs, few prevention programs for young children have been adequately designed for children younger than 7 or 8 years old. Such reviews found that most programs have either not been evaluated at all, or "the evaluations have such serious flaws that no meaningful conclusions can be drawn from them" (p. 215). In the meantime, research in the area of public health recommends that the focus on prevention should include a focus on health promotion (Turner, 2006). That is, prevention programs should help to develop and maintain known protective factors, and include effective dissemination of what is known to work in promoting effective parenting and positive family relationships (Sanders & Ralph, 2004).

Effective Parenting

There appears to be universal agreement among parents throughout the world that the main goal of parenting is to rear children to become productive and contributing members of society (Whiting & Edwards, 1988). Baumrind (1970, p. 106; cited in Teti & Candelaria, 2002) coined the term *instrumental competence* to describe a set of attributes that she believed represented child outcomes that were highly valued by middle-income parents in the United States:

Instrumental competence refers to behavior which is socially responsible and independent. Behavior which is friendly rather than hostile to peers, cooperative rather than resistive to adults, achievement rather than non-achievement oriented, dominant rather than submissive, and purposive rather than aimless, is here defined as instrumentally competent.

As discussed by Grych (2002), descriptions of effective or competent parenting generally involve certain classes of parental behaviour: (1) sensitivity and responsivity to children's needs; (2) expression of affection and acceptance; and (3) exertion of appropriate control or discipline, which involves encouraging increasingly mature and autonomous behaviour in addition to setting limits, providing consequences for behaviour, and monitoring. An issue that may interfere with identifying the characteristics of an effective parenting program is that while a program may be effective in producing the intended outcomes of the program, such outcomes are bound by the program's definition of "effective parenting" and its associated notions about appropriate and effective parenting practices.

Parenting Styles and Effective Parenting

Baumrind (1967, 1968) identified three major parenting styles that have had significant influence on the understanding of parenting competence, especially as it exists in the United States. As described by Teti and Candelaria (2002, p. 157), these are as follows:

- (1) **Authoritarian parenting style.** This style is identified by high levels of control and maturity demands, low levels of nurturance, and low clarity of communication. Authoritarian parents expect absolute obedience from their children and are likely to resort to strong punitive measures whenever children deviate from that standard; the parent's word is final.

Children raised by authoritarian parents in the U.S. have been found to have low levels of instrumental competence; they exhibit more hostile behaviour, are shyer with peers, are overly dependent on parents, and are less achievement oriented. An analysis of data from the National Longitudinal Survey of Children and Youth (NLSCY) data on the role of parenting in younger children found that harsh parenting was the primary determinant of behaviour problems for both children aged 2-3 and 8-9 years (Miller, Jenkins & Keating, 2002). A one-point increase on a 10-point scale of harsh parenting was related to a 50% increase in risk for behaviour problems. Analysis of long-term data from the NLSCY linked higher levels of

aggressive child behaviour and anxiety and lower levels of pro-social behaviour with punitive parenting practices (Statistics Canada, 2005).

- (2) ***Permissive parenting style.*** Permissive parenting is characterized by high levels of nurturance and clarity of communication and low levels of control and maturity demands. Children are allowed great freedom in choosing activities. Their parents are openly accepting and supportive of their child's behaviour, and parents make little effort to exert control over it or set standards of child conduct. Discipline involves the use of reasoning only. The parent actively seeks out the child for input regarding household rules and regulations.

Children raised in permissive homes in the U.S. tend to exhibit nonassertive behaviour, dependency on parents, and poor self-control. As with children raised by authoritarian parents, children raised by permissive parents have a reduced capacity to cope with frustration and disappointment and to adapt to the challenges in everyday life.

- (3) ***Authoritative parenting style.*** This style is characterized by high levels of parental control, nurturance, clarity of communication and maturity demands. Authoritative parents exert firm control over their children's behaviour and set clear standards of conduct for the child. Such parents openly acknowledge and incorporate the child's perspective in disciplinary matters, within limits that are acceptable to the parent. Discipline involves the combined use of reason and power, but not to the point of harsh physical discipline or severe restriction of the child's autonomy, with reference to established standards of conduct.

Children raised by parents using the authoritative style in the U.S. have been found to show the highest levels of instrumental competence; they are friendlier with peers, more independent and assertive, cooperative with parents and achievement oriented. The authoritative parenting style has been characterized as the benchmark for successful parenting (Johnson et al., 2006).

Research conducted since Baumrind first described the parenting styles has been "remarkably consistent" (Teti & Candelaria, 2002) in the U.S., Canada, and among families of European descent (Chao & Tseng, 2002) in countries that can be described as primarily individualist in orientation. However, there is some disagreement by researchers with respect to the applicability of Baumrind's authoritative model to cultures that are described as primarily collectivist, such as China (Chao & Tseng). Some cross-cultural researchers have found Baumrind's parenting styles to exist in both cultures where independence is said to be emphasized (individualist) and those where interdependence is said to be emphasized (collectivist). More research is needed to identify the effects of different styles of parenting within other cultures (Sorkhabi, 2005). These findings suggest that in countries such as Canada which value the cultural mosaic, care should be taken not to assume that authoritative parenting will produce similar child outcomes for all families, nor to assume that such outcomes will be perceived to be beneficial by all families. Such considerations may be particularly important to public health administrators in their decisions to offer parenting programs within populations characterized by families of diverse cultural backgrounds.

Attachment and Effective Parenting

Attachments are the lasting emotional ties between infants and their parents which usually develop within the first year of life. The nature and quality of this relationship differs substantially with each parent and child. Attachment theory is based on the idea that the early relationship which develops between an infant and their parent or primary caregiver provides the foundation for further development. Secure attachment in infancy is believed to have an important influence on the likelihood of success in later social relationships. Attachment is not the same as bonding. Bonding refers to the parent's tie to their infant which develops within the first few hours of life. While infants are capable of developing multiple attachments (e.g. to mothers, fathers, grandparents, etc.), there is usually one parent who is their "primary attachment figure" (Appleyard & Berlin, 2007). Healthy Attachment Working Group, Calgary Health Region has considered the literature and offers the following definition of attachment:

Attachment is a basic human need that has evolved for the purpose of protection and survival of the human infant. Attachment develops through the interaction between parent(s) (or primary caregiver) and child. It can be secure or insecure. When attachment forms well, infants and young children develop a sense of security in their parent's ability and willingness to protect them from harm and to be responsive to their needs. The child uses attachment behaviors to attain or maintain proximity to the parent in a bid for security, comfort and attention. Optimal attachment develops when parental responses are sensitive, timely and matched to the child's cues. While attachment is formed over time, the first year is a critical period of development. Initial attachment experiences form the template for all future relationships. (Trifunov, 2007, p. 4)

Research has demonstrated that attachment during infancy predicts aspects of social development during childhood and adolescence such as empathy, social competence and behaviour problems. A child who had a secure attachment with her parent as an infant is more likely in childhood to be independent and self confident, to have appropriate interactions with peers and teachers, to manage her emotions, to be focused, curious and motivated in school, and to have strong problem solving skills (Appleyard & Berlin, 2007). Strong infant-parent relationships appear to act as a protective factor against the development of a variety of emotional, behavioural and health problems (Benoit et al., 2001). While an insecure attachment does not equate with developmental and adjustment problems, it has been shown to predict them. A child with an insecure attachment as an infant is more likely in childhood to have poor social skills (e.g. withdrawal, aggression), to act out and be disobedient, to have poor communication skills, to be impulsive and easily distracted, and to lack curiosity and motivation in school (Appleyard & Berlin, 2007).

While more detailed classifications have been identified in the research, there are two basic patterns of attachment, "secure" and "insecure". Secure attachment predicts more optimal developmental outcomes, and has been predictive of indicators of emotional well-being such as self-confidence, ego-resiliency, and play competence (Egeland, 2004; Elicker et al, 1992; Londerville & Main, 1981; Sroufe, 1983).

As described by Appleyard and Berlin (2007, pp. 2-3), parental and infant/early childhood behaviours that are typically associated with secure and insecure attachment are listed below.

Secure Attachment

A child with secure attachment is able to use his or her parent as a source of comfort and a "secure base" from which to explore. Such a child feels confident in his parent's availability so that he can fully explore and play on his own.

Parental Behaviours Typically Associated with Secure Attachment

- Sensitive and responsive care
- Clear, consistent, developmentally appropriate expectations and supervision
- Warm, positive, and responsive verbal interaction
- Seeing the child as a unique individual, having insight into the child (i.e. why he does what he does)
- "Holding the child in mind" (i.e. awareness of and ability to reflect on the parent's own feelings and responses to the child)

Infant and Early Childhood Behaviours Typically Associated with Secure Attachment

- Comfort exploring in presence of an attachment figure
- When hurt, going to an attachment figure (e.g. mother, father, grandparent) for comfort
- Seeking help when needed
- Willingness to comply with requests with minimal conflict
- No pattern of controlling or directing the behaviour of caregivers (i.e. no role-reversal)

Insecure Attachment

A child with insecure attachment is not able to use his/her parents for comfort or as a secure base, therefore he/she does not feel comfortable in fully exploring and playing alone.

Parental Behaviours Typically Associated with Insecure Attachment

- Interfering with the child's attempts at exploration (i.e. overly controlling, intrusive)
- Unclear, inconsistent, developmentally inappropriate expectations and supervision
- Ignoring the child's needs and cues
- Inconsistent, unreliable responsiveness
- Hostile, threatening and frightening behaviours
- Prioritizing the parent's needs over the child's (e.g. being a self-absorbed parent)
- Behaving like a child or treating the child as though he/she is in charge (i.e. role-reversal)

Infant and Early Childhood Behaviours Typically Associated with Insecure Attachment

- Excessive dependence
- Marked shyness, withdrawal or unfriendliness
- Failure to seek contact, comfort when needed
- Indiscriminate friendliness or contact seeking
- Punitive, bossy behaviours
- Over-concern with the parent's well-being (i.e. role-reversal)
- Disoriented or frightened in presence of the parent, such as approaching while looking away, stilling, freezing, or rocking
- Promiscuous, sexualized behaviour

The positive long-term developmental outcomes associated with a secure attachment relationship suggest that effective parenting programs should incorporate attachment based therapeutic intervention and/or prevention supports and programs. Recent summaries of attachment research (Appleyard & Berlin, 2007; Trifunov, 2007) suggest that programs supportive of the development of secure attachment relationships should:

- Help parents to understand the importance of, and their responsibility in responding to situations according to the needs of the child, comforting and being supportive of their child, and facilitating their child's exploration of the world.
- Aim at enhancing positive parental behaviours such as responsiveness, sensitivity, encouragement and involvement through discussion, play, role modeling and video feedback techniques.
- Help parents understand "typical" child development and developmental milestones through the provision of information and examples.
- Help parents to reflect on their own parenting strengths and challenges.
- Help parents to think about how their child's challenging behaviours may be related to his/her relationship difficulties with the parent, and suggest strategies for improving parent-child attachments.

One of the most widely used parenting programs known to promote healthy attachment is Parent-Child Interaction Therapy (also NCAST, the Nursing Child Assessment Satellite Training). Other programs designed to support healthy relationships between young children and their parents include: Attachment and Biobehavioral Catch-up (ABC); Bringing Baby Home; Child-Parent Psychotherapy (CPP); The Circle of Security (COS); Dyadic Developmental Psychotherapy; DIR/Floortime; Modified Interaction Guidance; Parent-Child Mother Goose Program; Partners in Parenting Education (PIPE); Promoting First Relationships (PFR); Right from the Start; Theraplay; Watch, Wait, and Wonder (Appleyard & Berlin, 2007 (Trifunov, 2007). Trifunov (2002) provides a more thorough discussion of attachment and programs that foster healthy attachment. In particular, Trifunov presents a detailed description of Ainsworth's (1972, 1978, 1989) three categories of attachment and a fourth category of attachment later identified as insecure-disorganized/disoriented by Main and Soloman (1990). Trifunov also provides explanations of the different phases of attachment.

Criteria for Determining Efficacy of Parenting Education Programs

Researchers often use different evaluation criteria when rating the effectiveness of parent training programs. They debate the terminologies and establish minimum requirements for interventions to be regarded as effective. As discussed by Turner (2006), the term *efficacy* is typically used to describe outcomes from clinical evaluation of interventions within controlled research environments, with carefully defined populations, tight experimental controls (e.g., randomized group comparison methodology), and outcome measurement in targeted areas, using clinically validated tools. The terms empirically based or evidence-based refer to interventions that have undergone rigorous efficacy research.

Adopting an intervention that has been identified as *effective* does not guarantee that the various strategies and procedures used will be effective in another context. Additionally, the availability of insufficient evidence to determine the effectiveness of an intervention should not be interpreted as evidence that the intervention is ineffective. Insufficient evidence indicates that further research is merited in the intervention.

To be considered ready for broad dissemination, an intervention must meet effectiveness criteria that have been established, have the ability to go to scale, including program materials, cost information, and monitoring and evaluation tools available for practitioners. Following dissemination, further examination of effectiveness in community settings should involve assessment of the cost-effectiveness of evidence-based interventions, considering client outcomes within the context of staff training and staff retention and changes in service delivery practices (see Turner, 2006).

The Cochrane Collaboration is the largest organization in the world engaged in the production and maintenance of systematic reviews. These reviews are available online through the official website: <http://www.cochrane.org>. Several large organizations, such as Rand Corporation's *Promising Practices Network*, the Office on Child Abuse and Neglect's *Emerging Practices*, and The California Evidence-Based Clearinghouse for Child Welfare have devoted a major portion of their work to establishing evidence-based criteria that can be used to compare and classify the relative effectiveness of programs. The criteria include evaluation quality, research design, sample size, outcomes, defined goals, and the existence of measures that can assess changes related to outcomes. The set of terms used by other organizations may include "well-established", "efficacious" or "experimental."

The California Evidence-Based Clearinghouse for Child Welfare (website: <http://www.cachildwelfareclearinghouse.org/>) is an organization that helps to identify and disseminate information regarding evidence-based practices relevant to child welfare. The organization has developed a classification system that uses criteria regarding the clinical and/or empirical support for a program, the program's acceptance within the field, and the potential of the program for harm to assign a summary classification score on a scale from 1 to 6. A lower score represents a greater level of scientific evidence and support for the practice (an *effective practice* with the strongest evidence) and a larger score represents a lower level of scientific evidence and support for the practice (a *concerning practice* that appears to pose substantial risk

to children and families).

California Evidence-Based Clearinghouse for Child Welfare

The detailed description of the California Evidence-Based Clearinghouse for Child Welfare rating scale is as follows:

1. Well Supported - Effective Practice

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it.
- **Multiple Site Replication:** At least two rigorous randomized controlled trials (RCT's) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.
- In at least two of the RCT's meeting criteria for "C" above, the practice has shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of the evidence supports the effectiveness of the practice.

2. Supported - Efficacious Practice

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
- At least two rigorous randomized controlled trials (RCTs) in highly controlled settings (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.
- In at least two of the RCT's meeting criteria for "C" above, the practice has shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

3. Promising Practice

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describe how to administer it.
- At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) has established the practice's efficacy over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

4. Acceptable/Emerging Practice - Effectiveness is Unknown

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.
- The practice lacks adequate research to empirically determine efficacy.

5. Evidence Fails to Demonstrate Effect

- Two or more randomized controlled trials (RCT's) have found the practice has not resulted in improved outcomes, when compared to usual care.
- If multiple outcome studies have been conducted, the overall weight of evidence does not support the efficacy of the practice.

6. Concerning Practice

- If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or
- There is a reasonable theoretical, clinical, empirical, or legal basis suggesting that the practice

constitutes a risk of harm to those receiving it, compared to its likely benefits.

Rand Corporation Promising Practices Network

Rand Corporation operates the Promising Practices Network, a group of individuals and organizations who are dedicated to providing quality evidence-based information about what works to improve the lives of children, families and communities. Rand Corporation is a "nonprofit research organization providing objective analysis and effective solutions that address challenges facing the public and private sectors around the world" (www.promisingpractices.net). In addition to more than 150 researchers and consultants who are RAND staff, organizational and individual members partner with RAND to provide guidance. Programs may be evaluated if they impact one of the following groups of indicators: healthy and safe children, children ready for school, children succeeding in school, strong families. As described on the Promising Practices Network website, the following evidence criteria are used to evaluate programs:

1. Proven Program:

- Program must directly impact one of the indicators used on the site.
- At least one outcome is changed by 20%, 0.25 standard deviations, or more.
- At least one outcome with a substantial effect size is statistically significant at the 5% level.
- Study design uses a convincing comparison group to identify program impacts, including randomized-control trial (experimental design) or some quasi-experimental designs.
- Sample size of evaluation exceeds 30 in both the treatment and comparison groups.
- Program evaluation documentation is publicly available.
- Additional considerations play a role on a case-by-case basis. These may include attrition, quality of outcome measures, and others.

2. Promising Program:

- Program may impact an intermediary outcome for which there is evidence that it is associated with one of the indicators.
- Change in outcome is more than 1%.
- Outcome change is significant at the 10% level (marginally significant).
- Study has a comparison group, but it may exhibit some weaknesses, e.g., the groups lack comparability on pre-existing variables or the analysis does not employ appropriate statistical controls.
- Sample size of evaluation exceeds 10 in both the treatment and comparison groups.
- Program evaluation documentation is publicly available.

- Additional considerations play a role on a case-by-case basis. These may include attrition, quality of outcome measures, and others.

3. Not Listed on Site:

- Program impacts an outcome that is not related to children or their families, or for which there is little or no evidence that it is related to a PPN indicators (such as the number of applications for teaching positions).
- No outcome is changed more than 1%. No outcome change is significant at less than the 10% level.
- Study does not use a convincing comparison group. For example, the use of before and after comparisons for the treatment group only.
- Sample size of evaluation includes less than 10 in the treatment or comparison group. Distribution is restricted, for example only to the sponsor of the evaluation.
- Additional considerations play a role on a case-by-case basis. These may include attrition, quality of outcome measures, and others.

Characteristics of Effective Parenting Programs

What makes an effective parenting program? Surprisingly, the research available to answer this question remains inadequate. Early observations on the effectiveness of parenting programs made by Harmon and Brim (1980; cited in Fine & Henry, 1989) still ring true with researchers, even though over a quarter of a century has passed:

Our summation of the available evaluation research. . . rests on the premise that it is woefully inadequate - a reflection on the state of research and not necessarily on parent education itself. (p. 254)

Fine (1980; cited in Fine & Henry, 1989) elaborates on the effectiveness of programs at that time:

The findings to date are mainly that parents like parent education programs, each type of parent education program has its devotees, and many parents report that they are being helped. More empirical evidence is needed to support or refute these impressions, to discriminate among the input variables in parent education programs in relation to outcomes, and to study more holistically the effects of parent participation on family structure. Such research will inevitably lead the practitioner to develop and implement more effective parent education programs. (p. 23)

One of the major stumbling blocks that has prevented the evaluation process from progressing with time is that small, locally developed and implemented programs often have little funding

available to assessing program effectiveness and improvement in the manner discussed above by Fine (1980). As identified in the literature, the effectiveness of parenting education programs is typically assessed in terms of the program's ability to achieve its goals. Since each parenting program has a unique set of goals, comparison of outcome criteria among programs is a problem (Fine & Henry, 1989). Effective parenting programs vary in instructor qualifications, curriculum content, strategies, number of sessions, length of program, time spent with children, and target population. Some research indicates that there are broad principles and characteristics common to effective parenting education programs (Colosi & Dunifon, 2003; Corcoran, 2000; Dillon Goodson, 2005; Dore & Lee, 1999; Kumpfer, 1999; Layzer et. al., 2001; McMahon, 2006; Riley, 1994; Riley & Bogenschneider, 1992; Shaw, 2006; Tsang & Leung, 2005). These are listed below.

Effective Parenting programs:

1. Clearly state program goals as measurable outcomes. The emphasis is often on producing attitudinal, knowledge and behavioural changes on parents, children, the family unit, and the community as outcomes. The goals should include measures that can assess potential changes in the outcomes as a result of the program.
2. Are targeted to a specific age and/or developmental stage of children (e.g. "terrific twos"), and are accompanied with specific goals and outcomes.
3. Are of sufficient length and intensity relative to the severity of risk factors of the family. Most evidence-based programs require parental participation over 8 to 12 sessions (Bradley et al., 2003). Programs designed to support parents over the long term are more effective than those offered with a short term focus. They usually include repeated and intensive contact with parents ranging from several months to one or two years.
4. Target the whole family rather than solely the children or their parents.

Family-focused programs are generally more effective for families with relationship problems than either child-focused or parent-focused programs, particularly if they emphasize family strengths, resilience, and protective processes rather than deficits (DeMarsh & Kumpfer, 1985; Dision & Andrews, 1995).

5. Are tailored to important developmental milestones or major transition points in family life (e.g. new parents, parents that have newly divorced).

Interventions at milestones or times of transition are generally welcomed by parents because it is at those times that they are seeking information and support (Cowan & Cowan, 1995).

6. Focus on parental assets, rather than on the deficits or weaknesses parents may possess.
7. Incorporate an ecological approach to program content and design, which acknowledges the influence of neighborhoods, schools and the workplace on parenting. Successful programs tend to emphasize parenting and factors that might compromise its functioning, including consistent caregiving in other contexts (e.g. daycare, preschool), maternal well-being, the

economic dependence of the family, and marital quality. Rather than focusing on just one aspect (such as changing parental behaviour), the most successful programs affect the systems surrounding the parent and child as well. For instance, they may link the parent to continuing sources of social support through parent discussion groups, and connect parents to formal services when needed.

8. Involve parents in planning the design, content and evaluation of programs in which they will be active participants.

Community-level needs assessment studies provide valuable information which can help ensure that the parenting program(s) will consider and be responsive to the unique needs of the parents and families. Such studies should be conducted regularly in order that programs are able to monitor and address the changing needs of parents.

9. Recognize and target individual differences and needs in children, parents and their families; they make use of multiple-level delivery systems and intervention strategies to address individual needs. Offer both in-home visitation and group components.
10. Have developed ways to maximize parental investment by emphasizing the importance of early child development and link it to parenting skills and healthful parental decisions regarding their own well-being.
11. Develop collaborations with other organizations and agencies to make available a broad range of services that can assist and support parents. The reason that this works is that most organizations can only respond to part of the ecology of parenting. This also helps to avoid duplication of the efforts and expertise of others.
12. Employ staff members who have excellent interpersonal and facilitative skills, are well qualified and trained to deliver the program, sensitive to individual needs, and have good emotional health.

Effective programs devote considerable time to the initial training of staff and maintenance of staff qualifications over time. Some research has suggested the need for effective programs to make use of professional, trained staff to help parents rather than using paraprofessional staff. One reason suggested is that professional staff are usually bound to an ethical standard of conduct that non-professionals may not be. A major conflict with this view has been the argument of some that "parents can lead parents" (see Fine & Henry, 1989). Such a view is sometimes promoted by commercial parenting programs that downplay the importance of leader qualifications. As discussed by Debord (2002), paraprofessional parenting educators can develop into professionals through extensive participation in professional development activities.

Earlier research by Alexander, Barton, Schiavo and Parsons (1976) suggested that the effectiveness of parenting programs is highly tied to the trainer's personal efficacy and confidence, affective characteristics of genuineness, warmth, humor and empathy, and ability to structure sessions and be directive.

13. Have specific training programs and support material available to assist in the standardized use and dissemination of the parenting program,
14. Recognize and respond to cultural differences and their effects.

Tailoring parent training to recognize and be respectful of the cultural traditions of families improves recruitment, retention, and sometimes the effectiveness of the outcomes (Kumpfer, Alvarado, Smith & Bellamy, 2002; Turner, 2000).
15. Often provide parents with opportunities for peer support through group based learning.
16. Correct parents' negative interpretations of children's behaviours.
17. Have a problem solving focus.

Development of a collaborative process whereby parents are empowered to identify their problems and own solutions is important in developing a supportive relationship and reducing parent resistance and dropout (Sanders & Dadds, 1993; Webster-Stratton & Herbert, 1994).
18. Include anger and stress management components.
19. Employ interactive skills training methods (e.g. role play, active modelling, family practice sessions, homework practice and videos/CDs of effective and ineffective parenting skills, etc.) versus didactic lecturing. Such methods have been found to increase program effectiveness and client satisfaction, particularly with parents of low socioeconomic level (Webster-Stratton, 1994).

Factors Limiting the Effectiveness of Parenting Programs

Parenting programs are not effective with all families, and differ in their effectiveness with individual parents and children. Research suggests that the effectiveness of parenting education and parent support programs may be limited by the following factors, which may work alone or in combination with other factors (Boggs et al, 2004; Brown, 2001; Colosi & Dunifon, 2003; Hensler, Wilson & Sadler, 2004; Sanders & Ralph, 2004; Thomas, 1996):

1. Ingrained Parental Beliefs and Behaviours

Particularly when they are under stress, parents may continue to parent in ways that are familiar to them, even if they have acquired new parenting skills and knowledge about child development and want to change their behaviour. In addition to being influenced by the characteristics of the parent, the child, and the spousal relationship, environmental factors such as parents' social networks, their work environment, and their religious affiliations may influence parental beliefs. Some parents do not believe that they can influence the

development of their children, or believe that the extent to which they can do so is very limited. Some parents are less motivated to participate in parenting programs as they do not perceive their children to be at sufficient risk for problems.

2. *Insufficient Program Length/Intensity*

Program delivery must be intensive enough to bring about the desired change(s) in parental beliefs and behaviours within the allotted time. Many factors influence parent participation in, enthusiasm for and compliance to programs. Therefore, the level of program intensity required to produce the desired changes may be different with each parent involved.

3. *Parental Characteristics*

Parents who acquire knowledge may not be able to turn that information into the desired behaviour. Parental interest, abilities and participation in parenting programs may be limited by factors such as: cultural values, negative experiences with institutions that offer the programs, language barriers, income, time constraints, accessibility of programs, privacy concerns, low literacy, spousal conflict, domestic violence, parental deficits in social skills, parental deficits in communication skills, ineffective coping strategies and other factors. A parent who has a poor developmental history, psychological difficulties, and/or a drug or alcohol addiction may not be ready or able to learn skills that build better parent-child relationships. Some parents may have such great developmental needs of their own that they may have to attend to before they are able to effectively participate in programs that focus on their children.

4. *Program Characteristics*

Programs must be well suited and/or sufficiently adaptable to parents' individual contexts and environmental conditions. Parents who are stressed by personal and environmental conditions (e.g. neighborhoods with recurrent violence, persistent unemployment) may not be able to sufficiently benefit from programs that are not specifically tailored to their needs/contexts.

Parenting programs should strive to reduce levels of parental frustration by providing parents with the types of knowledge and skills that they seek/need. Findings from the National Survey of Early Childhood Health indicated that parental frustration predicts frequent use of early discipline practice, including a greater inclination to use aversive practices, and that lower parental emotional well-being is associated with reports of frequent yelling and spanking. Child developmental risk is associated with increased reports of yelling. Parents participating in the survey indicated that during health care visits, "guidance and discipline" is one of the least often discussed topics of children aged 10 to 18 months (43%) and children aged 19 to 35 months (45%). More qualitative research is needed to understand the reasons that parents use specific kinds of discipline techniques. Parke (2002) suggests that advising parents against the use of physical punishment is likely to be effective only if productive alternatives can be proposed.

5. *Low Program Participation Rates*

Low participation rates of parents in evidence-based parenting interventions have proven to be a major problem in the delivery of parenting programs (see Sanders & Ralph, 2004), especially for the families who are considered most at risk for the development of serious behaviour problems (Sanders et al, 1999). This has influenced the development of parenting interventions of varying intensity, alternative delivery formats (e.g. videotapes/DVDs, workbooks, reading materials, the Internet), and the development of other venues for parenting programs to take place (primary health care settings, places of work, schools, religious organizations).

6. *Program Attrition/Dropout Rates*

Attrition during parent training programs is high; some programs experience parent attrition ranging from 40% to 60% (Wierzbicki & Pekarik, 1993). Some parents drop out of programs even before they begin the training; waiting lists to participate in programs are commonplace, and the delay between signing up for a program and beginning the training is often too long for parents to remain committed. High dropout rates pose significant barriers to effective service delivery. The causes and effects of parental attrition in parent training programs remains a largely unexamined area.

7. *Insufficient/Inadequate Training Materials*

This refers to insufficient manuals, training materials, or other resources available to parenting instructors which specify the components of the treatment protocol and how to conduct it.

8. *Insufficiently Qualified Staff*

Some programs/treatments are complex, and cannot be delivered by typical professionals who have received a reasonable level of training and supervision in its use.

One study indicated that the qualifications and social work experience of staff/facilitators impact the effectiveness of parenting programs (Tsang & Leung, 2005). Participants showed more significant changes pre-program and post-program in groups with facilitators who had higher qualifications (Master of Social Work and Bachelor of Social Work) than in groups with less qualified facilitators (Diploma of Social Work/others).

9. *Ingrained Beliefs and Behaviours of the Parent Educator/Leader*

The personal styles and attitudes of therapists cannot be separated from the therapy they provide (see Fiske et al., 1970; cited in Medway, 1989). Parents are more likely to implement the recommendations of more experienced psychiatric consultants than less experienced ones (Davidson & Schrag, 1969; cited in Medway, 1989).

10. Unsuitable Delivery Settings

Treatments that cannot be effectively delivered in common service delivery settings that provide population health services (such as clinics, schools, places of worship, etc.)

11. Barriers at Various Ecological Levels

Barriers to change at different ecological levels in each community/region must be overcome in order to fully implement evidence-based practices in the everyday, less structured and controlled ways that are characteristic of many services in population health approaches. The following key questions related to the identification of these barriers are adapted from the Kauffman Best Practices Project (Hensler, Wilson & Sadler, 2004) as follows:

- (a) Environment/Community Level: What barriers in the broad environment/community must be overcome to adopt and implement the parenting program? The environment/community includes barriers related to community acceptance of this program, cultural barriers to accepting the program, regulatory barriers, specific financial support barriers, etc.
- (b) Organizational level: What barriers exist within organizations (the health region, child advocacy groups, social service agencies, schools, hospitals, etc.) to adopting and implementing a parenting program?
- (c) Microsystem level: What barriers exist in microsystems within organizations (e.g. counselling department of a multi-service agency) to adopting and implementing the parenting program?
- (d) Individual level: What barriers exist to the adoption and implementation of a parenting program at the individual parent or individual clinician level? This would include barriers to therapists accepting and/or properly using the practice, or to a family or child's willingness to engage in the specific intervention.

Classification of Parenting Programs

Within the literature, parenting programs have been categorized in different ways:

A. Programming based on the types of service needs or delivery mode of children and families in their communities; for example:

- (a) Home-based/home visitation parenting programs. These provide child development services primarily through frequent home visits as well as through parent-child group socialization activities.
- (b) Center-based programs. These provide child development services primarily through

centers supplemented by parenting education and family support services.

- (c) e-Parenting or Web-Based Programs. These provide services to parents over the Internet. Web-based programs are often provided as an alternative way for parents to access parenting assistance if other types of programs are inaccessible or inconvenient.
- (d) Mixed-approach programs. These provide home-based services to some families, center-based services to some families, and a mix of home and center based services to some families. The mix of services varies, depending upon how the program is designed to meet families' needs.

Parenting Programs Delivered through Home Visitation Programs

Home visitation programs are social service programs that employ visits to the home as the core service (Rapoport & O'Brien-Strain, 2001). Home visitation has been a popular strategy for providing some or all components of parenting education programs - especially to families with multiple risks who may otherwise not seek or be able to access necessary assistance. It may be the only way to educate and support parents with multiple risks because they are least likely to attend conventional parenting education classes, go to clinics for prenatal or infant care, attend parent support groups, or find quality preschool experiences for their children (Hamburg, 1992). By visiting families in their homes and neighborhoods, home visitors can work with hard to reach parents and better understand the conditions that influence their parenting (Brown, 2001).

Parenting education is often only one component of home visitation programs, and is offered in an integrated manner with a larger array of support services. Delivery of a parenting program curriculum may be a small part of the numerous services provided by home visitation programs. There are typically two types of home visitation programs, "universal access" and "targeted access". Universal programs often systematically screen all families living in a variety of community niches through the use of individual risk assessment tools such as checklists. Theoretically, universal programs are available to all families who qualify based on individual-level requirements. Targeted programs are provided to families qualifying through some eligibility criteria based on demographic or population-based characteristics, such as first-time parents or teen mothers. Targeted programs do not screen on an individual level, and often experience difficulties in enrolling, engaging and retaining families.

Most home visitation programs seek to achieve multiple goals. Stated broadly, these include enhancing parental knowledge, attitudes and behaviours; promotion of child development; promotion of child health; prevention of child abuse and neglect; and promotion of maternal development (Brown, 2001). These programs must allow service provider flexibility to enable adequate and appropriate response to the changing needs of families.

As with the evaluation of parenting program, many difficulties have been encountered in the evaluation of home visitation programs; results have been largely mixed and inconsistent. A

major reason for this is that the complex social changes that are frequently expressed as desired outcomes of these programs are often interdependent and not easily measured. In addition, program elements, immediate outcomes, long-term outcomes, activities, strategies and evaluation plans vary widely from one program to another. Many of the outcomes are measured by self-reported variables, which may be unreliable and are often subjectively interpreted. Positive effects are not always extended across models with similar services, across different subgroups in the population, or across different replications of the same program (Rapoport & O'Brien-Strain, 2001). The voluntary participation in such programs also makes it difficult to predict whether findings can be generalized to other populations. These issues make it difficult to attribute the actual impact of home visitation on individual outcomes.

For programs studied using rigorous evaluation techniques, there is evidence of positive impacts of home visitation programs on the well-being of young children and their families. A review of the literature on home visitation programs found that almost all of the programs were associated with at least one improvement in the home environment or in parenting skills (Rapoport & O'Brien-Strain, 2001). Support visits for new parents have been found to improve mental health in children and parents in disadvantaged communities (NHW Centre for Reviews and Dissemination, 1997). Some research suggests that home visitation programs are more likely to affect parental nurturance than other parenting behaviours (Brooks-Gunn, Fuligni & Berlin, 2003; Van IJzendoorn, Juffer & Duyvesteyn, 1995).

Centre-Based Programs

Centre-based parenting programs generally operate out of schools, hospitals, universities or other agencies. They may provide child care, classes in child development and parenting, and other information and services. Centre-based early childhood education programs with a parenting component are often referred to as "center plus" programs. Some research suggests that center plus programs have positive effects on children such as improved vocabulary, reading achievement, math achievement, and IQ; but that they have few effects on socioemotional development in preschool (Barnett, 2002). School based interventions and parent training programs for children with behavioural problems have been found to improve both conduct and mental well-being (NHS Centre for Reviews and Dissemination, 1997).

e-Parenting or Web-Based Programs

While accurate numbers related to the access of parenting information through the Internet are not known, Long (2004) suggested that in 2003, over 48,000 web pages existed on the topic of parenting through the use of only one search engine (Google). E-Parenting programs enables families to access programs from home or their own communities, and participate in live webcasts featuring special guest speakers. Concerns about the privacy and confidentiality of potentially sensitive information shared on-line must be addressed before parents will feel free to use e-parenting on a wide-scale basis (Long, 2004).

There is a very limited evidence base regarding the effectiveness of web-based parenting programs. The evaluation of such programs will be even more difficult with the trend

towards a convergence of different technologies (e.g. computers and television will become more closely linked). The e-Parenting Network (www.eparentingnetwork.ca), funded in part by Human Resources Development Canada, and a program of the Canadian Institute of Child Health, is an innovative multimedia network that involves interactive web TV modules on various topics including child safety, nutritional issues, breastfeeding, vehicle/passenger safety, home safety, neighborhood safety, and positive parenting.

As discussed by Long (2004), there are significant concerns about the reliability and validity of parenting information available on the Internet. While such concerns exist for parenting programs delivered through other methods, the ease of disseminating the information "makes it a spawning ground for inaccurate and incomplete information (p. 374)". Long suggests that while e-parenting services may be cost-effective and intriguing, they may not always be in the best interests of many parents and children. Commercial sponsorships of websites, financial incentives related to program use, and programs that are sold to consumers for profit raise ethical concerns. The content of e-parenting programs may be more vulnerable to commercial influences and exploitation by unqualified entrepreneurs who are not bound by a professional code of ethics (Long, 2004).

B. Programming based on overall *types of outcomes desired*; for example:

- (a) Prevention programs, and
- (b) Intervention programs

C. Programming focused on parenting at *specific stages of child development*; for example:

- (a) Pre-natal programs,
- (b) Programs for infants/toddlers,
- (c) Programs for school-aged children, and
- (d) Programs for pre-adolescents

D. The *theoretical accessibility* of programs by parents in the population.

For instance, either programs that are *targeted* at a certain group of parents or *universal access* programs that are accessible by any parents. Some targeted programs are offered within larger universal programs. Universal access parenting education programs are offered to all parents, and are designed to inform and prepare parents for the duties and responsibilities of parenthood. They often focus on the safety and health of the child, occur in the child's early years, and are offered to parents to provide them with support and information. Universal programs may be thought of as primary prevention activities. From a public health perspective, their intent is to provide services to the broadest group of individuals in order to prevent developmental delays, prevent a health-threatening condition

from occurring, or to promote an optimal condition (Smith, Perou & Lesesne, 2002).

As described by Smith, Perou and Lesense (2002, pp. 395-397), some examples of long-lived *universally available* parenting programs that have been implemented over the past thirty years include:

- (1) Missouri Parents as Teachers (PAT) Program. Developed in 1981 by the state of Missouri, the major goals of the program are to assist parents in gaining knowledge of child development in order to give their children a solid foundation for school success and to increase parents' feelings of self confidence and competence. The program was revised in 1996 by the Parents as Teachers National Center to reflect the latest understandings about brain development and improved outcomes for children. The title of the new curriculum is *Born to Learn*. It typically includes home visits by credentialed para-professional parent educators who provide information on the child's development, model and involve parents in age-appropriate activities, and respond to concerns or issues that parents may have regarding their children. Parents also share insights and develop a support network in monthly group meetings.

- (2) Early Childhood Family Education Program (ECFE). Founded in 1975 by the Minnesota Department of Education, the program was designed for all families with children from birth through kindergarten. The goal of the program is to enhance and support the competence of parents in providing the best possible environment (developmentally appropriate) for the healthy growth of their children. Parents and children participate in weekly sessions that promote creative play activities, special events, and parental problem solving.

- (3) Minnesota Early Learning Design (MELD). Founded in 1973 by Ellwood, it is a primary prevention program for expectant parents and parents of children up to 2 years of age. The goal is to address the "universal needs" of parents through providing information in the areas of health, child development, child guidance, family management, and parental personal growth. The services are designed to be flexible and to meet the needs of targeted populations as well.

Universal access programs may focus on enrolling families with a "target" aged child (e.g. infant or pre-school age); however, the programs themselves are open to all families, not just those who are considered at risk for developmental or other problems. Universal programs may be thought of as primary prevention activities, which, from a public health perspective provides services to the broadest group of individuals (Smith, Perou, & Lesnsne, 2002).

Targeted programming may include:

- (a) Programs for parents of pre-school children,
- (b) Programs for parents of children with severe behavioural disorders,
- (c) Programs for parents of infants with fetal alcohol syndrome,

- (d) Programs for teen-aged parents,
- (e) Programs for parents with low incomes,
- (f) Programs for parents who are single,
- (g) Programs for parents who are divorcing or are divorced, and
- (h) Grandparents who are parenting grandchildren.

F. Programming focused on *specific parenting issues*; for example:

- (a) Appropriate discipline
- (b) Antisocial behaviour and chronic delinquency
- (c) Substance use prevention
- (d) Inter-parental conflict

G. Programming based upon *philosophical underpinnings*; for example:

(a) Behavioural Focused Approaches.

Behavioural approaches are based on observable child behaviour and the environmental circumstances that allow behaviour problems to persist. Such approaches use specific behaviour modification techniques to reinforce desirable behaviour and control undesirable behaviour. Such programs include: Triple P-Positive Parenting, the Incredible Years, and 1-2-3 Magic.

(b) Reflective/Relational Focused Approaches.

Reflective/Relational approaches focus on developing relationships and reflective skills. They encourage parents to reflect on the role that both parent and child play in developing relationships. These programs typically make use of techniques such as active listening, understanding and acceptance of a child's feelings. Examples of such programs include: Systematic Training in Effective Parenting (STEP), Parent Effectiveness Training (PET), Tips and Ideas on Parenting Skills (TIPS) and most parent discussion groups.

Philosophical Underpinnings of Parenting Programs

There are discrepancies in the literature regarding the classification of parenting programs by philosophical underpinning. The discrepancies in classification are in part due to the following:

1. Parenting education does not involve a singular process, rather encompasses a wide range of philosophies, programs, purposes and materials (Medway, 1989). Some family-serving agencies offer multiple programs within themselves, each having their own philosophy, goals and target population.
2. Most locally developed programs do not articulate the theoretical model (if any) on which they are based (Tsang & Leung, 2005).
3. Some parenting programs are not theoretically driven. For example, Head Start is a child-focused program that was designed in the United States to increase the school readiness of young children in low-income families. It provides a range of services, including medical, dental, mental health, nutrition and parental involvement; these interventions were intended to reduce or ameliorate the risks associated with being child in a low income, low education family.
4. In practice, some programs, while rooted in a specific theoretical orientation, are not delivered by therapists or parenting education professionals in a manner that is mutually exclusive of another theoretical orientation. This occurs because practitioners must decide the most effective mode of treatment for the child, parents, and family. For example, behaviour modification may be used to correct an isolated problem behaviour manifested by the child in Systematic Training for Effective Parenting (STEP), a relationship-based Adlerian program (Mooney, 1995).

A review of parenting programs by Bunting (2004) acknowledges the considerable overlap that can exist among the classifications; that is, the categories are often not mutually exclusive. Parenting programs are often structured around one of two predominant models of parenting programs: (1) Behavioural and (2) Reflective/Relational. It is often the case that a parenting program does not fit neatly into one of these two categories. There are also programs that are based on components of both models, some that are based on other models, and many that do not identify or subscribe to a particular theoretical base. Additionally, the actual program content and curricula of a particular program may be influenced by the personal philosophies, understandings, and experiences of those who deliver the program.

In the next section, broad descriptions of each model and several examples of parenting programs that may be classified within each are provided to assist the reader in distinguishing between the philosophies. We have only classified a few of the thousands of parenting programs that exist. Over a decade ago, Carter (1996) estimated that there were more than 50,000 parenting programs in the United States alone. These ranged from small 'mom and pop' gatherings to large multimillion dollar operations funded by state and federal governments. Carter (1996) found that

while many of the programs were eclectic in their approach, 75 percent of their contents were similar (cited in Heath, 2004).

Mooney (1995) points out that although the two models are rooted in "fundamentally disparate theoretical orientations", they are not necessarily mutually exclusive in practice. A therapist must consider the most effective mode of treatment, not necessarily the approach that conforms to the philosophical orientation of the therapist. For example, while a Reflective/Relational program may be used with a parent, it may be effective to augment the program with a behavioural modification program to "correct an isolated problem behaviour manifested by the child".

A. Behavioural Programs

Historically, behavioural parent training programs (also referred to as behavioural family interventions) were developed to alter the behaviour of children who exhibited behavioural problems; that is, behaviors that caused problems for the child's development, coping ability, and/or the family functioning. These programs were not developed to be used by parents irritated by their children exhibiting 'normal' behaviors associated with child development and learning, yet are frequently used by parents searching for discipline techniques. Behaviorist programs are based on social learning theories and are strongly influenced by the behaviour modification principles of B.F. Skinner. The focus of early behaviorist programs such as those associated with George Patterson and his colleagues at the Oregon Social Learning Center was to teach parents strategies to increase desirable behaviour and to reduce undesirable behaviour through the use of positive reinforcement (Patterson, 1982; Patterson, Reid, Jones & Conger, 1975) and punishment.

Through the years, behavioural interventions have also drawn extensively on other theoretical perspectives in psychology. As described by Sanders and Ralph (2004), these include:

- Social psychology - which has produced considerable advances in our knowledge of the development of social skills and how children manage social situations;
- Cognitive psychology - which has expanded to provide greater knowledge about cognitive processing and children's learning through skills acquisition, and social processing models;
- Ecological and contextual perspectives - which view parent-child relationships in a broader social setting, including the influence of experiences and support from the neighborhood, community, work, schools and media.

Some aims of behavioural parenting education are to promote child development and self-esteem; and to change children's behaviors by modifying parenting practices, interpersonal relationships and interaction patterns that have been identified as dysfunctional or as risk factors for the development of problem behaviour in children (Medway, 1989; Turner, 2006). In behavioural parent training programs, parents participate in skills training which often involves discussing different reinforcement and timeout procedures, with emphasis placed on the role the parent plays in the development and maintenance of child problem behaviors (Hollenstein, Granic, Stoolmiller

& Snyder, 2004). While behavioural programs have evolved over time, the focus tends to remain on changing child behaviors that irritate parents, with limited attention placed on parental reflection and attempting to understand the root causes of unwanted behaviour.

In an analysis of the theoretical and ideological assumptions on which behaviour modifications books and programs are based, Cagan (1980) found a consistent focus on what the child *does*, and not on thoughts, feelings or attitudes. He discovered that many techniques that were clearly punitive or harsh in nature had been reinterpreted by the program/book so that they no longer "appeared" to be punishment. Cagan also reported that there were significant differences among behavioural modification books and programs, and suggested that, "few parents . . . would be able to set up and follow the elaborate programs which are advocated" (p. 48).

Examples of Parent Behaviour Training Programs

1. Webster-Stratton Incredible Years Program

The Webster-Stratton Incredible Years program was developed as a program for children with severe behavioural disturbances, targeting children between the ages of 4 and 8 years. The short term goals are to reduce and prevent conduct problems in high-risk children, or children displaying conduct problems; and to promote their social, emotional and academic competence. Parents may be self-referred to the program or referred by a professional. Over the years, the program has evolved to include children aged 2 to 10 years old; the purpose of the program has broadened to the prevention of delinquency, drug abuse, and violence (see the official web site www.incredibleyears.com). The basic parent training program includes four separate components. In all four components, facilitators use videotaped scenes to encourage group discussion, problem-solving, and sharing of ideas. The "BASIC Parent-Training Program—Early Childhood" (BASIC—Early Childhood) is a core component of the Incredible Years series and includes 12 to 14 two-hour weekly sessions targeting children age 2 to 7 years old. The BASIC—Early Childhood curriculum emphasizes parenting skills to promote children's social competence and to reduce behaviour problems, and it teaches parents how to play with children, help children to learn, give effective praise and incentives, use limit-setting, and handle misbehavior.

2. Triple P Parenting Program

The Triple P-Positive Parenting Program, developed by Sanders and colleagues at the University of Queensland in Australia is a world-renowned behavioural parenting program that has adopted a population level approach to the promotion of effective parenting. While it is currently being promoted and implemented in some regions as a universal program by its founders, it is important to note that there is currently an insufficient evidence base to substantiate its effectiveness as a universal program. Triple P is a multi-level, preventatively oriented strategy that aims to enhance family protective factors and reduce risk factors associated with child maltreatment with the aim of preventing severe behavioural, emotional and developmental problems and child maltreatment.

A variety of theoretical approaches form the basis for the Triple P program, including social learning models, research into family behaviour therapy, developmental research on parenting and child competence, risk and protective factors identified from the field of psychopathology, social information processing models, and population health perspectives on family intervention that involve the recognition of the broad ecological context of human development (Sanders, Cann, & Markie-Dadds, 2003; Sanders, Markie-Dadds & Turner, 2003). The ecological perspective involves targeting social contexts that parents access for other reasons (e.g. taking a child to the doctor for a check-up) and enabling easier access to parenting services and support.

The Triple P model assumes that differing parental needs require multiple levels of support. It is targeted at five different levels of intervention ranging from universal support (general information for all parents) to mid-range (tip sheets, parenting advice, workshops) to the clinical level (specific services for parents who experience significant problems with their children). The program makes use of a wide range of program delivery modes including newsletters, leaflets, radio broadcasts, newspaper articles, videotapes, telephone help-lines, individual telephone-assistance, and group-based parenting assistance. Such an approach may assist in the reduction of high drop-out rates that have typically been associated with behavioural parenting interventions.

The province of Manitoba is currently expanding training opportunities for the Triple P programs. In 2005, the provincial government announced support of \$1.4 million to initially implement the program in the Winnipeg communities of the North End, Point Douglas, Elmwood and Seven Oaks, the Burntwood Regional Health Authority and the North Eastman Health Association. The Triple P program is one of a number early childhood development programs that Manitoba has invested in to support parents. Partnerships have been developed with community agencies, regional health authorities, child care centres, family resource centres, school divisions, pediatricians, and others. Training is provided to staff of these interested organizations and agencies across Manitoba, enabling parents the opportunity to access supports when needed from trained multi-disciplinary professionals within their community. Those professionals include public health nurses, day care staff, general practitioners, teachers, police officers and home visitors. Triple P is also being delivered in a smaller scale within other areas in Canada, including:

- The Regional Municipality of Halton, Ontario;
- The Children First Mental Health Centre in Windsor and Essex County in Ontario;
- The Windsor Regional Children's Centre in Windsor, Ontario;
- The Society of Organized Services in Parksville, British Columbia;
- Thrive! The Canadian Centre for Positive Youth Development in Waterloo, Ontario

The province of Alberta is currently conducting pilot projects of Triple P in selected Parent Link Centres within several provincial health regions.

3. 1-2-3 Magic

1-2-3 Magic is a behavioural program that teaches discipline techniques to parents of children who are in the range of 2 to 12 years of age. It was developed in the early 1980s by Dr. Thomas Phelan, an American clinical psychologist. The program is based on the assumption that children do not have the same reasoning capacity as adults. The principles of the program suggest that the two largest mistakes parents make when disciplining a child are too much talking (which can escalate into persuading, arguing or worse) and too much emotion (which puts the child in a position of control). Phelan believes that children cannot be reasoned with, and that the parent must tell the child what is acceptable behaviour and what is unacceptable.

1-2-3 Magic is typically taught in a group format with one or two 1.5 hour sessions per week for 4 to 8 weeks, where the recommended group size is 6 to 25. However, individuals can purchase or often borrow the training materials and educate themselves. According to the program, there are two basic issues. Either the child is doing something the parent wants them to *Stop*, or the child is not doing something the parent would like them to *Start*.

The training program emphasizes three steps:

- (1) Control obnoxious behaviour. Learn a simple technique to get your child to Stop what you do not want them to do (whining, arguing, tantrums, sibling rivalry, etc.)
- (2) Encourage good behaviour. Learn several effective methods to get your child to Start doing what you want them to do (cleaning rooms, going to bed, homework, etc.)
- (3) Strengthen relationships. Learn powerful techniques that reinforce your bond with your child.

Some of the behavioural management strategies used in this program include using positive verbal feedback, use of a kitchen timer method to challenge children to complete a task faster, a docking system where something is taken away (e.g. TV time, allowance) if something else (e.g. chores, homework) goes uncompleted, reminders of consequences, and a charting of behaviors. The main technique in this program is the use of time-outs. It is based on the principle that parents should not feel intimidated by demands or threats made by their children, nor give in to temper tantrums. For example, the parent counts aloud to the offending child by saying, "That's 1", "That's 2" and finally "That's 3 - now take 5", and then immediately have the child take a 5 minute time out in a specified, isolated location.

4. Confident Parenting Program

The Confident Parenting program was developed in the early 1970s by behavioural psychologist Dr. Robert Aitchison and his colleagues for use as a prevention and treatment program in the child mental health field. The formally structured program is grounded in the learning theories and principles associated with B.F. Skinner; it represents a social conditioning or social learning theory to parent training. The main goal of the program is to teach parents to reinforce children's

pro-social behaviors while redirecting deviant behaviors. The program teaches a restricted range of social principles with the use of reinforcing consequences. The consequences can be non-social (food, money, privileges, etc) or social (praise, punishment, attention).

The original program was developed for use in child mental health settings with parents whose children ages 2 through 12 were experiencing behaviour or emotional problems. With the dissemination of the program across the U.S., it is now being used more broadly in child protective service agencies as a treatment program for abusive parents, by early childhood education programs as part of their school readiness efforts, and in church-based programs as part of their general parenting education efforts (see official web site: www.ciccparenting.org). The program is delivered in 10 two hour sessions for small groups or in one day seminars for large groups. Parents learn how to use behaviour-specific praise, mild social disapproval, time outs, ignoring, and special incentives.

5. Parents are Teachers

Parents are Teachers, developed by Dr. Wesley C. Becker (1971), is a programmed child management book designed to train parents in systematically applying consequences based on behavioural principles (Lee & Brage, 1989). The book stresses the importance of using clear instructions and consequences in teaching appropriate behaviour to children. The contents of the book include: the use of reinforcement and punishment as consequences; kinds of reinforcements and punishments; how to reinforce and when to reinforce. Each unit is followed by a brief summary of major points and set of exercises. This program should not be confused with the "Parents as Teachers" program first developed by the state of Missouri.

6. Common Sense Parenting

Common Sense Parenting of Toddlers and Preschoolers is a parenting book that was written by Bridget Barnes and Steven York of Girls and Boys Town, an organization that specializes in the treatment and care of abused, abandoned and neglected girls and boys. The book was designed so that parents would find it practical, accessible and "parent friendly". As identified on the program's web site (www.boystownpress.org), Common Sense Parenting teaches how parents can "balance nurturing behaviors that demonstrate love and affection with the discipline all children need to learn and thrive." Based on an underlying behavioural approach, it offers information to parents about issues such as setting reasonable expectations for young children based on the child's age, development and abilities; teaching social skills; self-control; using consistency, consequences, and practice to help children learn expectations, how to create family traditions from everyday routines; and handling practical issues around toilet training, bedtime, and meals.

B. Reflective or Relationship-Based Programs

Reflective/Relationship-based parenting education (sometimes referred to as a Democratic approach) places a major emphasis on parental awareness, understanding, and acceptance of the child's feelings. It uses feelings as a means of affecting the child's behaviour and the parent-child interaction (see Medway, 1989). A variety of approaches based on different but related theories fall under this category. Some reflective/relationship-based parenting education programs are rooted in the client-centered therapy of Carl Rogers and parents are trained to use communication techniques used in that therapy. Attachment theory is the theoretical basis for relationship-based parenting programs. This is supported by evidence that secure attachment is significant for human development (National Research Council and Institute of Medicine, 2000). A relationship-based parenting intervention may provide the first trusting and desirable relationship a parent from a high risk population has experienced. Therefore, relationship-based programs perform a critical role in parental development, thus increasing the likelihood of attaining desirable long-term goals for both parent and child (Hiatt, Sampson & Baird, 1997). According to a report by the National Research Council and Institute of Medicine (2000), "the most reliable outcome of a secure attachment in infancy is a more harmonious parent-child relationship in the immediate years to come" (p. 236). It is important to emphasize that secure attachment in infancy does not guarantee the development of future positive developmental outcomes. However, research indicates that children with secure attachments generally have less difficulty in developing positive, supportive relationships with teachers, friends, and others.

The psychological theory of Alfred Adler has been applied to child rearing by Dinkmeyer and McKay (1976), Dreikurs and Soltz (1964), Popkin (1983), and others. Adler's approach is based on a democratic lifestyle based on social equality of parents and children. Accordingly, the Adlerian model focuses on understanding the goals of misbehavior, establishment of cooperative family environments, the use of logical and natural consequences to elicit cooperative behaviour, and the emphasis on mutual respect and encouragement techniques. In this approach, the misbehavior of children is viewed as being subconsciously directed toward gaining attention, obtaining power, or seeking revenge. Dreikurs viewed the goal of parenting as helping a child to become an adequate person who uses constructive means to obtain his or her own sense of significance and status (see Lee & Brage, 1989).

Examples of Reflective or Relationship-Based Programs

1. Parent Effectiveness Training (P.E.T.)

One of the original parenting programs offered in the United States, and based on Carl Rogers' work on client-centered psychotherapy (1957), Parent Effectiveness Training or P.E.T. was developed and introduced by Dr. Thomas Gordon in 1962 as a program for improving parents' childrearing practices. In 1970, he published his first book for parents, and in 1997, he developed a video-based version of P.E.T. called Family Effectiveness Training (F.E.T.).

The purpose of the P.E.T. program is to provide parents with insights and skills needed to raise more responsible children and to foster more satisfying family relationships through emphasis on communication and listening skills. It is based on the belief that children are not bad or mischievous; they simply behave in ways that satisfy their particular needs at the moment, and that it is the conflicting needs of parents and children that leads to power struggles, resentment, and the erosion of the parent/child relationship (see the official website of P.E.T., www.gordontraining.com). According to P.E.T., an effective parent would be genuine; self-disclosing; fallible; accepting and respectful of the feelings, ideas and values of spouses and children; and fair, using influence or persuasion rather than power (rewards and punishments) to meet personal needs (Alvey, 1994; cited in Smith, Perou & Lesesne, 2002). P.E.T. is a formally structured course that is intended to assist parents in building a warm, close and enjoyable relationship with their child and supporting the needs of each family member through fostering a family environment (Smith, Perou & Lesesne, 2002).

2. Systematic Training for Effective Parenting (S.T.E.P.)

Systematic Training for Effective Parenting (S.T.E.P.) was published in 1976. It was written by Don Dinkmeyer and Gary McKay, who were students of Rudolf Dreikurs. Dreikurs' work was based on the work of the psychologist Alfred Adler, of whom he had been a student. The S.T.E.P. program is based upon encouragement, mutual respect, discipline that is consistent with behaviour, firm limits, choices, making suggestions, joint decision making by parents and children, and a democratic family atmosphere. S.T.E.P. emphasizes the use of natural and logical consequences instead of reward and punishment discipline techniques. It stresses that encouragement will develop positive behaviour in children, and that motivation is important for the child to develop self control and self sufficiency (Lee & Brage, 1989). S.T.E.P. incorporates some of the communication strategies that are taught in the P.E.T. program. The program is based on four basic principles to building positive relationships (Alvy, 1994):

- Demonstrating mutual respect - Parental respect is earned by showing respect for the child's feelings, thoughts and privacy;
- Taking time for fun - Ensuring regular enjoyable times with children and the entire family;
- Encouragement - To feel adequate, children need frequent encouragement through minimizing the importance of children's mistakes while recognizing their assets and strengths;
- Communicating love - Spontaneous verbal expressions and nonverbal signs such as pats, hugs and kisses.

3. Active Parenting

Active Parenting, developed by Dr. Michael Popkin in the early 1980s, is a video-based parenting

education program that builds on the Adlerian philosophy and work of Rudolf Dreikurs, Don Dinkmeyer and Gary McKay, who published Systematic Training for Effective Parenting (S.T.E.P.) in 1976. It teaches a variety of discipline and communication skills, many of which are similar to those taught in the P.E.T. and S.T.E.P programs. Active parenting combines video segments, group discussion, reading and writing assignments, group and individual activities and practice in developing parenting skills. As outlined by Lee and Brage (1989) it is based on the following assumptions that most parents have sufficient love and commitment to parent well, but have not been given sufficient information, skills, or support. The skills taught in this program assist parents by helping them to learn how to guide the development of their children through the provision of freedom within limits. Freedom within limits means that freedom is ideal, but that so are the rights of others and the responsibilities of all.

4. Positive Discipline

Positive Discipline is a program that is based on the works of Dr. Jane Nelson, Lynn Lott, Cheryl Erwin, Kate Ortolano, Mary Hughes, Mike Brock, Lisa Larson and others. It was designed to teach children to become responsible, respectful, and resourceful members of their communities by teaching social and life skills in a manner that is respectful and encouraging for both children and adults. As identified on the official website (www.positivediscipline.com), Positive Discipline teaches adults to employ kindness and firmness at the same time, and is neither punitive nor permissive. The tools and concepts of Positive Discipline include:

- Mutual respect. Adults model firmness by respecting themselves and the needs of the situation, and kindness by respecting the needs of the child.
- Identifying the belief behind the behaviour. Effective discipline recognizes the reasons kids do what they do and works to change those beliefs, rather than merely attempting to change behaviour.
- Effective communication and problem solving skills.
- Discipline that teaches (and is neither permissive nor punitive).
- Focusing on solutions instead of punishment.
- Encouragement (instead of praise). Encouragement notices effort and improvement, not just success, and builds long-term self-esteem and empowerment.

5. How to Talk So Kids Will Listen, and Listen So Kids Will Talk

This adult-child communication book was originally printed in 1980 by Adele Faber and Elaine Mazlish. The book was updated in 1999, and includes information on how to assist children in dealing with their feelings, explore alternatives to punishment, encourage cooperation and

independence, and give praise. The program is now delivered in group workshops (with kits containing audio or video workbooks and reading materials).

6. Developing Capable People

Developing Capable People was first piloted in 1982 by H. Stephen Glenn. It is a program designed to assist parents and other adults in learning how to empower children and teens with seven "Life Principles": strong perceptions of personal capabilities, strong perceptions of personal power, self-discipline, communications, responsibility, values and principles (see official website: www.resiliencyinstitute.com). The program generally consists of nine 2.5 hour sessions in which information is shared through videotapes or DVDs, short assignments and exercises in the participant workbook, role playing, and reading assignments. A shorter version of the program may be given in six sessions or over a weekend. The program is presented by certified leaders who have taken a mandatory three-day Leader Training workshop. Only certified program leaders may purchase the leader's guide and participant workbooks, however the videotapes or DVDs may be purchased by others.

7. 1,2,3,4 Parents!

1,2,3,4 Parents! is an early childhood parenting program that was developed by Michael H. Popkin, Betsy Gard, and Marilyn Montgomery. It is based on the original Active Parenting parenting education programs developed by Popkin in 1993. The program is a multicultural video/DVD and discussion program for parents of children aged 1 to 4 years old. It addresses basic parenting skills, the ages and stages of child development, building the child/parent bond, non-violent discipline skills, the use of choices and consequences, and the power of encouragement (see official website: www.acriveparenting.com). The program is divided into three 90 minute sessions which are delivered by a leader to groups of 10 to 20 parents.

8. Nobody's Perfect

Nobody's Perfect was developed in the early 1980s by Health Canada and the Departments of Health of New Brunswick, Newfoundland, Labrador, Nova Scotia and Prince Edward Island. The program materials, introduced nationally in 1987, were updated in 1997 and published in English, French, and other languages (see official website: www.nobodysperfect.ca). The goals of the program are to increase parenting knowledge and skills, promote the healthy development of children, offer parents a safe place to meet, and give them a chance to think about their lives, their children, and their role as parents. Nobody's Perfect focuses on the first 5 years of childhood and was developed for parents who are young, single, socially isolated, geographically isolated, or who have limited formal education or income (Chislett & Kennett, 2007). The program is designed to be flexible and is tailored to meet the needs of both parents and organizations that sponsor programs. It is usually offered as a series of two hour group sessions over a period of six to eight weeks, but can be used one-on-one with individual parents. The

program is based on the understanding that adults learn best:

- When their background and life experiences are valued and respected.
- When they have a voice in deciding what they will learn, and the program is based on what parents want and need to learn.
- When they are part of a supportive group.
- When the program allows them to build confidence and self-esteem by offering opportunities to try new skills and behaviors.

According to Chislett and Kennet, revisions made to the Nobody's Perfect Facilitator's Guide in 2000 outlined a new educational format based on the concept of experiential learning. In this approach, facilitators are not teachers or experts, but orchestrate the learning process through the planning of the sessions.

C. Hybrid Programs

Examples of Hybrid Programs

1. Parent-Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy is an evidence-based treatment model used widely in the United States, with more recent dissemination to Australia (Nixon, 2001). Like the Triple P-Positive program, PCIT has attracted significant government funding in both the United States and Australia to support its implementation. It was initially developed for young children who were exhibiting behaviour disorders, and targets parents with children ages 2-12 with prior abuse reports who are at risk for engaging in future physical child abuse.

The theoretical underpinnings of PCIT are influenced by developmental theory and research relating parenting styles to child outcomes (Baumrind, 1967); attachment theory, which asserts that sensitive and responsive parenting helps young children to develop a stable attachment to his or her parent based on the belief that the parent will respond to the needs of the child; and social learning theory, that explains how parental behaviors shape the functional and dysfunctional interactions between parents and their children (Bell & Eyberg, 2002).

Parent-Child Interaction Therapy integrates a *behavioural approach to parent training with a relationship enhancement approach*. Therapists generally use a transmitter and receiver system where the therapist provides coaching from behind a one-way mirror. Parents are taught highly specific skills as they interact with their child to establish a nurturing and secure relationship while increasing their child's prosocial behaviour and decreasing the negative behaviour patterns of the parents (<http://pcit.php.ufl.edu>). PCIT progresses through two distinct phases: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). While CDI resembles traditional play therapy and focuses on strengthening the parent-child bond, PDI resembles

clinical behavioural therapy and focuses on improving the parent's ability to set limits, provide consistent discipline, and reducing the negative behaviour of the child.

Herschell et al. (2002) discussed the need for translational research to examine the effectiveness of PCIT in community based mental health centers rather than university supervised research studies. Since then, adaptations of the PCIT program have been made for treatment settings. Some of these adaptations included using "bug-in-ear" devices and walkie talkies, or having the therapist sit in the room. PCIT has been adapted and used effectively with foster parents, in Head Start settings, in residential treatment settings and shelters, for use in home as part of a larger intervention, for use in group treatment, for use with older children (8-12 years of age), for use with children with medical conditions, for use with families where child abuse has occurred, for use with children in foster care, and for use with families of various cultural backgrounds (e.g. Puerto Rican, Native American) and families in different countries (e.g. Hong Kong, Russia, England, Netherlands, Australia, Canada).

Outcome research has shown significant improvements in child problem behaviors and in the parent interactional style (Eisenstadt et al., 1993; Nixon, 2001; Schuhmann et al., 1998). In addition, research indicates that Parent-Child Interaction Therapy has long-term effects. An earlier follow-up study found that parent ratings of child behaviour problems, child activity level, and parenting stress remained similar to positive post-treatment levels, and that most of the children remained free of disruptive behaviour diagnoses (Eisenstadt et al., 1993). In an investigation by Schuhmann, Foote, Eyberg, and Boggs (1998) approximately 50% of the 13 children who participated in the study maintained benefits from intervention at the 2 year follow-up. Another study showed that improvements in child behaviors were maintained through one year, but by the 18 month follow-up, many children had reverted back to old behaviors (Funderburk et al, 1998 as cited in Nixon, 2002).

In one review of parenting programs, Brestan and Eyberg (1998) described PCIT as a "probably efficacious" treatment for children with externalizing and antisocial behaviour. Findings from a recent review and meta-analysis of behavioural parent training (Thomas & Zimmer-Gembeck, 2007) suggest that PCIT meets the criteria to be classified with the highest rating as a "well-established treatment." More recently, Edwards et al. (2001) conducted 1 year to 3 year follow-up assessments of PCIT; children and families who completed treatment maintained treatment gains over those periods of time, but families who dropped out of the program showed child disruptive behaviour and parenting stress at the pre-treatment levels. Eyberg et al., (2001) also examined long term outcomes of PCIT, and found that the frequency of maladaptive behaviour and related parental concerns were significantly lower than the pretreatment score at both the 1 and 2 year follow-up. Hood and Eyberg (2003) examined the maintenance of PCIT results 3 to 6 years after treatment. They concluded that, "the children not only maintained their gains but also showed continuing behavioural gains with time. The mothers' confidence in their ability to control their child's behaviour was also maintained" (p. 426).

Children whose parents who drop out of parent skills training programs fail to show significant improvements in behaviour. In one study, the results of families who completed PCIT were compared with those who dropped out of the study before completing treatment (Boggs et al., 2004). One to three years after families of preschoolers with disruptive behaviour disorders

began PCIT, families who successfully completed treatment maintained their gains, while those who dropped out showed no changes from pretreatment levels in either child disruptive behaviour or parenting stress. Such findings emphasize the importance of identifying ways to engage families in treatment and retain them until treatment is complete.

While PCIT has consistently been identified as an effective behavioural parent training program, it does have some limitations. As identified by Hensler, Wilson and Sadler (2004) these include:

- Parents and children need to have consistent ongoing contact in order to be able to effectively change their patterns of interaction. It is not appropriate for families in which the parent and child have very limited contact or no ongoing contact. PCIT usually requires between 14 and 20 weeks of therapeutic counselling.
- There is no research to support the use of PCIT with very young children (less than two and a half years of age, and limited research for use with children older than the age of 8.
- PCIT is not appropriate for use with parents with mental health issues that may include auditory/visual hallucinations and/or delusions.
- Due to the process of coaching parents, it is difficult to conduct PCIT with parents/children who are hearing impaired and/or who have significant expressive or receptive language skills.
- PCIT is *inadvisable* for use with parents who are sexually abusive, who engage in sadistic child abuse, or are seriously mentally ill as teaching the abusive parent better means of control over the child may be harmful.

Population health approaches require that interventions are economically feasible for the expected financial savings in the long term. Pade, Taube, Aalborg and Reiser (2006) attempted to increase the cost-effectiveness of PCIT by developing a shorter, *modified* PCIT program for use in a community setting. There were 73 participants in the initial sample and 23 in the 5-6 year follow-up sample. Despite reporting positive findings immediately after the intervention, the researchers reported that the shortened, modified version of PCIT may not be sufficient to reduce child problem behaviors, related parental problems and stress in the longer term (5 to 6 years later).

Recent developments in Bluetooth wireless technology is enabling PCIT to be delivered in a variety of settings, both in-home and at clinics through the United Way California Capital Region's program to reduce child abuse (Reed, 2006). The technology has enabled trained therapists to increase the overall number of PCIT sessions, provide treatment with greater cost-effectiveness and increases the accessibility of PCIT to at-risk populations. During traditional PCIT therapy sessions, a parent and their child are given toys with which to interact while counsellors observe from behind a one-way mirror and coach the parent through an earpiece. Such specialized rooms are often cost-prohibitive for community agencies and clinics. The new technology enables PCIT therapy sessions to be conducted within a person's home using a small video camera and monitor, and communicating through Bluetooth enabled cell phones and headsets. This significantly reduces the costs associated with PCIT, as specialized therapy rooms

are not needed. This method of implementing PCIT has doubled the number of PCIT sessions offered through a single clinic and allows parents to interact hands-free with their children in their home setting.

Overall Effectiveness of Behavioural Parenting Programs

While research on family intervention offers a strong empirical basis for the use of parent behaviour training programs, it has been repeatedly acknowledged in the literature that a clear bias exists towards conducting rigorous research on such programs because such programs lend themselves to being evaluated in such a manner. Therefore, rigorously designed studies demonstrating the effectiveness of this approach are more numerous and readily available than those supporting any other approach to treating children and families. Many behavioural management programs were originally developed to target parents of children with severe behavioural disorders. Despite this, behavioural programs are at times sought out and often misused by frustrated parents as every-day approaches/solutions to child discipline issues, even when children do not exhibit severe behavioural disorders. Research indicates that when used with children who have moderate or severe behaviour problems, behavioural parent training programs can result in positive outcomes, especially if the programs include both parents and pre-school teachers. Such positive outcomes have been demonstrated to generalize not only from the clinic setting to home, but also to community settings and school settings. Demonstrated improvements have been shown in the following areas: improvements in parenting strategies, improvements in parents' attitudes towards their children, reduced couple conflict over parenting, a greater sense of parenting competence, reduced stress. Other studies have reported reductions in maternal depression and improved satisfaction with relationships.

Group-based parent behaviour training interventions have been found to improve parenting in high risk groups, including parents with intellectual disabilities and parents who are abusive or neglectful or at risk of abuse and neglect (Barlow, 1997; Feldman, 1994; Macdonald & Winkley, 1999). One systematic review found that community group-based parent training programs produced greater changes in children's behaviour than individual clinic-based programs; however, the research is insufficient to demonstrate which specific aspects of group parent-training programs are the factors that bring about change (Barlow, 1997). Another systematic review of group-based parenting programs conducted by Barlow (1999) included three overviews of the effectiveness of parent training programs and 18 randomized controlled trials (16 studies and 2 follow-ups). It found that 5 of the randomized controlled trials were effective in producing large positive changes in child behaviour. Nine out of the remaining 11 randomized control trials produced positive changes in parents' perceptions of their child's behaviour.

The review of parenting programs with professional involvement conducted by Thomas et al. (1999) concluded that behaviorally based parenting programs based on parental empowerment models were more effective over time. The study found that when compared with control groups, experimental groups in all of the 14 studies examined reported statistically significant *short-term* positive effects on some child and/or parent behaviour measures. These changes included: decreases in negative physical/coercive discipline techniques, decreases in emotionally abusive

behaviours and parental criticism, increases in the maternal support network, increases in parental self-efficacy and satisfaction, increases in appropriate limit setting, increases in parental competence and increases in parental competence

While the use of certain punitive practices can often elicit temporary compliance, it has been shown to have limited effectiveness over the long term. For example, while corporal punishment such as spanking may be effective initially because of its shock value, research has shown it to be less effective with each use, sometimes leading to the escalation of punishment (American Academy of Pediatrics, 1998). The misuse of punishment and positive reinforcement to modify and control a child's behaviour has potentially deleterious side effects.

Findings from the National Longitudinal Survey of Children and Youth in Canada indicated that children who live in homes where punitive parenting techniques are used were more likely than others to exhibit aggressive behaviour. This relationship appeared for both genders, for low-income and higher-income families, and for all regions of Canada. Interestingly, children raised with a punitive parenting style at very young ages were not more aggressive than other children when they are older, as long as the parenting style becomes less punitive over time (Statistics Canada, 2004). These links do not imply that punitive parenting practices cause aggressive behavior in children, however, these findings are consistent with other research (Thomas, 2004). Some research on outcomes for young adults has indicated that those whose parents supported and guided their transition out of adolescence had healthy outcomes, whereas youth whose parents were overly punitive or coercive showed signs of inhibited psychological growth (Aquilino & Supple, 2001; Barrera, Prelow, & Dumka, 2002).

Overall Effectiveness of Reflective or Relationship-Based Programs

As identified by Mullis (1999), Adlerian parenting education groups frequently report changes in parental attitudes or feelings, but rarely report the assessment of behaviour change in children. Adlerian programs such as Active Parenting and S.T.E.P. often measure parental attitude, yielding more positive outcomes than data from children's reports of change in their parent's behaviour or parents' records of behaviour changes in themselves (Nye, 1989). In his assessment of two Active Parenting (Adlerian) programs, Mullis found that both programs resulted in a significant change in parental perceptions of behaviour, according to the questionnaire administered. Outcomes typical of Adlerian programs are that parents become more democratic with regard to child rearing and view their children's behaviours more favorably (Fine & Henry, 1989; Krebs, 1986). Studies have also indicated that S.T.E.P has decreased parental strictness and control (Campbell & Sutton; Nystol, 1982).

Summary

Further research is needed to evaluate the long-term impact of parenting programs (Thomas, 2007). As pointed out by Medway (1989),

Although it is intuitively appealing to ask whether one type of parenting education model is better than any other, outcome studies using one type of model cannot be compared to studies using another type of model since these studies differ not only in terms of the model treatment and the characteristics of group leaders but also in terms of the choice of outcome measure used (p. 251).

In Medway's review of 24 studies of behavioural, reflective and Adlerian programs, he concluded that all programs were highly effective in that participants and their children showed improvement on diverse measures that was 62% greater than similar populations who did not receive parent training. Gottlieb, Feeley and Baker (1995) indicated that no differences in outcomes exist between group and individual parenting approaches. Increased evidence indicates that group-based behaviorally oriented parenting programs tend to be more effective and tend to be maintained over time more than other types of programs, such as those that focus on changing parental attitudes (Barlow, 1999; Barlow & Coren, 2004; Bunting, 2004). Research within the United Kingdom indicates that while these programs can be effective, high drop-out rates result in only a minority of parents being able to benefit from such programs (Bunting, 2004). Early studies conducted by Schofield (1979) found that although behaviour training was effective in reducing deviant child behaviours, behaviour modification was significantly less effective than PET in increasing children's self esteem and positive parental consequences and family cohesion (Pinsker & Geoffroy, 1981).

Multi-level programs such as Triple P, the Incredible Years program, and Parent-Child Interaction Therapy continue to undergo rigorous evaluations to determine their effectiveness in improving child outcomes at the population level. An earlier review of behavioural parent training programs highlighted the scarcity of external program evaluations as a gap in the identification of evidence-based practices (Smith & Pugh, 1996). Since then, externally conducted trials have examined the impact of the Webster-Stratton videotape modelling program on parents and children in the United Kingdom (Gardner, Burton & Klimes, 2006; Paterson et al., 2002; Scott et al., 2001).

Nixon (2002) cited both the Triple P program and Parent-Child Interaction Therapy as programs with demonstrated efficacy based upon numerous studies with rigorous methodologies. While those trials reported significant positive results, the high drop-out rates for parental participation in the Paterson et al. and Scott et al. studies raise questions about the potential impact of behavioural parenting programs if they are to be available in population health contexts. Most recently, a review and meta-analyses of the behavioural outcomes of Parent-Child Interaction Therapy and the Triple P-Positive Parenting Program (Thomas, 2007) revealed positive effects of both interventions (e.g. improved parental warmth, reduced parental stress, decreased parental hostility), with effects that varied depending on intervention length, program components, and

source of outcome data.

Not all families benefit equally from parenting education. Despite the successes reported with many of these programs, there remains insufficient evidence of their influence at the population level in reducing the prevalence of childhood and adult problems (Bunting, 2004; Sanders, 2001). In part, this has been attributed to the inaccessibility of cost-effective programs through community services such as clinics and other social service agencies (Taylor & Biglan, 1998). Recent findings (Storch & Floyd, 2005; Thomas & Zimmer-Gembeck, 2007) assert that there is still insufficient evidence for the transportability and effectiveness of Triple P and PCIT from controlled clinical environments to community settings.

Since effective program implementation on a wide scale is critical for any evidence-based program to have significant community impact, some researchers argue that only programs that have demonstrated the ability to be effective through widespread community dissemination should be considered for population approaches:

Many programs evaluated and supported through scientific rigor are not well disseminated following successful research trials . . . Effective dissemination is critical for evidence-based research to have any significant community impact (Turner, 2006).

While Triple P and PCIT have been disseminated to community agencies in Canada, the USA and Australia, there have been no independent, published, or transportability studies from either intervention. That is, there is no current evidence for effectiveness of either Triple P or PCIT in a community setting (Thomas & Simmer-Gembeck, 2007)

The systematic review by Thomas et al. (1999) reported that group-based parenting programs were much more cost-effective than individual program formats, and tended to have better outcomes. One study reviewed by Barlow (1997) indicated that group-based parent training programs may be up to six times more cost effective and more acceptable to parents than programs provided individually. In group training, parents may experience less stigma because they are not alone or are not the only ones with stressors and problems. Group training can also satisfy individuals' needs for recognition, security, and affiliation, so that parents do not feel that they are alone (Garvin, Gutierrez, & Galinsky, 2004).

The findings of this literature review suggest that most parenting programs have some positive effects on parental attitudes, however, that there are no guarantees that attitudes nor changes in parental behaviours are sustained over an extended period of time. As suggested nearly two decades ago by Medway (1989), the parent's own goals should be considered by parents and service providers in the selection of the appropriate program(s) to use. In a review of Adlerian, Parent Effectiveness Training, and behavioural research, Mooney (1995, p. 228) suggests that choosing a parenting program should be based on the nature of the parent referral:

- (1) If there is no specific behavioural problem and time is not an issue, then training in *non-behavioural* approaches such as Adlerian, STEP, or PET may be indicated.

These focus on the family system rather the child alone, and work on increasing parental democratic attitudes, empathy and adaptive communication patterns. These approaches also

emphasize alterations in parental behaviour. If these programs are to produce successful outcomes, parents must be willing to change their interactional patterns.

- (2) If the presenting problem involves a rapid behavioural change in a specific area of the child's life, parent training in *behaviour modification* may be most effective.

However, the behavioural intervention's overall impact should be assessed to ascertain whether the problem was truly an isolated one. Frequently another problem arises once the original difficulty is ameliorated. A behavioural approach appears best suited for referrals in which the acquisition or extinction of a specific behaviour pattern is desired.

The guidelines provided by Mooney (1995) suggest that for parenting programs which are intended to be offered on a universal basis, relationship-based programs (e.g. Adlerian, PET, STEP) are a more suitable choice than behavioural programs.

Conclusion

Public health professionals must carefully consider the attributes and characteristics of the parenting program(s) chosen for widespread implementation. No single parenting program can possibly be identified as optimal, effective and cost-effective for the multitude of target populations, contexts, and outcomes that must be considered in a population health model. The review of the literature on parenting programs indicates that despite increasing attempts to determine the long-term effectiveness of parenting programs on improving parental outcomes such as improved maternal psychosocial health, parental attitudes, maternal confidence, parental knowledge, and maternal motivation; further research is still required (Barlow & Coren, 2004; Bunting, 2004; Thomas et al, 1999; Thomas, 2007).

Evidence-based research may serve to increase the level of confidence that decision-makers have in recommending, funding and supporting particular programs for implementation; however, even positive and robust findings across many studies cannot guarantee the success that a particular program will have on individuals, groups, and the population at large. While certain parent training programs and approaches may be promoted as having potentially detrimental effects on children, it has also been established that most parent training programs have some positive effects on those who complete them.

There is a current emphasis on recognizing and serving the individual needs of families, yet due to the limited number of controlled studies and clinical trials that are conducted in real, community based settings, it is not possible to guarantee that a particular parenting program will be useful and effective with all families. Furthermore, resistance and barriers to change exist to varying degrees in families and the organizations responsible for the delivery of parenting programs in everyday practice. The approach that is most realistic in the population health model is to: (a) provide clinicians with choices as to the best possible interventions that they determine to be used with families (Hensler, Wilson & Sadler, 2004), and (b) provide parents with accessibility to a range of evidence-based programs and services that will help to meet their individual needs. Programs with professional involvement are more likely to lead to improvements in some parent, child and/or parent interaction outcomes (Thomas et al., 1999).

Limited research has been done to determine the parenting needs and program preferences of specific parent groups. This has led some organizations to adopt or continue following the curriculum of a general program, or rely on global population characteristics (Jacobson & Engelbrecht, 2000). In order for programming to be appropriate and responsive to parental needs, it is essential that there is sufficient knowledge about what parents actually want to learn about and what kind of information and supports they seek. Effective programs are responsive to the unique needs of parents and entail an interaction between parent characteristics, program resources, and outcomes (Powell, 1993; Tucker, Gross, Fogg, Delaney, & Lapporte, 1998; Weigel & Martin, 1993). The uniqueness in family environments and structures creates challenges for parent educators to meet the needs and preferences of parents with appropriate programming. Largely because of financial constraints, evaluations of parenting programs tend to limit the gathering of parental information to questions related to parental satisfaction with the

program and instructors. Research indicates that parents usually rate the parenting programs they complete highly, regardless of the theoretical basis of the program. While it may seem reasonable to ask which types of programs are better - those that are primarily based on behaviour modification, or those that are relationship-based - there is no simple answer. Parenting programs must be tailored to the needs of the parent(s), child and family for maximum effectiveness.

If decisions must be made about the types of parenting programs to be available in a population, specific information about the parenting-related needs of the population must be known. Needs assessments are an important part of obtaining such information, and might include: (a) the kinds of information and guidance parents are seeking; (b) demographic information about the parent(s) and child; (c) information about the child; (d) parenting practices and beliefs; (e) values regarding child rearing; (f) frequency of use and reasons for using corporal punishment and other punitive discipline techniques; (g) types of support desired; (h) the emotional well-being of the parent(s); (i) topics of interest for parents; (j) the specific things that are the source of frustration for parents, and (k) awareness, use of, or needs for various sources of support.

Finally, it is important to keep in mind that there are limitations to what parenting education programs can accomplish. Hoff-Ginsbert and Tardiff (1995) summarized their review of many parenting programs by concluding:

... there are limits to how much parenting behavior can be changed by educating parents or by convincing them of different values. . . Parental education will affect those aspects of parenting that derive from parents' belief about children's abilities and about the value of different childrearing practices, but it will not change practices that derive from the larger social structure or from individual personality characteristics. The research suggests that the influences of the larger social structure and individual personality are substantial. (pp. 180-181)

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Appendix B

Potential Outcomes when Conducting a Population Level Parenting Needs Assessment

Potential Outcomes when Conducting a Parenting Needs Assessment

- To provide evidence of specific needs and inform effective program planning, development and implementation.
- To identify potential program interventions and related outcomes for future evaluations.
- To provide baseline data with which future findings may be compared.
- To enable estimates of resource needs and costs associated with particular parenting programs.
- To enable the identification of target groups for specific types of parenting programs.
- To enable the gathering of data which may identify neighborhood specific gaps and barriers.
- To help clarify the vision of 3 Cheers with respect to the direction the parenting program direction should take in the next decade.
- To assist in the identification and establishment of priority areas for 3 Cheers parenting programs.
- To provide a data-based rationale for programs, particularly if funding is being sought.
- To enable the planning of prevention efforts that are a good match for the needs of the community - socially, politically and economically.
- To assist with the generation of new ideas in the areas of marketing parenting programs.
- To identify ways to increase the accessibility of parenting programs to specific groups within the population.
- To identify ways to ensure or improve the cultural relevance of parenting programs (or acknowledge similarities/differences).
- To enable the planning of strategically targeted programs and services in certain neighborhoods and communities.
- To provide insights to program design and planning processes.
- To provide valuable information about possible service-related and implementation issues.
- To identify similarities and differences between service provider, professionals' beliefs, and parent beliefs about parenting needs within the population and within specific groups in the population.
- To be used to help build relationships between parents and other organizations within the community.
- To be used to help sustain and build relationships among organizations within the community with respect to the parenting services provided.

Appendix C

Possible Data to be Collected in a Population Level Needs Assessment of Parents

Possible Data to be Collected in a Population Level Needs Assessment of Parents

Prior to conducting a needs assessment, it is essential to identify the specific types of data that must be collected. The research related to effective parenting programs suggests that in order for parenting program planning to be approached in a comprehensive, inclusive, and systematic manner, the following questions should be considered:

1. What are the developmental assets (i.e. concrete, positive experiences and qualities demonstrated to be important in raising children that become healthy, caring, responsible adults) that the children have?

Developmental assets are divided into 8 areas of human development: Support, Empowerment, Boundaries and Expectations, Constructive Use of Time, Commitment to Learning, Positive Values, Social Competencies, Positive Identity.

Examples of Assets:

- Family support - Family life provides high levels of love and support to the child.
- Caring neighborhood - The child experiences caring neighbors.
- Caring school climate - The school provides the child with a caring, encouraging environment.
- Parent involvement in schooling - Parent(s) are actively involved in helping the child succeed in school.
- Safety - The child feels safe at home, at school and in the neighborhood.
- Adult role models - Parent(s) and other adults model positive, responsible behavior.
- Positive peer influence - Child's friends model responsible behavior.

2. What are the major child-rearing beliefs and values of specific groups of parents?
3. Are there common child-rearing beliefs and values of the population as a whole?
4. What are the current parenting styles of specific groups of parents?
5. What are the actual parenting behaviors and practices of specific groups of parents?
6. How are the *actual* beliefs and values of parents related to their *self-reported* beliefs and values?

Childrearing beliefs are more closely linked to childrearing behaviors among middle-class mothers than among working-class mothers (Tulkin & Cohler, 1973).

Potentially examine the following:

- (a) Extent to which parents value conformity.
- (b) Parental beliefs about control and discipline.

What is the nature of discipline practices used by parents?

e.g. How often do you find it necessary to use the following practices to get your child to behave?

- (a) spanking*
- (b) slapping*
- (c) yelling*
- (d) punishing for bad behaviors*
- (e) rewarding for good behaviors*

In direct control practices, to what extent are mothers controlling, restrictive, intrusive, punitive and disapproving. In indirect control practices, managerial control is exercised through the experiences parents provide their children and the physical environments they create for their children. The physical environments may be altered through the provision of appropriate play materials, variety of daily stimulation, organized activities, skill activities such as reading, club memberships, private lessons, membership in team sports, participation in church-related activities (Hoff, Laursen & Tardiff, 2002). Managerial practices help to prevent discipline issues from arising.

- (c) Amount and types of maternal involvement with child and amount of warmth exhibited towards the child.
- (d) Extent to which parents value self-direction in their child.
How parents encourage the development of self-direction in their child.
- (e) Parental beliefs about their own parenting self efficacy. (Lower socioeconomic status parents are less likely than higher self-efficacy parents to believe that they have influence over their child's outcomes and are therefore less likely to endorse positive outcomes as childrearing goals and less likely to engage in "competence promoting parenting" (Brody, Flor & Gibson, 1999).
- (f) Parental and cultural beliefs about the causes of illness and disease.
- (g) Beliefs about how physically close mothers should stay to their infants.
High-touch versus low-touch cultures. What are the beliefs and practices related to breastfeeding, age of weaning, infant wearing (carrying infants and keeping them in close physical contact), mother-infant proximity in sleeping arrangements? High-touch practices encourage more nurturing behaviors and infant attachment.

6. What is the nature, quality and amount of verbal interaction of parents with children?

Is this related to the education level of mothers, as is suggested by the literature? What implications does this have for the promotion and development of basic and advanced literacy courses for mothers?

7. What is the nature of the physical and social settings that parents provide for their children? Is this limited by external factors, such as lack of transportation, lack of programs, financial issues, etc.?
8. How much quality time does each parent spend daily with the child (e.g. playing stimulating games with, reading with)?
9. To what extent is the accessibility of health services related to factors that parents have no control over?
e.g. Has the lack of sufficient health cost coverage ever prevented your child from getting the care they needed (medical, dental, counselling, etc.)?
10. Are there indications that child safety and surveillance may not be a priority for certain parents or groups of parents?
e.g. During the past 12 months, how many times did your child have to go to a hospital emergency room for health care?
11. Are there other caregivers who require knowledge and assistance with parenting issues?
e.g. Is there someone who shares day-to-day parenting duties with you - someone who regularly helps you supervise and care for your child or children?
12. Are there prescribed customs of childcare? How are cultural beliefs and values related to parenting practices? i.e., Are patterns of parenting handed down across generations?
13. What are the effects on children of different cultural approaches to parenting, both immediately in their lives and over the longer course of their development?
14. What are the socialization expectations, pressures and practices placed upon children, and at what ages of children are these associated with? eg. obedience, independence, responsibility, amount of responsibility for responsible work (infant care, help with food preparation, household chores).
15. What are the psychological characteristics of the adult caregivers?
e.g., What is the verbal IQ of the caregivers; with what level of verbal complexity do parents speak with their infants and toddlers?
What is the level of complexity with which parents think about development and parenting?
How do mothers view infant survival and infant death, and how does this affect their expectations and behaviors?
How do parents view post-natal depression, and how do these beliefs influence whether they seek professional help and other types of support?
16. What child development knowledge and parenting skills do parents of particular groups have within the population?

17. Possible demographic data to be collected:

- Gender
- Martial status
- Age
- Ethnicity
- Income
- Education
- Employment status
- Family Size
- Number of children under the age of 6
- Residency (years lived in their current community)
- Number of different community programs participated in
- Number of critical events (risk factors) experienced in the past year:
 - Income decreased substantially
 - Death of an immediate family member
 - Chronic illness or disability
 - Moved to a new location
 - Home destroyed
 - Alcohol or drug problem
 - Serious money issues
 - Divorce
 - Separation from spouse or partner
 - Entered new school
 - Pregnancy
 - Birth of youngest child
 - Trouble providing children with clothing or shoes
 - Death of a parent
 - Trouble with teachers at school

18. What level of confidence do parents currently have in their ability to parent?

19. How important is it for parents to meet other parents who have similar interests and concerns?

How important are the following changes in child behavior to parents?

- Child becomes more independent
- Improved language development and communication skills
- Child gets along better with other children.
- Child self-confidence increases
- Child gets along better with other adults

20. What level of knowledge do parents have around developmental milestones and appropriate behavioral, psychological and social expectations of children?

21. Are there specific areas that parents want clear, straight forward, realistic, manageable strategies and practical knowledge and advice about? For instance, topics related to:
- (a) Behavior management (e.g. tantrums, biting, hitting, shouting, whining, complaining, ignoring parents' requests or instructions, learning to share, altering habits learned as a baby, establishing and maintaining routines)
 - (b) Feeding (e.g. dealing with grandma/auntie providing sweets, oral health, food safety, choking, food allergies)
 - (c) Sleep issues (e.g. not staying in bed, coming into the parents' bed, fear of the dark, bad dreams, need for night lights, transition from crib to bed, establishing different sleep times)
 - (d) Toilet Training (e.g. bladder training, bowel training, lack of interest in using toilet, bed wetting)
 - (e) Physical Development and Health (e.g. hearing and eyesight, language development, identification of developmental problems, when to seek professional advice, recognition of common illnesses, immunization information, head-lice)
 - (f) Emotional and Social Development (e.g. what is positive parenting?, updates on current parenting practices and theories, facilitating a child's independence, how to build a child's confidence level, influencing communication skills and relationships/interaction with other family members/friends, providing comfort and security to toddlers, information on the effects of separation/divorce on the child, practical ideas related to play, dealing with toddler boredom and the pressure of having to satisfy toddler demands for stimulation)\
 - (g) Childcare (e.g. finding and assessing various childcare options, social and educational benefits of various childcare options, advice about handling conflicts in approaches between parents and childcare workers)
 - (h) Safety (e.g. injury prevention)
22. What are the psycho-social/emotional issues experienced by parents?
- (a) Development of confidence in own parenting skills
 - (b) Understanding and accepting own emotions
 - (c) Handling stress and frustration,
 - (d) Feeling valued and retaining a sense of individuality
 - (e) Dealing with feelings of guilt stemming from own behavior and feelings towards toddler
 - (f) Time management

- (g) Strategies for addressing the impact of practical and emotional pressures on adult relationships
- (h) Need to understand sources of negative emotions towards child/parenting and practical techniques for coping with those emotions
- (i) Need for reassurance in addressing feelings of guilt (e.g. not spending enough quality time with toddler, use of childcare/being a working parent, coping with impatience toward toddler, division of parental attention among siblings)
- (j) Advice on how to develop relationship with toddler.
- (k) How to establish personal support networks
- (l) How to cope with issues commonly experienced by single parents

23. Where do parents turn to for advice on parenting?

Why do parents turn to these sources? (anonymity, convenience, lack of time).

24. Where/how would parents like to have parenting advice available?

25. What are the preferred formats for different types of parenting education and advice?

26. What are the barriers to parents seeking help and advice on parenting?

- embarrassment
- concerns about confidentiality
- worried about being stigmatized and being labeled a "failure" as a parent

27. What are the Environmental Conditions that infants are being raised in, and how does this affect child development?

Conditions Related to the Tasks of Parenting

- (a) Structure. These are parenting activities that involve the control and organization of objects, events, policies and social encounters (Bradley, 2002).

Crowding is one example of structure within an environment. A study by Evans, Maxwell and Hart (1999) found that parents who lived in crowded homes spoke in less complex sentences with their children and were verbally less responsive, compared with parents who lived in uncrowded homes - even when researchers controlled for the family's overall socioeconomic status.

- (b) Surveillance. This refers to the regulatory system parents perform to keep track of the whereabouts and activities of the child and the child's surrounding circumstances (Bradley, 2002). High surveillance/supervision is most commonly associated with the goal of protecting the child from harm.

- In the last 12 months, have you delayed or decided not to get your child immunized for any reason?
 - Do you currently smoke cigarettes daily or occasionally?
 - About how long has it been since your child last saw a dentist (including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists).
 - When you are driving and your child rides in the vehicle with you, how often does he/she ride in a child safety seat (infant seats, toddler seats, booster seats)?
 - When you are driving and child rides in the vehicle with you, how often does he/she wear a seatbelt. Would you say he/she wears a seatbelt?
 - How often does your child wear a helmet when riding a bike, scooter, skateboard or rollerblades?
 - Has your child been injured in the past month so that he/she could not participate in his/her usual activities for one day or more?
- (c) Support. Support constitutes the acts and conditions that respond to human social and emotional needs (Bradley, 2002). A supportive environment provides guidance or direction for adequate functioning in other environments. Little is known about how often parents offer various types of support to their children, nor the ways in which supportive actions affect the social and physical environment of children.
- (d) Stimulation. Stimulation consists of the sensory data provided by the environment that engages attention and provides information that can be used to develop competence and continued effort toward life-enhancing goals (Bradley, 2002). While stimulation from a variety of objects and events appears to benefit children, some types and amounts of stimulation have been found to affect cognitive development negatively. Exposure to chronic noise has been found to lead to elevated blood pressure, disturbances in concentration and coping, and disturbances in others with whom children interact. Stimulation includes the variety of activities and environments that children are exposed to outside the home (taking children to the grocery store, library, physician, museum, zoo, playground, church, live musicals or theatre performances, etc.). Stimulation also includes the variety of objects and information provided within the home (e.g. pictures on bedroom walls, board games, musical instrument, developmentally appropriate books, daily newspapers, home computer, equipment useful for physical development or sports).
- (e) Sustenance. These are parenting acts and conditions designed to promote biological integrity necessary for physical and psychological development; they include the provision of adequate nutrients, shelter and conditions for the maintenance of health

(see Bradley, 2002). This includes protecting children against adverse conditions such as pollutants, passive cigarette smoke and exposure to heavy metals and other toxins.

Conditions Related to the Social, Ambient, Built and Community Environments

- (a) Social Conditions. As discussed by Bradley (2002), research has found that it is easier for mothers to provide nurturing and stimulating care for children if the parent has access to social support and is not confronted with aversive social conditions. Spousal support is generally associated with greater involvement and more nurturing care of mothers. Parental treatment of children has found to be harsher and more restrictive in families where siblings are present. The strain of dealing with sibling conflict has been identified as one reason for this.
- (b) The Ambient Environment. The ambient environment consists of all the surrounding environmental conditions that can affect parenting practices (see Bradley, 2002). Esthetics such as the absence of trees and vegetation, degree of residential density, deterioration of property, presence of graffiti and vandalism in neighborhoods, high neighborhood noise levels, and unsafe, unfriendly environments has been found to be associated with family instability and maladaptive behavior that affect parents' emotions negatively.
- (c) The Built Environment. The built environment consists of the physical settings that may influence behavior by facilitating certain activities and obstructing others (see Bradley, 2002). The physical setting can communicate messages about the intentions and values of adults who control the settings (e.g. preparing a nursery for an infant to sleep in a separate room from the parents). Adaptations to the physical setting can affect the attitudes and behaviours of children. One researcher found that placing a mirror near the bed of emotionally disturbed girls resulted in increased efforts to maintain a good appearance and promoted more positive behaviour (Berenson, 1967).
- (d) The Community and Material Environment: Access to Resources.

28. What basic information is needed about the development of the child/children of the parent being surveyed that can be connected with parenting?

For example:

- low birth weight
- health issues of child/children
- injury record
- mother's receipt of early prenatal care
- age of mother at birth
- health of mother during pregnancy
- fetal environment during pregnancy (maternal nutrition, smoking, alcohol consumption, use of illegal substances, exposure to radiation, etc.)

- what evidence is there of the development of healthy attachment between the child and parent(s)?

Other Issues:

More information is needed about how the opportunities, constraints and challenges within the environment affect parents' abilities to pursue and fulfill their roles as caregivers.

Other Questions:

1. How do we describe meaningful effects in terms of the impact of parenting on the lives of children? It is not quantifiable (Hoff, Laursen, Tardiff, 2002).
2. Can we gain sufficient information through surveys of parents? Without the use of ethnographic methods, is it possible to derive an adequate understanding of the relationships between culture and parenting? How is this possible without the insertion of the inherent cultural bias that the researcher(s) may hold?

Consider:

(a) Potential sampling issues in population level surveys as identified by Carol Crill-Russell of Invest in Kids.

(b) Sampling issues identified in the literature:

- Recruiting lower SES participants is much more difficult than recruiting higher SES participants. Attrition rates are much higher for lower SES participants when they are recruited (Spoth, Goldberg and Redmond, 1999).
- It is probably also true that parents who are committed to their parenting role join and continue in research on parenting at greater rates than do uninterested parents, although there does not appear to be evidence of this in the literature (Hoff, Lauren and Tardif, 2002). Different participation and attrition rates threaten the validity and generalizability of research on the relation between SES and parenting.
- There may be parenting phenomena specific to particular groups of parents that are not linearly related to SES.
- Questionnaires based on parent self-report may have significant limitations with respect to validity and reliability. This may be especially true in sections requiring parents to describe and rate their behaviours. While independent ratings of parental behaviours are a preferred method of assessment, such methods are time-intensive, costly, and often impractical to carry out.