Evidence review: An analysis of the evidence for parenting interventions in Australia

October 2012

Parenting Research Centre

Commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs

Parenting Research Centre
raising children well

Prepared by the Parenting Research Centre

Catherine Wade, PhD
Senior Manager, Implementation

Michelle Macvean, PhD
Manager, Knowledge Synthesis

Jessica Falkiner
Research Assistant

Ben Devine
Research Assistant

Robyn Mildon, PhD
Director, Knowledge Exchange and Implementation

Disclaimer

This analysis of parenting interventions was commissioned by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). It was conducted over a six-week period in May and June 2012. Evidence predating 2002 was not considered in the review of Australian programs. Readers are advised to consider new evidence arising post the publication of this review when selecting and implementing parenting interventions.

Parenting Research Centre
Level 5, 232 Victoria Parade
East Melbourne Victoria 3002
Australia
Phone: + 61 3 8660 3500
www.parentingrc.org.au

CONTENTS

Analysis of parenting programs

1 EXECUTIVE SUMMARY

Overview

This analysis of parenting programs was conducted by the Parenting Research Centre for the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the funders of Family Support Programs (FSP) in Australia. The report provides an analysis of the evidence for parenting interventions, with a focus on: target populations; target child, parent and family outcomes; and ratings of effectiveness. Factors to consider when implementing programs in the Australian context are also presented.

Methods

Step A: Program information and effectiveness ratings were collated from international web-based clearinghouses and evidence for additional programs was sought from systematic reviews of parenting programs.

Step B: A Rapid Evidence Assessment (REA) of Australian evaluations of parenting programs was conducted. Published and unpublished literature dated 2002–2012 was included, with programs rated for effectiveness.

Findings

The analysis found 34 international and 25 Australian programs with strong evidence, with only two programs with strong evidence at both the international level and within Australia (i.e., Triple P and Parent-Child Interaction Therapy). A large proportion of the programs with good evidence targeted child behaviour specifically in children with identified behavioural problems. Other outcomes, in particular basic child care, were targeted infrequently in the programs with strong evidence. There is little evidence for programs targeting specific groups of parents, such as those with intellectual disabilities or mental illnesses and teen parents.

Conclusions and limitations

Further rigorous program evaluations are needed to determine the effectiveness of many of the reviewed programs. Although systematic in its approach, this analysis was time-limited and some programs may have been missed from review. Readers are advised to seek updated evidence before selecting and implementing programs.

2 INTRODUCTION

2.1 Background

Parenting programs are interventions that aim to influence child outcomes by enhancing parenting knowledge, behaviour or cognition. The person referred to as 'parent' may be any adult, biologically related to the child or not, who fulfils the caregiving role.

This analysis was commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the funders of Family Support Programs (FSP) in Australia. The report provides information to help FSP providers select and implement evidence-based and promising parenting programs.

Providers of FSPs are funded to deliver integrated early intervention services to families, particularly those who are vulnerable and at risk of poor outcomes due to complex needs or limited resources.

The aim of this report is to build knowledge about parenting programs that are effective and show promise of achieving change in FSP target families by researching the evidence-base about existing parenting programs. By this approach the report extends upon previous reviews of the evidence base by examining the international scientific literature as well as the published and unpublished literature, specifically focusing on Australian evaluations of parenting programs. Furthermore, the report discusses critical aspects of the implementation of evidence-based programs in the Australian context. As such, we anticipate this report will be a valuable tool to inform the effective delivery of parenting programs across Australia, and will provide direction for FaHCSIA to move the FSP forward.

The report addresses the following questions:

- What are the proposed outcomes from parenting programs that may be relevant for FSP families?
- What programs exist to meet those outcomes for these families?
- What is the evidence for the effectiveness of those programs?
- What aspects of the implementation of evidence-based parenting programs are important to consider for the Australian context?

To achieve the above aims, the report is structured as follows:

Definitions

Definitions for relevant terms and constructs within the report are clarified.

An outcomes framework

The report articulates a comprehensive list of key child, parent and family outcomes relevant to FSP-funded services and other similar funded services. The outcomes framework guides the identification and categorisation of parenting programs to be included in subsequent analyses. The framework is used to clarify the desired effects of parenting programs, and to identify which available programs may influence relevant outcomes for those receiving FSP-funded services.

Review evidence for parenting programs

Given the outcomes specified that could be relevant for FSP-funded services, the report provides a comprehensive review of the evidence base for parenting programs that are aimed at addressing these key child, parent and family outcomes. We have used two complementary approaches to assess the level of evidence for each parenting program and presented this in the context of achieving these key outcomes:

- **Step A**: We collated information about the effectiveness of each program from established and authoritative international clearinghouses on evidence-based and promising programs and practices, and from previous systematic reviews and meta-analyses of parenting programs.

- **Step B**: The report presents the results of a Rapid Evidence Assessment (REA) of programs delivered and evaluated in Australia. A major focus of the report is on evidence-based programs that are delivered in the Australian context, with the intention of capturing evidence about programs used by FSP-funded agencies. Given the criteria for inclusion of papers used by the large international clearinghouses (e.g. published in peer-reviewed journals), we anticipated they would miss Australian-developed or adapted parenting programs which may meet our criteria for Promising programs. Furthermore, many of the parenting programs identified in Step A have not been used in Australia, nor are they available for use in Australia. Therefore, Step B involves an Australian-focused REA which provides comprehensive detail about the evidence supporting both established parenting programs and local innovations that have been evaluated in Australia. This REA extends upon the international evaluation by including both published and unpublished literature. This approach to reviewing the evidence for parenting programs recognises the value of best practices that emerge from sources other than the empirical literature. In this way, we were able to identify many of the local adaptations of established programs and innovative programs developed to meet an emerging local need. We believed this approach would more successfully capture evidence about programs used by FSP-funded agencies than a traditional systematic review of the published peer-reviewed literature.

Implementation considerations

The report also discusses relevant considerations underlying the implementation of the best practice parenting programs identified in earlier steps. Recognising that some of the programs previously identified may be more implementable than others within particular service settings, here we provide a summary of what it takes to implement a program effectively.

By providing FaHCSIA with detail about both the evidence base for parenting programs and, importantly, with detail about critical considerations for the implementation of evidence-based programs, the report is a valuable tool to assist in decision-making about the usefulness of individual parenting programs for achieving particular child and family outcomes within FSP-funded services.

2.2 Definitions for the purpose of this analysis

Parenting programs

To conduct this analysis, it was necessary to develop a clear definition of what would and what would not be included in our search for programs in the clearinghouse analysis and in the REA. For this purpose, we define parenting programs as parent or parenting interventions, programs or services in which parents, caregivers or guardians receive direct/targeted education, training or support. The overall objective of the program is to improve child outcomes either by increasing the parent's knowledge, skills or capacity as a caregiver, or by improving parent-child interactions, parent outcomes such as parent wellbeing, or family outcomes such as family relationships.

The following *will not* be considered parenting programs:

- programs that provide direct education or training to children
- programs that provide community-wide education where a parent may or may not receive education (i.e. parent is not the target, the community is)
- programs that provide indirect education to parents via their children (e.g. a notice sent home with the child about the importance of reading)
- tip sheets or information pamphlets handed out to parents in isolation of other forms of intervention.

Parent

For the purpose of this report, we define a parent as an adult person performing in the role of a primary caregiver to a child. Such a person may be different from the person who is the child's biological parent. This definition therefore may include grandparents, step-parents, foster parents or other carers.

Evidence-based programs

The terms evidence-based and evidence-informed are often used interchangeably in the literature and in the service delivery sector (Kessler, Gira, & Poertner, 2005).

A widely accepted definition of evidence-based programs is the competent and high fidelity implementation of programs and practices that have been demonstrated to be safe and effective (Chaffin & Fredrick, 2004).

Evidence-informed programs have been described as the use of current best evidence combined with the knowledge and experience of practitioners and the views and experiences of service users in the current operating environment (Chaffin & Friedrich, 2004; Petch, 2009).

Acknowledging the differences in these definitions, yet considering that the scope of the current review is to evaluate both published and unpublished evidence for programs, as well as studies that employ a broad range of research methodologies, in this report we will use the term evidence-based programs to refer to both evidence-based and evidence-informed programs.

Outcome

An outcome can be thought of as a measurable change or benefit for someone. For example, a child and family outcome might be an increase in the parent's knowledge of early child development or an improvement in a child's physical health. Outcomes are different from

outputs, which focus on *what was done* to try to achieve change in outcomes. An advantage of using outcomes rather than outputs as an indicator of change is that they can help everyone to focus on what is actually intended to change as a result of a program.

2.3 Outcomes framework for analysis of parenting programs

This section of the report outlines a framework for considering important child, parent and family outcomes relevant to parenting programs for families targeted by FSP. By documenting this outcomes framework we can identify what programs exist to meet outcomes in certain areas. The outcomes framework will be used to clarify the desired effects of parenting programs, and to identify what programs are available that aim to influence particular outcomes for children, parents and families.

An outcomes framework

Many frameworks exist to explain desirable aspects of child, parent and family wellbeing. We have developed a framework that identifies categories of outcomes which we believe could encompass the aims of FSP. We chose these child, parent and family outcomes based on evidence from the literature that shows what is most important to children and adolescents.

Beginning with the documented outcomes of the FSP (see Appendix 1), we examined other relevant outcome frameworks in order to develop a suitable outcomes framework for the analysis of parenting programs. These frameworks included the National Early Years Learning Framework (Australian Government Department of Education, Employment and Workplace Relations; DEEWR, 2009), the Victorian Government Best Interests Framework for vulnerable children and youth (Victorian Government Department of Human Services, 2007), the Victorian Government Department of Education and Early Childhood Development Child and Adolescent Outcomes Framework (DEECD, 2009), the Child Social and Emotional Well-Being Framework developed by the United States Administration for Children, Youth and Families (U.S. Department of Health and Human Services, 2012) and the OECD Child Well-Being Framework (OECD, 2009).

The outcomes framework developed for this report classifies relevant outcomes into six broad categories which we believe encompass the aims of the FSP (see Box 1). These categories of outcomes are consistent with a systems approach to thinking about the multifaceted and interacting family, community and societal influences on children, as articulated by Bronfenbrenner (1989). The six categories of child and caregiver outcomes are: child development, child behaviour, safety and physical wellbeing, basic child care, parent-child relationship and family relationships. Programs may aim to influence parent outcomes (e.g. increase parent skills and behaviours, increase parent knowledge or confidence, or change parent attitudes) or they may aim to influence child outcomes (e.g. behaviour, skills, knowledge, learning or cognitive development, attitudes, confidence, safety). Some programs will address outcomes across a number of categories. For example, a program that teaches parents skills in playing with their child in order to improve the likelihood that children listen to their parents when given an instruction would be categorised as having outcomes in both child behaviour and parent-child relationship.

Box 1. Proposed outcomes framework for the analysis of parenting programs

Child development: normative standards for growth and development; antenatal and infant development (e.g. antenatal and parental smoking and mother's alcohol/drug use, foetal and early childhood exposure to trauma or abuse, birth weight, breastfeeding, immunisation); covers infancy, early childhood through to adolescence; overall health; temperament; language and cognitive development (e.g. early childhood brain development, pre-academic skills, approaches to learning, successful in reading, writing, literacy and numeracy, problem-solving and decision-making skills, completion of secondary education, academic achievement, school engagement, attachment and retention, truancy, absenteeism); child adaptive behaviour (e.g. self-care skills, motor skills); parent promotion of child health and development; parent knowledge of child development.

Child behaviour: includes both internalising and externalising behaviour difficulties; problem behaviour; consistent parenting; child behaviour management; positive child behaviour and pro-social behaviour; social and emotional development (e.g. mental health, identity, social competence, self-control, self-esteem, self-efficacy, emotional management and expression, trauma symptoms, coping, emotional intelligence); law-abiding behaviour and underage convictions (particularly for adolescents); risk avoidance and risky behaviour (e.g. youth pregnancy, youth suicide, youth smoking, substance use).

Safety and physical wellbeing: includes optimal physical health and healthy lifestyle (e.g. adequate nutrition, free from preventable disease, sun protection, healthy teeth and gums, healthy weight, free from asthma, adequate exercise and physical activity, healthy adult/parent lifestyle); safety (e.g. safe from injury and harm, free from abuse and neglect); stability, material wellbeing and economic security (e.g. ability to pay for essentials, adequate family housing, family income and family social capital); effects of long-term exposure to persistent poverty.

Basic child care: for example, bathing, putting baby to bed, clothing, food and nutrition, child self-care, avoidance of neglect.

Parent-child relationship: includes parent-child interactions (e.g. positive interactions between parents and children, emotional warmth and responsiveness, absence of hostility); consistency and reliability (e.g. children able to rely on supportive adults, providing guidance, providing adequate boundaries); attachment; stimulating learning and development.

Family relationships: includes the parental relationship and relationships between other family members (e.g. child free from exposure to conflict or family violence, positive family functioning, stability in relationships, connection to primary caregiver, connection to family); social relationships and social support (e.g. connection to school and friends, connection to community, connection to culture); family's community participation; community resources; good parental mental health.

3 METHOD AND RESULTS

Considering the outcomes specified in the framework proposed in Section 2, this section of the report provides a comprehensive review of the evidence base for parenting programs aimed at addressing these child, parent and family outcomes. We assess the level of evidence for existing parenting programs using two complementary approaches:

> **Step A**: An analysis of the effectiveness of programs based on information collated from established and authoritative international clearinghouses on evidence-based and promising programs and practices, and from previous systematic reviews and meta-analyses of parenting programs.
>
> **Step B**: A Rapid Evidence Assessment (REA) of programs delivered and evaluated in Australia.

3.1 Review of evidence for parenting programs

3.1.1 Step A: Effectiveness of recognised parenting programs

We assessed the effectiveness of individual parenting programs in the first instance by collating evidence from established and authoritative international clearinghouses, then by checking previous systematic reviews and meta-analyses of parenting programs for new evidence.

Web-based clearinghouses were included as an information source if they met the following criteria:

a) Provided ratings of child, parent or family programs
b) Specified child, parent or family outcomes and the target population
c) Used experts in the field to rate programs
d) Used rating scales or systems which have clear criteria for inclusion.

Clearinghouses that met these criteria, and were therefore accessed to identify relevant parenting programs, are listed in Box 2.

Box 2. Clearinghouses accessed for the analysis of parenting programs

- National Resource Centre for Community-Based Child Abuse Prevention (CBCAP)
  http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory
- The California Evidence-Based Clearinghouse (CEBC)
  http://www.cebc4cw.org/
- The US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA)
  http://nrepp.samhsa.gov/
- Promising Practices Network on Children, Families and Communities (Promising Practices Network)
  http://www.promisingpractices.net/programs.asp

- The Coalition for Evidence-Based Policy's Social Programs that Work (Social Programs that Work)
  http://www.evidencebasedprograms.org/

- Blueprints for Violence Prevention (Blueprints)
  http://www.colorado.edu/cspv/blueprints/index.html

- Strengthening America's Families: Effective Family Programs for Prevention of Delinquency (Strengthening America's Families)
  http://www.strengtheningfamilies.org/

- The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (OJJDP)
  http://www.ojjdp.gov/mpg/

From these clearinghouses, we identified programs that met our definition of parenting programs (see 'Definitions' section in the Introduction), and extracted the following information about each program: program name, description, outcomes, target population, setting and dose. We also noted whether the program was used in Australia. We conducted a systematic search for evidence associated with recognised parenting programs, beginning with the CBCAP, which provided a comprehensive list of programs targeting child abuse prevention, many of which were parenting programs. We added further program details from the other clearinghouses to CBCAP-listed programs. We searched the CEBC for additional parenting programs not identified by CBCAP and extracted program details accordingly. We gleaned further detail of CECB-listed programs from the remaining clearinghouses. Finally we searched SAMHSA and the remaining clearinghouses until we had identified all eligible, recognised programs and collated their details.

In addition to providing information about each program as well as evidence for the effectiveness of that program, the clearinghouses assigned ratings of program effectiveness. See Appendix 2 for a summary of the rating schemes used by each clearinghouse. We recorded the clearinghouse ratings for individual programs in our description of each program. While the ratings derived from the clearinghouses, viewed in conjunction with a description of the rating schemes, provide useful information about each parenting program, they have their limitations: the rating schemes vary across clearinghouses, sometimes returning different ratings for the same program across clearinghouses; the recency of the rating varies; the evidence used to produce the rating varies; and the focus of each clearinghouse varies.

To address these limitations we ranked the clearinghouses to determine the most suitable clearinghouse rating for each program. CEBC and CBCAP provide clearly described, multi-level, rigorous rating schemes, with their top-ranking programs providing evidence from randomised controlled trials (RCTs) that have been replicated and that demonstrate maintained effects. As the purposes of CEBC are more applicable to the current analysis (in that it reviews a broad range of child welfare-related programs), it was ranked first and CBCAP second (because it rates programs specifically targeted at child abuse prevention). To determine the ranking of the other clearinghouses, we considered whether they had clear, usable categories for the purpose of this analysis and whether their top ranking required rigorous evidence (RCTs, maintenance and replication). We subsequently ranked the order of the clearinghouses as: CEBC, CBCAP, Social Programs that Work, Blueprints, Strengthening America's Families, OJJDP, SAMHSA, PPN. We therefore adopted the rating of the highest ranked clearinghouse that rated the program.

CEBC provided clear information about the evidence used when ranking programs but also provided ratings for programs *without* having access to all available evidence. For programs relevant to the current analysis, one program was rated by CEBC even though CEBC did not have access to all available evidence. In this case the Manager of Knowledge Synthesis at the Parenting Research Centre (second author of this report) checked the rating schemes and evidence available for this program (available on two clearinghouses) and found that the definitions of the ratings provided by the two clearinghouses were similar. The rating provided by CEBC was chosen in this instance as this program was ranked higher by CEBC than by the other clearinghouses.

Furthermore, we found discordant ratings for 13 programs across clearinghouses (for example, a program was rated 'Well Supported' in one clearinghouse and 'Promising' in another). In these circumstances, the Manager of Knowledge Synthesis compared the recency of ratings available for this program across all clearinghouses and determined which rating was the most suitable to use. For all but one program, the higher ranked clearinghouses carried the most recent ratings and so we used the highest ranked available rating in the current analysis. The one exception was a program that received a rating of 'Cannot be rated' from Strengthening America's Families but *was* rated by SAMHSA. We used the SAMHSA rating, as Strengthening America's Families does not have a rating category for programs of lower rigour, whereas SAMHSA has the potential to rate these programs.

A summary of the evidence for the effectiveness of each program identified in the clearinghouse analysis is provided in Appendix 3. We believe the information provided in Appendix 3 (and further discussed in section 3.2 below) will be useful to local agencies and to FaHCSIA to guide decisions about evidence-based program selection for particular target groups, settings or desired child, parent and family outcomes. Programs in Appendix 3 are listed in order of their rating from most effective to least effective. An exception to this ordering system applies to programs rated by SAMHSA that used numerical ratings for multiple outcomes and was thus inconsistent with the style of other clearinghouse rating systems. Appendix 4 provides a detailed description of each parenting program. These summary descriptions can be used to locate information about the program itself (intended outcomes, who the program is intended to be useful for, where and how it should be delivered), about the ratings of the effectiveness of the program, and about whether it has been used in Australia.

After extracting data from each of the identified clearinghouses to ensure we had identified all relevant programs and found the most recent evidence (all of which may not have been considered by each clearinghouse), we reviewed evidence provided in published systematic reviews and meta-analyses. To identify relevant reviews and meta-analyses we conducted extensive searches of systematic review electronic databases including those listed in Box 3.

Box 3. Systematic review electronic databases

- The Cochrane Library
  http://www.thecochranelibrary.com/view/0/index.html
- The Campbell Library
  http://www.campbellcollaboration.org/library.php
- The Guide to Community Preventive Services
  http://www.thecommunityguide.org/index.htm

- The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre)
  http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=62
- The Joanna Briggs Institute
  http://www.joannabriggs.edu.au/Search.aspx
- Centre for Reviews and Dissemination
  http://www.crd.york.ac.uk/crdweb/SearchPage.asp
- The Community Guide to Preventive Services
  http://www.thecommunityguide.org/index.html

3.1.2 Step B: Rapid Evidence Assessment of Australian evaluations of parenting programs

Rapid Evidence Assessment (REA) is a type of systematic literature review which employs accepted methods to accelerate or streamline traditional systematic review processes, facilitating the synthesis of evidence in an area within a short time period (Ganann, Ciliska & Thomas, 2010). REAs are increasingly being employed as valid alternatives to traditional systematic reviews when there are time limitations. REAs use systematic review methods to search and evaluate the literature, but the comprehensiveness of the search may be restricted.

The aim of the REA conducted for this analysis was to determine which parenting programs reporting parent, child or family outcomes have been evaluated in Australia and to identify the evidence for those programs.

Evaluations of parenting programs reporting outcomes were identified via a systematic search of the following:

a) electronic databases (MEDLINE, PsycInfo, ERIC, CINAHL, The Cochrane Library)
b) electronic databases of the grey literature (see Box 4)
c) selected Australian journals that are unlikely to be included in electronic databases (see Box 5)
d) Australian child and family organisation websites and Australian Government and state and territory government websites were accessed for additional published and unpublished program evaluations (see Box 6)
e) two documents provided by FaHCSIA were checked for any additional programs: 'A Summary of Key Findings of Papers & Reports on Parenting Practices & Programmes' and 'A Summary of Key Findings of Papers & Reports on Parenting Practices & Programmes – AIFS Papers'
f) FSP-funded agencies were contacted for additional published and unpublished program evaluations (only for agencies who had noted in a FaHCSIA survey of early 2012 that evaluation results were available upon request).

Box 4. Electronic databases of the grey literature

- OpenGrey
  http://www.opengrey.eu/
- New York Academy of Medicine Grey Literature Report
  http://www.nyam.org/library/online-resources/grey-literature-report/
- National Library of Medicine, Medline Plus
  http://www.nlm.nih.gov/medlineplus/
- National Health Service (NHS) Evidence
  https://www.evidence.nhs.uk/
- Online Computer Library Center
  http://www.oclc.org/default.htm
- Trove – National Library of Australia
  http://trove.nla.gov.au/

Box 5. Journals that were hand-searched

- Developing Practice: The Child, Youth and Family Work Journal
  http://www.acwa.asn.au/developing_practice11.html
- InPsych
  http://www.psychology.org.au/publications/inpsych/
- Family Matters
  http://www.aifs.gov.au/institute/pubs/fammats.html
- Australian E-journal for the Advancement of Mental Health
  http://auseinet.com/journal/
- Advances in Mental Health
  http://amh.e-contentmanagement.com/

Box 6. Organisation and government websites that were hand-searched

- Australian Institute of Family Studies (AIFS)
  http://www.aifs.gov.au/
- Child Family Community Australia (CFCA) Information Exchange
  http://www.aifs.gov.au/cfca/index.php
- Promising Practice Profiles
  http://www.aifs.gov.au/cafca/topics/index.html

- Closing the Gap
  http://www.aihw.gov.au/closingthegap/
- Australian Domestic and Family Violence Clearinghouse
  http://www.adfvc.unsw.edu.au/
- Australian Government websites and state, territory and local government websites
  http://australia.gov.au/

Using our predetermined definitions of outcomes and parenting programs, papers reporting evaluations were selected for inclusion by a member of a three-person team trained by the Manager of Knowledge Synthesis at the Parenting Research Centre. Papers were not included if no outcomes were reported; for example, if papers only reported participant acceptability or satisfaction ratings, or program output or process data they were not included.

Methods used to accelerate the REA process included analysing only papers written in the previous ten years, limiting the search to Australian evaluations, including only English language papers and not searching reference lists for further papers.

A four-person team was trained by the Manager of Knowledge Synthesis to extract data from the eligible papers. These data included program name, program aim, intended program outcomes, study design, mode, setting, dose, study participants and main findings. If there was more than one paper arising from the same study, the team collated data from the multiple papers into a single summary of that study.

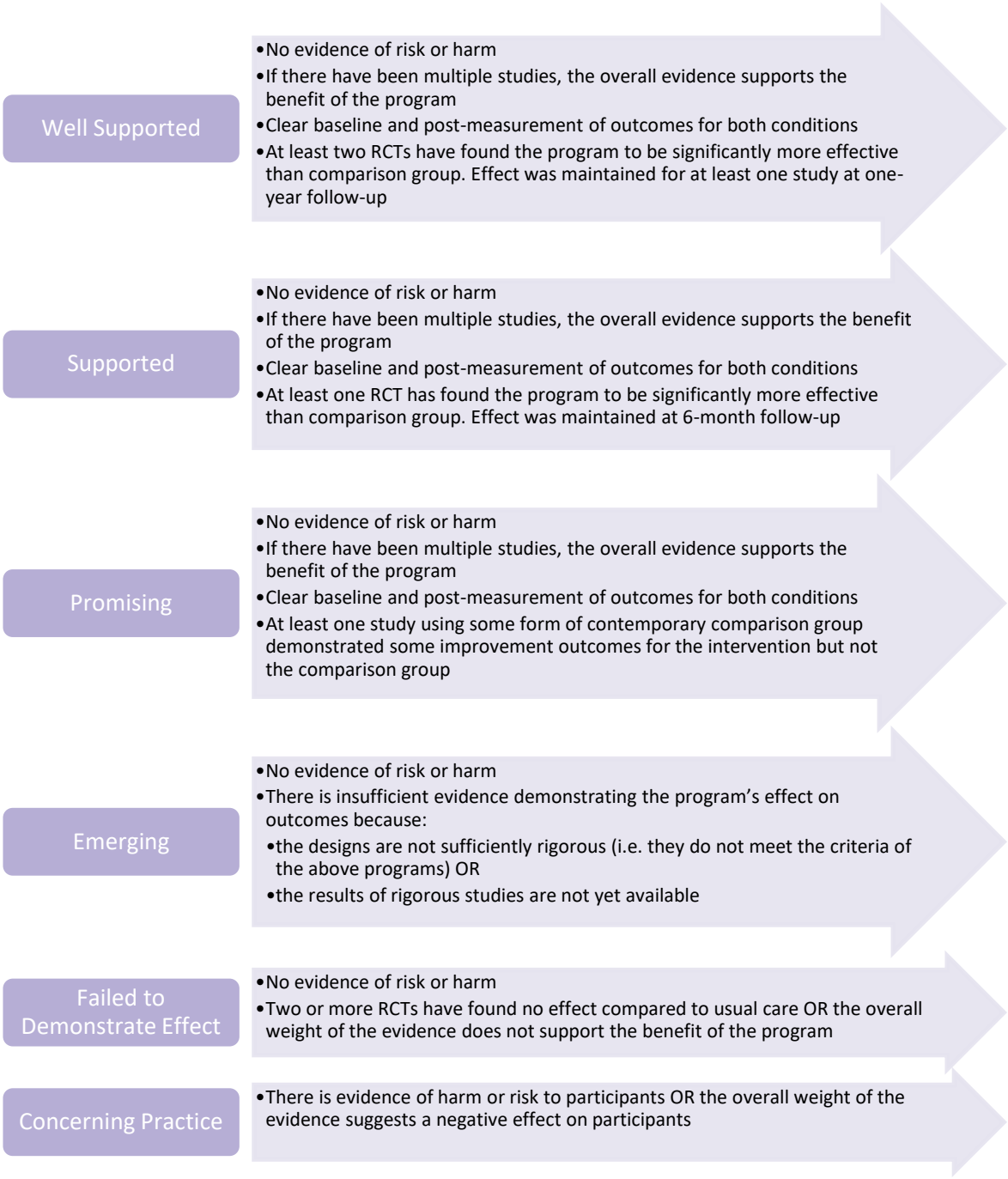
The effectiveness of each program was rated based on evidence from all papers found in the REA for that program. The rating scheme employed for this REA is presented in Figure 1.

Due to time limitations associated with the REA, the rating scheme was not as stringent as in the clearinghouse analysis, although the REA rating scheme was based on the schemes employed by the CEBC and CBCAP. For instance, conducting a more detailed analysis of individual study rigour was not feasible within the scope of the current analysis. Nevertheless, the ratings serve as a guide to where each program falls on an effectiveness continuum, from programs providing more evidence of effectiveness (Well Supported) through to programs with limited available Australian evidence (Emerging Practice), through to no effects (Failed to Demonstrate Effect) or harmful effects (Concerning Practice). See Appendix 5 for the template used to extract detail from each paper and Appendix 6 for the template used to rate each program.

A summary of the evidence of the effectiveness of each program (or, where necessary, each paper) identified in the REA is provided in Appendix 7. This summary can be used to locate information about the evaluated parenting program (intended outcomes, who the program is intended to be useful for, where and how it was delivered), and about our rating of the effectiveness of the program. While it was not always possible to identify whether FSP-funded services were using any of the programs identified in the REA, programs that were delivered with FSP funding are highlighted in orange in Appendix 7. It is anticipated that the information presented in Appendix 7 (and further discussed in section 3.2 below) will be useful to local agencies and to FaHCSIA to guide decisions about evidence-based program selection for particular target groups, settings or desired child, parent and family outcomes. Appendices 8–12

present the detailed data extraction performed with each paper identified for inclusion in the REA. There is one appendix for each rating level.

Figure 1. Rating scheme for REA of Australian evaluations of parenting programs



3.2 Summary of findings

3.2.1 Findings from the clearinghouse analysis

Program ratings

The clearinghouse analysis identified 151 parenting programs that target child, parent and family outcomes. Thirty-four of those parenting programs are Well Supported or Supported by international evidence.

Target outcomes

Programs typically targeted more than one child, parent and family outcome, with Well Supported and Supported programs identified in the clearinghouse analysis most frequently targeting child behaviour (*n* = 26). Most other outcomes were targeted by a similar number of Well Supported and Supported programs, with 24 addressing child development, 23 addressing family relationships, 22 addressing safety and physical wellbeing and 15 focusing on the parent-child relationship. There were 4 programs targeting basic child care.

Target populations

For programs rated as Well Supported or Supported in the clearinghouse analysis, the most frequently targeted population was children with internalising and externalising behavioural problems (*n* = 14). Seven programs targeted parents and children with substance abuse problems. Two programs focused on children who had committed or who were at risk of committing sexual abuse. Two programs catered for families involved in the justice system, two targeted children who have experienced trauma, and two targeted children at risk of out-of-home care. Other programs targeted the following populations: foster parents, children at risk of poor birth outcomes, parents with limited education, children with special needs, new parents, those at risk of child abuse and neglect, and low-income families. In terms of child age, two programs targeted pregnant parents, one targeted premature infants, one targeted children aged 0–5 years, three targeted preschoolers, two targeted children across the preschool and primary-school ages, and seven targeted primary school-aged children. One program catered for children 0–12 years and one from birth to 18 years. Seven programs were specifically for adolescents and two programs targeted preschool ages through to adolescence.

Gaps in clearinghouse evidence

The clearinghouse analysis identified few Well Supported or Supported programs targeting basic child care. With regards to family, child and parent concerns, there were few programs with sufficient evidence that targeted areas other than child behaviour. There were few programs for infancy, no programs for parents with disabilities or mental health issues and no programs for teenage parents.

Systematic reviews and meta-analyses

We examined 21 reviews and meta-analyses (see Box 7), initially searching for any recent evidence about the programs identified in clearinghouse analysis and then searching for additional evidence-based parenting programs that had not been identified in the clearinghouse analysis. Table 1 provides an overview of the systematic reviews and meta-analyses, including detail about additional evidence and programs.

In summary, for target populations and outcomes that were well-covered by programs identified to be Well Supported or Supported in the clearinghouse analysis (i.e. programs addressing child and adolescent social, emotional and behavioural wellbeing, conduct disorder, antisocial behaviour and delinquency, and childhood injury and home safety), there was no additional recent evidence about programs in the clearinghouse analysis, nor were there additional programs to include. The exceptions were five promising studies addressing home safety and childhood injury (King, 2001; McDonald, 2005; Nansel, 2002; Posner, 2004; Rhoads, 1999) as described in the review by Kendrick and colleagues (2007b), that provided some evidence of the effectiveness of interventions targeting specific home safety and injury prevention issues (e.g. minimising exposure to dust lead), but each study needed replication and longer-term follow-up.

For target populations and outcomes that were not well-covered by programs identified to be Well Supported or Supported in the clearinghouse analysis (e.g. basic child care) there were a number of studies that provided limited evidence of effectiveness of parenting programs not cited in the clearinghouse analysis which may be worth exploring further. The Community Mothers Program (Johnson, 1993) was cited by two systematic reviews/meta-analyses (Black, 2004 and Kendrick et al., 2007a) and showed some promise as a home visiting program focusing on healthcare, nutritional improvement and overall child development. In the absence of replication and long-term follow-up, the Community Mothers Program may be worth exploring as a promising parenting program.

Other studies showing promise but also in need of replication and long-term follow-up included the following:

- Bryanton and Beck (2010) described three studies (St James-Roberts, 2001; Stremler, 2006; and Symon, 2005) that provided some evidence for the effectiveness of parenting programs addressing infant sleep problems.
- Priest and colleagues (2008) described six studies (Greenberg, 1994; Emmons, 2001; Abdullah, 2005; Hovell, 2000, 2002; and Kreiger, 2005) providing evidence of the effectiveness of interventions targeting children's exposure to tobacco smoke.
- Waters and colleagues (2011) described one study (Harvey-Berino 2003) that demonstrated some evidence of the effectiveness of a parenting program (the Active Parenting Curriculum) targeting child obesity.
- Welsh and colleagues (2011) described one study (Dolinar, 2000) that provided limited evidence of the effectiveness of a home-based asthma education program.

Therefore, while the clearinghouse analysis presented in Appendices 3 and 4 provided a good indication of evidence-based parenting programs targeting issues of frequent concern to families and support services, our review of available systematic reviews and meta-analyses revealed parenting interventions that show some promise of effectiveness in areas of child health that have few Well Supported or Supported programs.

Box 7. Systematic reviews and meta-analyses reviewed for the clearinghouse analysis

Barlow, J., & Parsons, J. (2003). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. *Cochrane Database of Systematic Reviews*, 2003 (2). DOI: 10.1002/14651858.CD003680.children. Retrieved May 16, 2012, from the Cochrane Library Database.

Barlow, J., Smaigalic, N., Bennett, C., Husband, N., Jones, H., & Coren, E. (2011). Individual and group based parenting for improving psychosocial outcomes for teenage parents and their

children. *Cochrane Database of Systematic Reviews*, 2011 (3). DOI: 10.1002/14651858.CD002964.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Barlow, J., Coren, E., & Stewart-Brown, S. (2005). Parent-training programmes for improving maternal psychosocial health. *Campbell Systematic Reviews*, 2005 (3). DOI: 10.4073/csr.2005.3. Retrieved May 16, 2012 from the Campbell Collaboration Database.

Bayer, J., Hiscock, H., Scalzo, K., Mathers, M., McDonald, M., Morris, A., Birdseye, J., & Wake, M. (2009). Systematic review of preventive interventions for children's mental health: What would work in Australian contexts*? Australian and New Zealand Journal of Psychiatry*, 43, 695-710.

Black, M., & Kemp, L. (2004). *Volunteer home visiting: A systematic review of evaluations*. Sydney: Centre for Health Equity Training Research and Evaluation, University of NSW. Retrieved May 2012, from http://notes.med.unsw.edu.au/cphceweb.nsf/resources/CHETRErpts1to5/$file/Black_M_(2004)_VHomeVisit_Lit_Review.pdf.

Bryanton, J., & Beck, C. (2010). Postnatal parental education for optimizing infant general health and parent-infant relationships. *Cochrane Database of Systematic Reviews*, 2010 (1). DOI: 10.1002/14651858.pub3. Retrieved May 16, from the Cochrane Library Database.

Coren, E., Hutchfield, J., Thomae, M., & Gustafsson, C. (2010). Parent training support for intellectually disabled parents. *Cochrane Database of Systematic Reviews*, 2010 (6). DOI: 10.1002/14651858.CD007987.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S., & Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. *Cochrane Database of Systematic Reviews*, 2012 (2). DOI: 10.1002/14651858.CD008225.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Gagnon, A., & Sandell, J. (2007). Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database of Systematic Reviews*, 2007 (3). DOI: 10.1002/14651858.CD002869.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, 36, 567-589.

Kendrick, D., Barlow, J., Hampshire, A., Polnay, L., & Stewart-Brown, S. (2007a). Parenting interventions for the prevention of unintentional injuries in childhood. *Cochrane Database of Systematic Reviews*, 2007a (4). DOI:10.1002/14651858.CD006020.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Kendrick, D., Coupland, C., Mason-Jones, A., Mulvaney, C., Simpson, J., Smith, S., et al. Home safety education and provision of safety equipment for injury prevention. *Cochrane Database of Systematic Reviews*, 2007b (1). DOI: 10.1002/14651858.CD005014.pub2.

Retrieved May 16, 2012, from the Cochrane Library Database.

Littell, J., Popa, M., & Forsythe, B. (2005). Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Campbell Systematic Reviews*, 2005 (1). DOI: 10.4073/csr.2005.1. Retrieved May 16, 2012, from the Campbell Collaboration Database.

Lui, S., Terplan, M., & Smith, E. (2008). Psychosocial interventions for women enrolled in alcohol treatment during pregnancy. *Cochrane Database of Systematic Reviews*, 2008 (3). DOI: 10.1002/14651858.CD006753.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Miller, S., Maguire, L., & Macdonald, G. (2011). Home-based child development interventions for preschool children from socially disadvantaged families. *Cochrane Database of Systematic Reviews*, 2011 (12). DOI:10.1002/14651858.CD008131.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Piquero, A., Farrington, D., Welsh, B., Tremblay, R., & Jennings, W. (2009). Effects of early family/parent training programs on antisocial behavior and delinquency. *Campbell Systematic Reviews*, 2008 (11). DOI: 10.4073/csr.2008.11. Retrieved May 16, 2012, from the Campbell Collaboration Database.

Priest, N., Roseby, R., Waters, E., Polnay, A., Campbell, R., Spencer, N., et al. (2008). Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke. *Cochrane Database of Systematic Reviews*, 2008 (4). DOI: 10.1002/14651858.CD001746.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Thomas, R., & Zimmer-Gembeck, M. (2007). Behavioral Outcomes of Parent-Child Interaction Therapy and Triple P-Positive Parenting Program: A review and meta-analysis. *Journal of Abnorm Child Psychol*, 35, 475-495.

Waters, E., de Silva-Sanigorski, A., Hall, B., Brown, T., Campbell, K., Gao, Y., et al. (2011). Interventions for preventing obesity in children. *Cochrane Database of Systematic Reviews*, 2011 (12). DOI: 10.1002/14651858.CD001871.pub3. Retrieved May 16, 2012, from the Cochrane Library Database.

Welsh, E. M. H., & Li, P. (2011). Home-based educational interventions for children with asthma. *Cochrane Database of Systematic Reviews*, 2011 (10). DOI: 10.1002/14651858.CD008469.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Woolfenden, S., Williams, K. J., & Peat, J. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. *Cochrane Database of Systematic Reviews*, 2001 (2). DOI: 10.1002/14651858.CD003015. Retrieved May 16, 2012, from the Cochrane Library Database.

Table 1. Summary of review of systematic reviews and meta-analyses following the clearinghouse analysis

Paper	Population and/or outcomes targeted	Conclusions
Barlow et al. (2003)	Emotional & behavioural adjustment in children under three years	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Barlow et al. (2011)	Teen parents	No clear conclusions about specific interventions or intervention components that are effective, therefore no recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Barlow et al. (2005)	Maternal mental health	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Bayer et al. (2009)	Behavioural & emotional problems in children	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Black (2004)	Home visiting programs	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although the Community Mothers program (Johnson, 1993) may be worth exploring (no replication and follow-up not published in peer-reviewed journal).
Bryanton & Beck (2010)	Infant health, crying, sleep, injury prevention & parent-child relationships	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although three studies (St James-Roberts, 2001; Stremler, 2006; and Symon, 2005) provide limited evidence of the effectiveness of interventions to address infant sleep problems, with the need for replication and longer-term follow-up.
Coren et al. (2010)	Parents with intellectual disability	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Furlong et al. (2012)	Behavioural and cognitive behavioural groups for conduct problems in 3–12 year olds	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Gagnon & Sandall (2011)	Antenatal education for childbirth or parenthood	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.

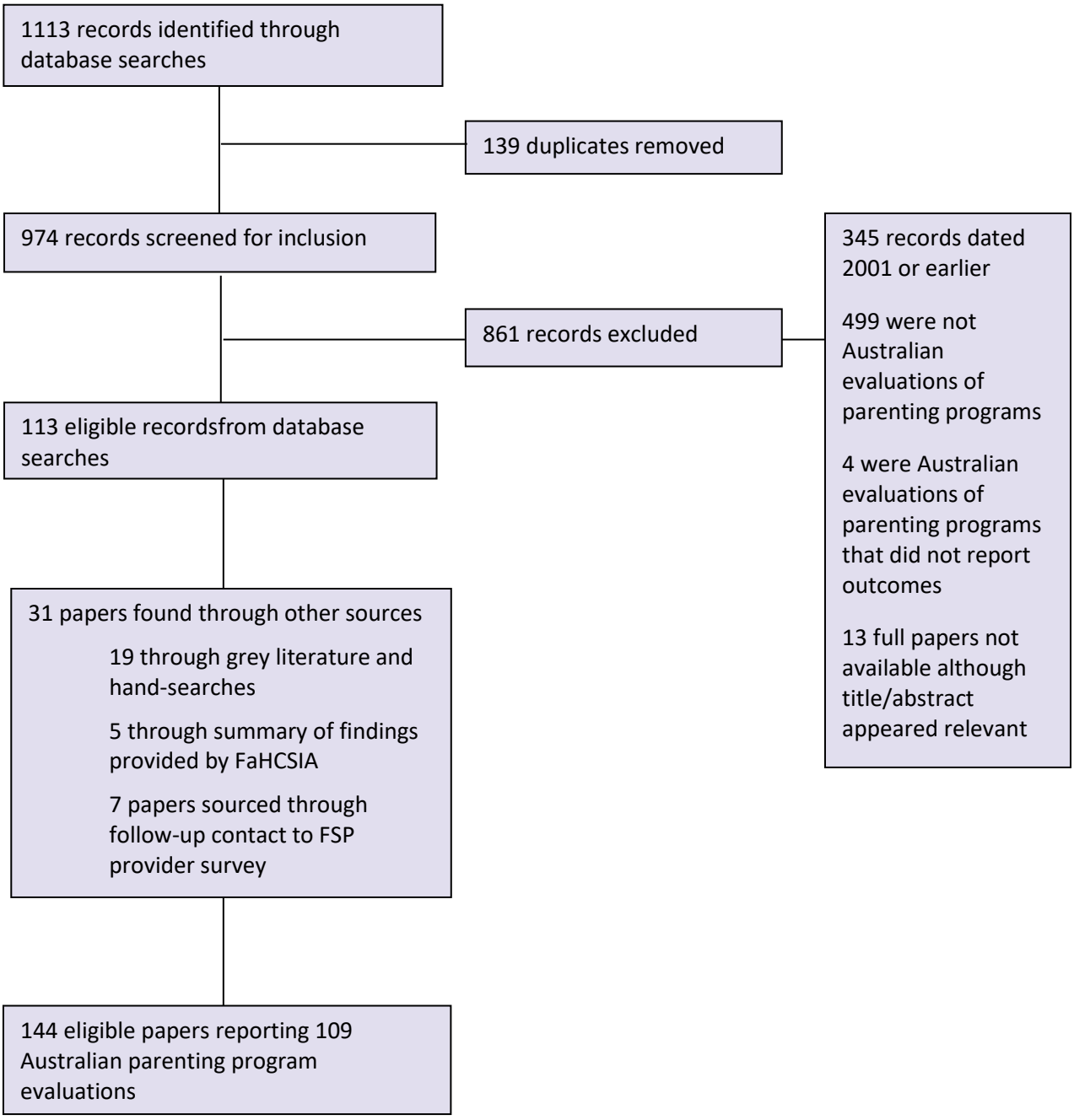
Paper	Population and/or outcomes targeted	Conclusions
Kaminski et al. (2008)	Child behaviour & adjustment	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Kendrick et al. (2007a)	Childhood injury	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although the Community Mothers program (Johnson, 1993) may be worth exploring (no replication and follow-up not published in peer-reviewed journal).
Kendrick et al. (2007b)	Home safety & injury prevention	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although a number of studies (King, 2001; McDonald, 2005; Nansel, 2002; Posner, 2004; and Rhoads, 1999) provided limited evidence of the effectiveness of interventions targeting specific home safety and injury prevention issues (e.g. minimising exposure to dust lead), but there is a need for replication and longer-term follow-up.
Littell et al. (2005)	Multisystemic therapy for social, emotional & behavioural problems in youth	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Lui et al. (2008)	Psychosocial interventions for alcohol-abusing pregnant women	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Miller et al. (2011)	Socially disadvantaged children	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Piquero et al. (2008)	Antisocial behaviour & delinquency	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.
Priest et al. (2008)	Exposure to tobacco smoke	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although a number of studies (i.e., Greenberg, 1994; Emmons, 2001; Abdullah, 2005; Hovell, 2000, 2002; and Kreiger, 2005) provided limited evidence of the effectiveness of interventions targeting children's exposure to tobacco smoke, but there is a need for replication and longer-term follow-up.
Thomas & Zimmer-Gemback (2007)	Behaviour in children 3 to 12 years old	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.

Paper	Population and/or outcomes targeted	Conclusions
Waters et al. (2011)	Obesity prevention in children	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although one study (Harvey-Berino, 2003) provided limited evidence of the effectiveness of a parent education program (the Active Parenting Curriculum) targeting child obesity, but there is a need for replication and longer-term follow-up.
Welsh et al. (2011)	Childhood asthma	No recent evidence about programs in the clearinghouse analysis and no additional programs identified, although one study (Dolinar, 2000) provided limited evidence of the effectiveness of a home-based asthma education program but there is a need for replication and longer-term follow-up.
Woolfenden (2001)	Adolescents with conduct disorder/delinquency	No recent evidence about programs in the clearinghouse analysis and no additional programs identified.

3.2.2 Findings from the Rapid Evidence Assessment of Australian evaluations

A flow chart of papers identified for inclusion in the REA is presented in Figure 2. Drawing on all searched sources of evaluations of Australian parenting programs, we located 144 unique and eligible papers concerning 109 programs.

Figure 2. A flow chart of papers identified for the REA of Australian parenting program evaluations



Program ratings

Of the 109 programs identified in the REA, only two were rated Well Supported: Triple P and Stepping Stones Triple P (see Appendix 8). Triple P is aimed at parents of children with behavioural problems aged 2–12 years, and Stepping Stones is a variation of Triple P for parents of children aged 2–12 years with a disability and behavioural problems. These programs demonstrated an effect on outcomes in more than one RCT with maintenance of effect of at least 12 months. There is good evidence for various delivery modes for both programs, including individual and group, standard and enhanced.

Twenty-three REA programs were rated as Supported (see Appendix 9). Six of these were variations of Triple P, including Indigenous and Teen Triple P. A further two Supported programs were trials of a brief parent group discussion based on Triple P. Unlike some programs that are Triple P adaptations, these brief interventions were designed by Triple P developer Matthew Sanders, and may represent initial testing of new Triple P variations. Two further Triple P variations were rated as Promising. The appearance of many Triple P programs in the REA is not surprising given that it is a widely-implemented Australian-developed program. Other programs classified as Supported in the REA were developed in both Australia (e.g. NOURISH, PRAISE, Parents Under Pressure) and internationally (e.g. Parent-Child Interaction Therapy).

In all there were 27 Promising programs in the REA (see Appendix 10). These programs used less rigorous designs than the Well Supported and Supported programs, although their findings did demonstrate some benefit of the program over the outcomes for a comparison or control condition. These Promising programs were a combination of those developed in Australia (e.g. ABCD, Signposts) and international programs (e.g. 1-2-3 Magic, HIPPY).

The majority of REA programs (*n* = 53) were rated as Emerging (see Appendix 11). These programs were found to have caused no harm and may have shown some benefit, however, study designs were not rigorous enough to demonstrate effectiveness. For example, these studies employed no comparison group or presented only post-intervention data.

Only four programs in the REA Failed to Demonstrate Effect (see Appendix 12). No REA programs were rated as a Concerning Practice. That is, none were found to cause harm.

Target outcomes

Similar to the findings regarding programs identified in the clearinghouse analysis, the majority of REA programs focused on outcomes related to child behaviour. Of the Well Supported and Supported programs (*n* = 25), 18 targeted child behaviour, 16 addressed the parent-child relationship, eight focused on family relationships, seven targeted safety and physical wellbeing, five targeted child development and only one focused on basic child care.

Of the Promising and Emerging programs (*n* = 80), 45 targeted child behaviour, 40 focused on parent-child relationships, 32 targeted child development, 29 targeted family relationships, 16 focused on safety and wellbeing and 14 targeted basic child care.

Target populations

Populations targeted by programs identified for the REA were varied. The most frequently targeted population among the 25 Well Supported and Supported programs was children with behavioural problems (*n* = 6). Two further programs focused on the behavioural concerns of children with disabilities. One program targeted gifted children, one targeted withdrawn

children, one targeted children with asthma, one targeted children who are regular fat dairy consumers but are healthy and three targeted overweight/obese children. One program targeted pregnant parents, one targeted parents with anxiety, one targeted parents on methadone maintenance or in the justice system, one targeted working parents and one targeted first-time parents. One program targeted Indigenous families and one targeted families from low socioeconomic areas. In terms of child age, there were four programs targeting preschoolers and two targeting ages 2–12 and adolescents. There was one program for each of these ages: infants; those aged up to 10; and ages 1–16.

Of the 80 Promising and Emerging REA programs, 13 programs targeted children with behavioural problems and 11 targeted children with disabilities or developmental delays. There were four programs targeting infants that were unsettled, three programs targeted overweight or obese children, one targeted children with extensive dental caries, one targeted children with substance abuse concerns and one targeted children with eczema. Four programs targeted parents with disabilities or learning difficulties, four targeted new parents, two targeted vulnerable parents or children, two targeted parents with anxiety or depression, two targeted pregnant parents, one targeted parents with relationship problems, one targeted separated or divorced parents, one targeted disadvantaged mothers, one adolescent mothers, and one targeted mothers with mental illness. There were two programs targeted at low socioeconomic families, one targeted families at risk of possible child protection involvement, one targeted families with court orders and one targeted homeless families. There were a number of programs that targeted particular cultural groups, such as Indigenous families (*n* = 7), African families (*n* = 2), one targeting Japanese families and one targeting migrant/refugee families. Child age groups targeted among the Promising and Emerging programs included premature infants in one program, infants (*n* = 6), children under 5 years (*n* = 5), preschoolers (*n* = 9), primary schoolers (*n* = 9), adolescents (*n* = 2), and children up to the age of 12 (*n* = 4). The remaining 44 Promising and Emerging programs did not specify a target child age group.

Gaps in the Australian evidence

There were few programs supported by good Australian evidence that targeted basic child care, safety and physical wellbeing, child development and family relationships. Most of the programs with good evidence targeted preschool children, with few effective programs targeting infants, primary-school aged children and adolescents. Children with behavioural concerns were targeted by several programs, whereas children with other specific issues had limited effective programs available to them. Programs for parents from diverse backgrounds, including Indigenous parents, parents with learning difficulties, mental health concerns or substance abuse problems as well as teen parents were not well catered for among the Well Supported or Supported Australian programs identified in the REA.

3.2.3 Combining clearinghouse and Rapid Evidence Assessment findings

Few programs found in the Australian REA were rated by the clearinghouses. Triple P (Well Supported in REA and clearinghouse analysis), Parent-Child Interaction Therapy (Well Supported in clearinghouse analysis and Supported in REA), 1-2-3 Magic (Supported in clearinghouse analysis and Promising in REA) and Parenting Wisely (Promising in both) were the only programs found in the clearinghouse analysis that also had Australian evidence. There were also the Triple P variations, which we rated separately in the REA, but were included in the overall Triple P ratings by the clearinghouses. Families and Schools Together (FAST) was rated as Well Supported in the clearinghouse analysis but the evidence for the Galiwin'ku version of FAST in Australia is only rated Emerging. The observation that most of the REA programs were not rated in the

clearinghouse analysis suggests that many REA programs were evaluations of local innovations. The evidence for these Australian innovations varies from Emerging to Supported. Based on the rigorous review of effectiveness undertaken by the clearinghouses combined with evidence from the available Australian evaluations, the most effective parenting programs identified by the current report are Triple P and Parent-Child Interaction Therapy. Both programs cater for children with behavioural problems, with Parent-Child Interaction Therapy focusing on preschoolers and Triple P targeting ages 2–12 years. While there is international evidence for programs targeting all outcomes (albeit a limited number of Supported or Well Supported programs targeting basic child care), the Australian evidence for programs targeting outcomes other than child behaviour is limited.

3.3 Critical considerations regarding the implementation of evidence-based parenting programs

Evidence-based programs and practices are defined as the competent and high fidelity implementation of programs and practices that have been demonstrated to be safe and effective (Chaffin & Fredrick, 2004). So far this report has identified parenting programs that have been demonstrated to be safe and effective. This section now addresses issues related to the quality implementation of these programs by describing critical considerations regarding the implementation of evidence-based parenting programs.

While the identification of evidence-based programs and local innovations can be helpful when practitioners, agencies, and policy makers are searching for programs in which to invest, the emphasis on identifying and cataloguing effective programs has not been matched by a corresponding effort to systematically assess the extent to which programs are implemented and to evaluate the impact of this on program outcomes (Aarons, Sommerfield & Walrath-Greene, 2009). This is despite strong evidence that the quality of the implementation of a program has an impact on desired outcomes.

Implementing evidence-based programs is complex and challenging, and many previous efforts to implement evidence-based programs in the family support sector have not reached their full potential due to a variety of issues inherent in both the family support service setting and the implementation process itself (Aarons, Hurlburt & Horwitz, 2011; Mildon & Shlonsky, 2011). Without addressing these organisational and individual challenges as part of a planned, purposeful and integrated implementation strategy, interventions, even effective ones, may not produce the desired effects for parents and children. Therefore, attention to **how** a program is implemented is as important to child, parent and family outcomes as **what** is implemented. To ensure that government spending is directed at services and programs known to be associated with positive results, and to ensure that limited dollars are invested in programs that are more likely to make a difference to families, we must attend to both the evidence that a program works, and the way that program should be implemented to achieve good results.

Rating schemes classifying the levels of evidence for programs (such as those described in Appendix 2) are sometimes extended beyond evidence of the effectiveness of the program to include a description of considerations related to the implementation of that program. Programs which demonstrate strong ratings across these implementation considerations are sometimes referred to as 'Model' programs. Model programs are Well Supported, evidence-based programs which are available for dissemination with full and effective support for implementation from the program developers or implementation specialist consultants. Usually such programs are based on a clearly defined theory of change and incorporate methods to encourage treatment fidelity

such as the provision of delivery manuals, standardised training and other technical assistance (e.g. coaching or supervision requirements, data collection procedures to measure change, treatment adherence checklists).

In addition to the materials and technical assistance available to support program implementation, other important considerations address the match between the program and the service context. A comprehensive implementation strategy will include specific actions carried out within a planned, long-term implementation and maintenance process. A range of frameworks exist for considering implementation support in the family support sector. Below we provide a summary of the core considerations highlighted by existing implementation frameworks to guide the effective implementation of parenting programs. Key considerations include the following:

- availability of staff with competencies matched to the skills required to implement the program
- capacity to deliver competency-based training which will lead staff to develop the skills and behaviours necessary for a particular task by delineating important components of the task
- providing work-based, opportunistic and reflective consultation and coaching to staff
- using implementation fidelity measures and program outcome measures to inform decision-making
- using supportive and facilitative administrative systems to better integrate the practice or program into the organisation (Mildon & Shlonsky, 2011).

Box 8 (see following page) summarises these and other important aspects of implementation identified within implementation science literature that should be considered when selecting an evidence-based program to deliver to families and when planning for the implementation of that program.

Box 8. Implementation considerations for parenting programs

Appropriateness of program aims and outcomes

- Is the program based on a clearly defined theory of change?
- Are there clear program aims?
- Are there clear intended outcomes of the program that match our desired outcomes?

Targeted participants

- Is the target population of the program identified and does it match our intended target population?
- What are the participant (child, parent or family) eligibility requirements (ages of caregivers or children, type of person, presenting problem, gender)?

Delivery setting

- What are the program delivery options (e.g. group, individual, self-administered, home-based, centre-based)?
- Is there flexibility in delivery modes that suit our service context?

Costs

- What are the costs to purchase the program?
- What are the costs to train staff in the program?
- What are the ongoing costs associated with purchasing manuals and technical assistance (e.g. coaching and supervision of staff)?
- What are the costs to implement the program with families (in terms of staff time, resources to deliver, travel cost to agency, travel cost to families, costs to families in terms of time off work and childcare)?
- Are cost-effectiveness studies available?

Accessibility

- Are the materials, trainers and experts available to provide technical assistance (i.e. training, coaching and supervision) to staff who will deliver the program?
- Is the program developer accessible for support during implementation of the program?
- Does the program come with adequate supporting documentation? For instance, are the content and methods of the intervention well documented (e.g. in provider training courses and user manuals); are the content and methods standardised to control quality of service delivery?
- Are the program content and materials suited for the professionals and parents we work with, in terms of comprehension of content (e.g. reading level of materials, amount of text to read or write, use of complex terminology)?
- Does the program suit our service's access policies (e.g. 'no wrong door' principles; 'soft' entry or access points; community-based access; access in remote communities)?

Technical assistance required

- What are staff training needs (frequency, duration, location, cost)?
- What amount of ongoing technical assistance is required (including top-up training, coaching or supervision)?

Fidelity

- What are the requirements around the fidelity or quality assurance of delivery of the program components to families? That is, how well do practitioners need to demonstrate use of the program either during training or while they are working with families (e.g. are there tests, checklists or observations that they need to perform during training; are there

certain things they need to do to prove/show to the trainers that they are using the program correctly, such as video-taped sessions, diaries, checklists about their skills or use of the program with families)?
- Are there certain program components that MUST be delivered to families? That is, if they don't do X, they are not actually using the program as intended.
- What are the program dosage or quantity requirements for effective results (i.e. how often and for how long do families need to receive the intervention)? Can our service meet those requirements?

Data and measurement of effectiveness
- How is progress towards goals, milestones and outcomes tracked?
- What are the requirements for data collection (i.e. what measures are recommended, how often are they to be administered, who can administer them)?
- How accessible and relevant are the developer-recommended evaluation tools (ease of access, cost, ease of administration and scoring, relevance to Australian context)?

Staff selection
- What are the necessary staff qualifications or skill requirements (i.e. who can deliver the intervention)? Does our service have such staff or can our service acquire such staff?

Languages
  - What languages is the program available in and does that match our client population?
  - Is the program relevant and accessible to particular cultural and language groups (e.g. Indigenous families)?

Services face a range of challenges when selecting and implementing evidence-based programs. One significant challenge is that an evidence-based program may not exist for a service provider's identified needs, selected target population, and service and cultural context. Alternatively, or sometimes additionally, the monetary cost of an evidence-based program may be too high, which is a difficulty community-based services often face. While the cost of *not* implementing an evidence-based program should also be considered in such circumstances, it is nonetheless the case that cost is often a barrier to the quality implementation of evidence-based programs.

Another significant challenge facing services is deciding the extent to which a program should be adapted or not to fit the context and, if done, how it should be adapted with quality and to good effect, retaining the essential elements of the program that contribute to its effectiveness. In general, when working with evidence-based programs it is best to work towards strong adherence to the program as is, to ensure program fidelity and to avoid possible dilution of the benefits of the program. Nevertheless, adaptation and local innovation are sometimes necessary in order to meet emerging needs and suit specific populations. In such cases it is important to evaluate adapted or innovative programs to ensure that intended child and family outcomes are being met, and that harm is not being caused. Ideally, where an evaluation reveals that an adapted or innovative program demonstrates promise (that is, has been reasonably well evaluated and was shown to have some positive outcomes), ongoing evaluation should be performed to establish higher levels of evidence.

4 SUMMARY AND LIMITATIONS

4.1 Summary

This report has drawn together information to provide FaHCSIA with recommendations for better practice to achieve key parenting outcomes for FSP-targeted families.

In the context of the outcomes identified within the outcomes framework proposed as relevant to FSP service providers (see Section 2.3), we examined the evidence for existing parenting programs and provided a rating of the level of evidence for individual programs. This information can be easily interpreted by FaHCSIA to guide decisions about the effectiveness of parenting programs for achieving particular child and family outcomes.

Further, the report provides a framework for considering critical components related to the implementation of parenting programs.

Taken together, the central considerations in this report — the current international and Australian evidence regarding best practice in parenting programs, as well as implementation concerns such as the cost, timing and ongoing support needs required to effectively deliver programs — provide a useful tool to guide the selection and implementation of evidence-based parenting programs for FSP-funded services.

The analyses described in this report have helped to identify the best available program options for FSP providers to use when working toward particular child, parent and family outcomes.

The clearinghouse analysis identified 34 Well Supported and Supported programs (Appendix 3), and the REA identified 25 Well Supported and Supported programs (Appendix 7). While the clearinghouse analysis pointed to a range of programs that have good evidence of effectiveness (including Multisystemic Therapy, Incredible Years, Nurse Family Partnership, Triple P and Parent-Child Interaction Therapy), the REA showed strong evidence of effectiveness for a more modest number of programs (i.e. Triple P and Stepping Stones Triple P).

At the Supported level of evidence, the REA identified a range of programs with reasonable evidence of effectiveness, including those targeting gifted children, withdrawn children, children with specific health problems (i.e. asthma, overweight and obesity), pregnant parents, parents with anxiety, methadone users or parents in the justice system, working parents, new parents, Indigenous parents and families in poverty.

The REA of Australian evaluations showed evidence for many programs at Promising and Emerging levels. These Promising and Emerging programs warrant further investigation as potential future evidence-based programs. This is particularly the case for programs targeting existing gaps including the following specific populations: parents experiencing difficulties managing infant sleep, overweight and obese children, children with specific health problems (i.e. dental caries, substance use, eczema), parents with learning difficulties, parents with mental health problems, couples experiencing relationship problems, homeless families, and different cultural groups including Indigenous, African and migrant/refugee families.

The clearinghouse analysis provided evidence for Well Supported and Supported programs for a range of specific populations, including programs for pregnant women, foster parents, parents with limited education, families in poverty, new parents, children at risk of committing sexual abuse, children with substance abuse problems, children in the criminal justice system, children exposed to trauma and children at risk of out-of-home care.

Both the clearinghouse and the REA analyses identified programs at the Supported level that covered the range of child age from infancy to adolescence, where age of target children was specified.

Across both the clearinghouse analysis and the REA, Well Supported and Supported programs were targeted mainly at outcomes related to child behaviour. The REA also identified a number of Well Supported and Supported programs targeted at outcomes related to the parent-child relationship. The clearinghouse analysis also identified Well Supported and Supported programs addressing outcomes related to child safety and physical wellbeing, child development and family relationships. Few programs targeted basic child care outcomes across both the clearinghouse analysis and the REA.

Clear gaps remain in the availability of Well Supported and Supported programs for parents with intellectual disabilities, parents with mental health problems, and teen parents. Promising programs may fill some of these gaps, although more rigorous evaluation of these programs is warranted. There is a need for more research to extend Australian evidence for Promising and Emerging programs. Importantly, the field needs to invest in high quality evaluation that meets international standards of rigour.

While of critical importance, identifying evidence-based programs is only the beginning of the process. **How** a program is implemented is as important to outcomes as **what** is implemented. Despite this, implementation issues often receive limited attention both when selecting a program to implement, and when actually implementing that program within a service. This report provided an overview of key considerations regarding implementation, and provided a framework to guide the selection of an appropriate, effective program that is likely to be implementable within the existing service context. Key implementation considerations include those related to the program itself (e.g. training, coaching and documentation) and those related to the service (staff, context, population served). The cost to agencies of not attending to implementation can be high.

4.2 Limitations of the report

There were a number of limitations imposed on the content of this report, due mainly to the time restrictions to complete the analyses. These limitations are detailed below.

4.2.1 Child and family-focused initiatives

The current report did not include an analysis of broad child- and family-focused initiatives that provide a suite of interventions, and which may include parenting programs within that suite. Given that such initiatives are broader than simply ‘parenting programs’, they fall outside the scope of the current analysis. For example, such initiatives often provide community-level intervention or child-focused day care or school-based programs in addition to parenting components. Evaluations of such initiatives typically do not separate out analyses of different components of the intervention, therefore where it was not possible to delineate the specific effects of the parenting program component of an initiative, these evaluations could not be included in the analysis. Some international examples are Sure Start (United Kingdom) and Early Head Start (United States of America). Australian examples include Communities That Care, Healthy Start, Pathways to Prevention, Communities for Children, Best Start (Victoria), Brighter Futures (New South Wales) and Families as First Teachers (Northern Territory).

Similarly, the analysis did not include papers describing evaluations of primarily child-centred or school-based programs. Some such programs do include a parenting component, such as

teachers talking to parents about how to extend the school-based program at home. However, the parenting component may not be consistently described as being a necessary component of the program. Examples of such programs from the United States of Ameica include the Abecedarian Project, Milwaukee Project (sometimes called the Family Rehabilitation Program) and Perry Preschool Program , which are specialised early intervention day care programs for children in disadvantage. Local Australian examples include NEWPIN (New Parent and Infant Network) and YALP (Yachad Accelerated Learning Project).

4.2.2 Clearinghouse analysis

The breadth of data extracted from clearinghouses about parenting programs was limited to important information that could be gathered quickly and consistently. Therefore some detail about individual programs was not collected; for instance, language options and staff qualifications required to deliver the program.

4.2.3 Rapid Evidence Assessment

While systematic reviews are essential to a true understanding of the evidence associated with effective programs, they can be costly in terms of the time and personnel required (at least a year to identify, extract and analyse all relevant studies; Hemingway & Brereton, 2009). Increasingly being recognised as a valid form of systematic review, REAs are emerging as superior alternatives to traditional literature reviews when there are time and staffing limitations. REAs are literature reviews that use methods to accelerate or streamline traditional systematic review processes, facilitating the synthesis of evidence in an area within a short time period (Ganann, Ciliska & Thomas, 2010).

The methods used to accelerate the current REA included analysing only papers written in the previous ten years, limiting the search to Australian evaluations, including only English language papers and not searching reference lists for further papers. Masters or doctoral dissertations that were not located online via electronic database searches were not included. As a consequence of the search restrictions imposed on the REA, the report may have missed some articles; for example, 345 papers dated prior to 2002 were not screened for inclusion. There may have been papers among these that provided more detail about the parenting programs and possibly further evidence for the programs under review or evidence for additional programs. Papers written earlier than 2002 may have provided more detailed description about a program that was included in the REA, including detail related to mode, setting or even results. Furthermore, there may have been occasions where a paper reporting only follow-up data was written between 2002 and 2012, but an earlier paper may have provided RCT-level evidence of effectiveness.

The breadth of data extracted from individual papers within the REA had to be limited to important information that could be gathered quickly and consistently. Therefore some detail about the studies was not collected, including any adaptations or modifications made to a recognised parenting program, a detailed description of the content of the parenting program (program aims and outcomes were extracted), whether the parenting program described had a manual or treatment guidelines, and information regarding how the content of the program was delivered (e.g. modelling, didactic learning, discussion, rehearsal).

Some detail about the rigour of the evaluation was not considered in the evaluation of the evidence supporting Australian evaluations included in the REA. For example, sample size was not included as a consideration, therefore studies that included intervention or comparison groups with as few as three participants were included. Furthermore, the quality and

appropriateness of statistical analyses employed within individual studies were not evaluated. We reported the main findings as they were described by the study authors, but did not validate that their analyses were appropriate or executed accurately.

4.2.4 Static analysis of parenting programs

This analysis was completed in June 2012 and readers are advised that new evidence will emerge after publication of this report. We recommend that any new evidence is taken into consideration when selecting and implementing parenting interventions.

5 REFERENCES

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health & Mental Health Services Research, 38*, 4-23.

Aarons, G. A., Sommerfeld, D. H., & Walrath-Greene, C. M. (2009). Evidence-based practice implementation: The impact of public vs. private sector organization type on organizational support, provider attitudes, and adoption of evidence-based practice. *Implementation Science*, 4(83), 1–13.

Abdullah, A. S. M., Mak, Y. W., Loke, A. Y., & Lam, T. H. (2005). Smoking cessation intervention in parents of young children: A randomised controlled trial. *Addiction, 100,* 1731-1740.

Australian Childhood Foundation (2012). ACF bringing up great kids program: Nixon Street Primary School Report May 2012.

Australian Government Department of Education, Employment and Workplace Relations; DEEWR. (2009). *Belonging, Being & Becoming: The Early Years Learning Framework for Australia*. ACT: Commonwealth of Australia.

Bailey, E. L., Van Der Zwan, R., Phelan, T. W., & Brooks, A. (2012). The 1-2-3 Magic Program: Implementation outcomes of an Australian pilot evaluation with school-aged children. *Child & Family Behavior Therapy, 34*(1), 53-69.

Bamberg, J., Findley, S., & Toumbourou, J. (2006). The BEST Plus approach to assisting families recover from youth substance problems. *Youth Studies Australia, 25,* 25-32.

Barlow, J., Coren, E., & Stewart-Brown, S. (2005). Parent-training programmes for improving maternal psychosocial health. *Campbell Systematic Reviews*, 2005 (3). DOI: 10.4073/csr.2005.3. Retrieved May 16, 2012, from the Campbell Collaboration Database.

Barlow, J., & Parsons, J. (2003). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. *Cochrane Database of Systematic Reviews*, 2003 (2). DOI: 10.1002/14651858.CD003680.children. Retrieved May 16, 2012, from the Cochrane Library Database.

Barlow, J., Smaigalic, N., Bennett, C., Husband, N., Jones, H., & Coren, E. Individual and group based parenting for improving psychosocial outcomes for teenage parents and their children. *Cochrane Database of Systematic Reviews*, 2011 (3). DOI: 10.1002/14651858.CD002964.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Barratt-Pugh, C., & Allen, N. (2011). Making a difference: Findings from "Better Beginnings" a family literacy intervention programme. *Australian Library Journal, 60*(3), 195-204.

Bartu, A., Sharp, J., Ludlow, J., & Doherty, D. A. (2006). Postnatal home visiting for illicit drug-using mothers and their infants: A randomised controlled trial. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 46*(5), 419-426.

Bassett, H., Lloyd, C., & King, R. (2003). Food Cent$: Educating mothers with a mental illness about nutrition. *British Journal of Occupational Therapy, 66*(8), 369-375.

Bayer, J., Hiscock, H., Scalzo, K., Mathers, M., McDonald, M., Morris, A., Birdseye, J., & Wake, M. (2009). Systematic review of preventive interventions for children's mental health: What would work in Australian contexts? *Australian and New Zealand Journal of Psychiatry, 43,* 695-710.

Bayer, J. K., Hiscock, H., Ukoumunne, O. C., Scalzo, K., & Wake, M. (2010). Three-year-old outcomes of a brief universal parenting intervention to prevent behaviour problems: Randomised controlled trial. *Archives of Disease in Childhood, 95*(3), 187-192.

Beatty, D., & Doran, A. (2007). *Hey, Dad! for indigenous dads, uncles and pops. Evaluation Report*. UnitingCare Burnside and CentaCare. Retrieved May 2012, from http://www.aifs.gov.au/afrc/docs/heydadeval.pdf

Beatty, S. E., Cross, D. S., & Shaw, T. M. (2008). The impact of a parent-directed intervention on parent-child communication about tobacco and alcohol. *Drug and Alcohol Review, 27*(6), 591-601.

Berry, L. S., Stoyles, G., & Donovan, M. (2010). Postseparation parenting education in a family relationship centre: A pilot study exploring the impact on perceived parent-child relationship and acrimony. *Journal of Family Studies, 16*(3), 224-236.

Bevan, N. (Ed.). (no date). *Rapid Evidence Assessment Toolkit.* Published by Government Social Research. Available at: http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment

Black, M., & Kemp, L. (2004). *Volunteer home visiting: A systematic review of evaluations*. Sydney: Centre for Health Equity Training Research and Evaluation, University of NSW. Retrieved May 2012, from http://notes.med.unsw.edu.au/cphceweb.nsf/resources/CHETRErpts1to5/$file/Black_M_(2004)_VHomeVisit_Lit_Review.pdf

Bor, W., Sanders, M. R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology, 30*(6), 571-587.

Bronfenbrenner, U. (1989). Ecological systems theory. *Annals of Child Development, 22*, 723-742.

Brown, T. (2008). An evaluation of a new post separation and divorce parenting program. *Family Matters, 78*, 44-51.

Bryanton, J., & Beck, C. (2010). Postnatal parental education for optimizing infant general health and parent-infant relationships. *Cochrane Database of Systematic Reviews*, 2010 (1). DOI: 10.1002/14651858.CD004068.pub3. Retrieved May 16, 2012, from the Cochrane Library Database.

Burke, K., Brennan, L., & Warren, C. (2012). Promoting protective factors for young adolescents: ABCD Parenting Adolescents Program randomized controlled trial. *Journal of Adolescence* (2012), doi:10.1016/j.adolescence.2012.05.002.

Burke, S., Soltys, M., & Trinder, M. (2008). A preliminary evaluation of the Together Parenting Program - a stand alone component of the Exploring Together Program. *Australian e-Journal for the Advancement of Mental Health, 7*(1), 1-10.

Burrows, T., Warren, J. M., Baur, L. A., & Collins, C. E. (2008). Impact of a child obesity intervention on dietary intake and behaviors. *International Journal of Obesity, 32*(10), 1481-1488.

Burrows, T., Warren, J. M., & Collins, C. E. (2010). The impact of a child obesity treatment intervention on parent child-feeding practices. *International Journal of Pediatric Obesity, 5*(1), 43-50.

Bustos, T., Jaaniste, T., Salmon, K., & Champion, G. D. (2008). Evaluation of a brief parent intervention teaching coping-promoting behavior for the infant immunization context: A randomized controlled trial. *Behavior Modification, 32*(4), 450-467.

Cann, W., Rogers, H., & Matthews, J. (2003). Family Intervention Services Program Evaluation: A brief report on initial outcomes for families. *Australian e-Journal for the Advancement of Mental Health, 2*(3), 1-8.

Cann, W., Rogers, H., & Worley, G. (2003). Report on a program evaluation of a telephone assisted parenting support service for families living in isolated rural areas. *Australian e-Journal for the Advancement of Mental Health, 2*(3).

Cashmore, A. W., Noller, J., Johnson, B., Ritchie, J., & Blinkhorn, A. S. (2011). Taking the pain out of waiting: The oral health counselling experiences of parents of children with extensive dental caries. *Health Education Journal, 70*(4), 407-419.

Cefai, J., Smith, D., & Pushak, R. E. (2010). Parenting Wisely: Parent training via CD-ROM with an Australian sample. *Child & Family Behavior Therapy, 32*(1), 17-33.

Centre for Community Child Health. (2011). Local evaluation final report: Horn of Africa Parent Support Group.

Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26(11)*, 1097-1113.

Cliff, D. P., Okely, A. D., Morgan, P. J., Steele, J. R., Jones, R. A., Colyvas, K., & Baur, L. A. (2011). Movement skills and physical activity in obese children: randomized controlled trial. *Medicine and Science in Sports and Exercise, 43*(1), 90-100.

Collins, C. E., Okely, A. D., Morgan, P. J., Jones, R. A., Burrows, T. L., Cliff, D. P., et al. (2011). Parent diet modification, child activity, or both in obese children: an RCT. *Pediatrics, 127*(4), 619-627.

Coren, E., Hutchfield, J., Thomae, M., & Gustafsson, C. (2010). Parent training support for intellectually disabled parents. *Cochrane Database of Systematic Reviews*, 2010 (6). DOI: 10.1002/14651858.CD007987.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Costin, J., & Chambers, S. M. (2007). Parent management training as a treatment for children with oppositional defiant disorder referred to a mental health clinic. *Clinical Child Psychology and Psychiatry, 12*(4), 511-524.

Costin, J., Lichte, C., Hill-Smith, A., Vance, A., & Luk, E. (2004). Parent group treatments for children with oppositional defiant disorder. *Australian e-Journal for the Advancement of Mental Health, 3*(1), 1-8.

Crisante, L. (2003). Training in parent consultation skills for primary care practitioners in early intervention in the pre-school context. *Australian e-Journal for the Advancement of Mental Health, 2*(3), 1-10.

Dadds, M. R., & Roth, J. H. (2008). Prevention of anxiety disorders: Results of a universal trial with young children. *Journal of Child and Family Studies, 17*(3), 320-335.

Daniels, L. A., Mallan, K. M., Battistutta, D., Nicholson, J. M., Perry, R., & Magarey, A. (2012). Evaluation of an intervention to promote protective infant feeding practices to prevent childhood obesity: Outcomes of the NOURISH RCT at 14 months of age and 6 months post the first of two intervention modules. *International Journal of Obesity* advance online publication, 19 June 2012; doi:10.1038/ijo.2012.96.

Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment, 32*(4), 381-390.

Dean, C., Myors, K., & Evans, E. (2003). Community-wide implementation of a parenting program: The South East Sydney Positive Parenting Project. *Australian e-Journal for the Advancement of Mental Health, 2*(3).

Department of Education and Early Childhood Development; DEECD. (2009). *Victorian Child and Adolescent Monitoring System (VCAMS): 150 Indicators.* Melbourne: Children's Services Coordination Board, Victorian Government Departments.

Dolinar, R. M., Kumar, V., Coutu-Wakulczyk, G., & Rowe, B. H. (2000). Pilot study of a home-based asthma health education program. *Patient Education and Counseling, 40,* 93-102.

Don, N., McMahon, C., & Rossiter, C. (2002). Effectiveness of an individualized multidisciplinary programme for managing unsettled infants. *Journal of Paediatrics and Child Health, 38*(6), 563-567.

Emmons, K. M., Hammond, S. K., Fava, J. L., Velicer, W. F., Evans, J. L., & Monroe, A. D. (2001). A randomised trial to reduce passive smoke exposure in low-income households with young children. *Pediatrics, 108,* 18-24.

Elias, G., Hay, I., Homel, R., & Freiberg, K. (2006). Enhancing parent-child book reading in a disadvantaged community. *Australian Journal of Early Childhood, 31*(1), 20-25.

Elliot, J., Prior, M., Merrigan, C., & Ballinger, K. (2002). Evaluation of a community intervention programme for preschool behavior problems. *Journal of Paediatrics and Child Health, 38*(1), 41-50.

Family Relationships Institute. (2011). Evaluation of couples/parenting weekend program 2010-2011.

Fisher, J., Rowe, H., & Feekery, C. (2004). Temperament and behaviour of infants aged 4-12 months on admission to a private mother-baby unit and at 1- and 6-month follow-up. *Clinical Psychologist, 8*(1), 15-21.

Fisher, J. R., Wynter, K. H., & Rowe, H. J. (2010). Innovative psycho-educational program to prevent common postpartum mental disorders in primiparous women: A before and after controlled study. *BMC Public Health, 10*(1), 432-432.

Flaherty, R. (2008). *Trialling a 1-2-3 Magic Parenting Program in a rural Australian child protection setting. Final Report*. NSW Institute of Rural Clinical Services and Teaching. Retrieved May 2012, from http://www.ruralheti.health.nsw.gov.au/__documents/complete-projects/rosa_flaherty_report.pdf

Flaherty, R., & Cooper, R. (2010). Piloting a parenting skills program in an Australian rural child protection setting. *Children Australia 35*(3), 18-24.

Flynn, C., & Hewitt, L. (2007). Community Bubs Program: Evaluation Report June 2007.

Fraser, K., Wallis, M., & St. John, W. (2004). Improving children's problem eating and mealtime behaviours: An evaluative study of a single session parent education programme. *Health Education Journal, 63*(3), 229-241.

Frye, S., & Dawe, S. (2008). Interventions for women prisoners and their children in the post-release period. *Clinical Psychologist, 12*(3), 99-108.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S., & Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. *Cochrane Database of Systematic Reviews*, 2012 (2). DOI: 10.1002/14651858.CD008225.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Gagnon, A., & Sandell, J. (2007). Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database of Systematic Reviews*, 2007 (3). DOI: 10.1002/14651858.CD002869.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Gannan, R., Ciliska, D., & Thomas H. Expediating systematic reviews: methods and implications of rapid reviews.(2010). *Implementation Science, 5*(56).

Giallo, R., Treyvaud, K., Matthews, J., & Kienhuis, M. (2010). Making the transition to primary school: An evaluation of a transition program for parents. *Australian Journal of Educational & Developmental Psychology, 10*, 1-17.

Gibbs, L., Waters, E., Robinson, J., Young, S., & Hutchinson, A. (2009). Assessing the feasibility of distributing child poison safety messages through three existing parent information pathways. *Injury Prevention, 15*(6), 418-420.

Golley, R. K., Magarey, A. M., Baur, L. A., Steinbeck, K. S., & Daniels, L. A. (2007). Twelve-month effectiveness of a parent-led, family-focused weight-management program for prepubertal children: A randomized, controlled trial. *Pediatrics, 119*(3), 517-525.

Greenberg, R. A., Strecher, V. J., Bauman, K. E., Boat, B. W., Fowler, M. G., Keyes, L. L., et al. (1994). Evaluation of a home-based intervention program to reduce infant passive smoking and lower respiratory illness. *Journal of Behavioral Medicine, 17,* 273-290.

Grillo, M., Gassner, L., Marshman, G., Dunn, S., & Hudson, P. (2006). Pediatric atopic eczema: The impact of an educational intervention. *Pediatric Dermatology, 23*(5), 428-436.

Guenther, J. (2011). *Evaluation of FAST Galiwin'ku program*. FAST, Northern Territory. Retrieved May 2012, from http://www.fastnt.org.au/documents/File/Galiwinku_FAST_evaluation_report.pdf

Halford, W. K., Petch, J., & Creedy, D. K. (2010). Promoting a positive transition to parenthood: A randomized clinical trial of couple relationship education. *Prevention Science, 11*(1), 89-100.

Harvey-Berino, J., & Rouke, J. (2003). Obesity prevention in preschool Native-American children: A pilot study using home visiting. *Obesity Research, 11,* 606-611.

Hastings, S. R., & Ludlow, T. R. (2006). P5 - A participatory program promoting pleasurable parenting: Preliminary evidence for a community-based parenting program. *Journal of Family Studies, 12*(2), 223-245.

Hauck, Y. L., Hall, W. A., Dhaliwal, S. S., Bennett, E., & Wells, G. (2012). The effectiveness of an early parenting intervention for mothers with infants with sleep and settling concerns: A prospective non-equivalent before-after design. *Journal of Clinical Nursing, 21*(1/2), 52-62.

Havighurst, S. S., Harley, A., & Prior, M. (2004). Building preschool children's emotional competence: A parenting program. *Early Education and Development, 15*(4), 423-447.

Havighurst, S. S., Wilson, K. R., Harley, A. E., & Prior, M. R. (2009). Tuning in to kids: An emotion-focused parenting program—initial findings from a community trial. *Journal of Community Psychology, 37*(8), 1008-1023.

Havighurst, S. S., Wilson, K. R., Harley, A. E., Prior, M. R., & Kehoe, C. (2010). Tuning in to kids: Improving emotion socialization practices in parents of preschool children-findings from a community trial. *Journal of Child Psychology and Psychiatry, 51*(12), 1342-1350.

Hawes, D. J., & Dadds, M. R. (2005). The treatment of conduct problems in children with callous-unemotional traits. *Journal of Consulting and Clinical Psychology, 73*(4), 737-741.

Hawes, D. J., & Dadds, M. R. (2007). Stability and malleability of callous-unemotional traits during treatment for childhood conduct problems. *Journal of Clinical Child and Adolescent Psychology, 36*(3), 347-355.

Hayes, L., Matthews, J., Copley, A., & Welsh, D. (2008). A randomized controlled trial of a mother-infant or toddler parenting program: Demonstrating effectiveness in practice. *Journal of pediatric psychology, 33*(5), 473-486.

Hemingway, P., & Brereton, N. What is a systematic review? What is...? series. (2009). Retrieved May 2012, from: http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/Syst-review.pdf

Hendrie, G. A., & Golley, R. K. (2011). Changing from regular-fat to low-fat dairy foods reduces saturated fat intake but not energy intake in 4-13-y-old children. *American Journal of Clinical Nutrition, 93*(5), 1117-1127.

Heyne, D., King, N. J., Tonge, B. J., Rollings, S., Young, D., Pritchard, M., et al. (2002). Evaluation of child therapy and caregiver training in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(6), 687-695.

Hill, A., Hill, R., & Moore, S. (2009). Product evaluation in a social marketing and community development context: A case study and initial report. *Social Marketing Quarterly, 15*(2), 92-104.

Hiscock, H., Bayer, J. K., Price, A., Ukoumunne, O. C., Rogers, S., & Wake, M. (2008). Universal parenting programme to prevent early childhood behavioural problems: Cluster randomised trial. *British Medical Journal, 336*(7639), 318-321.

Hovell, M. F., Metltzer, S. B., Wahlgren, D. R., Matt, G. E., Hofstetter, C. R., Jones, J. A., et al. (2002). Asthma management and environmental tobacco smoke exposure reduction in Latino children: A controlled trial. *Pediatrics, 110,* 946-956.

Hovell, M. F., Zakarian, J. M., Matt, G. E., Hofstetter, C. R., Bernert, J. T., & Prikle, J.(2000). Effect of counselling mothers on their children's exposure to environmental tobacco smoke: Randomised controlled trial. *British Medical Journal, 321,* 337-342.

Hudson, A., Cameron, C., & Matthews, J. (2008). The wide-scale implementation of a support program for parents of children with an intellectual disability and difficult behaviour. *Journal of Intellectual & Developmental Disability, 33*(2), 117-126.

Hudson, A. M., Matthews, J. M., Gavidia-Payne, S. T., Cameron, C. A., Mildon, R. L., Radler, G. A., et al. (2003). Evaluation of an intervention system for parents of children with intellectual disability and challenging behaviour. *Journal of Intellectual Disability Research, 47*(Parts 4/5), 238-249.

Ireland, J. L., Sanders, M. R., & Markie-Dadds, C. (2003). The impact of parent training on marital functioning: A comparison of two group versions of the Triple P-Positive Parenting Program for parents of children with early-onset conduct problems. *Behavioural and Cognitive Psychotherapy, 31*(2), 127-142.

Jay, J., & Rohl, M. (2005). Constructing a family literacy program: Challenges and successes. *International Journal of Early Childhood, 37*(1), 57-78.

Joachim, S., Sanders, M. R., & Turner, K. M. (2010). Reducing preschoolers' disruptive behavior in public with a brief parent discussion group. *Child Psychiatry and Human Development, 41*(1), 47-60.

Johnson, Z., Howell, F., & Molloy, B. (1993). Community mothers' programme: Randomised controlled trial of non-professional intervention in parenting. *British Medical Journal, 306,* 1449-1452.

Jones, R., Wells, M., Okely, A., Lockyer, L., & Walton, K. (2011). Is an online healthy lifestyles program acceptable for parents of preschool children? *Nutrition and Dietetics, 68*(2), 149-154.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36*, 567-589.

Kelleher, L., & Johnson, M. (2004). An evaluation of a volunteer-support program for families at risk. *Public Health Nursing, 21*(4), 297-305.

Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., et al. (2011). Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Archives of Disease in Childhood, 96*(6), 533-540.

Kendrick, D., Barlow, J., Hampshire, A., Polnay, L., & Stewart-Brown, S. (2007a) Parenting interventions for the prevention of unintentional injuries in childhood. *Cochrane Database of Systematic Reviews*, 2007a (4). DOI:10.1002/14651858.CD006020.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Kendrick, D., Coupland, C., Mason-Jones, A., Mulvaney, C., Simpson, J., Smith, S., et al. (2007b) Home safety education and provision of safety equipment for injury prevention. *Cochrane Database of Systematic Reviews*, 2007b (1). DOI: 10.1002/14651858.CD005014.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Kennedy, S. J., Rapee, R. M., & Edwards, S. L. (2009). A selective intervention program for inhibited preschool-aged children of parents with an anxiety disorder: Effects on current anxiety disorders and temperament. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(6), 602-609.

Kessler, M. L., Gira, E., & Poertner, J. (2005). Moving best practice to evidence-based practice in child welfare. *Families in Society, 86(2)*, 244-250.

Khan, M. S., O'Meara, M., Stevermuer, T. L., & Henry, R. L. (2004). Randomized controlled trial of asthma education after discharge from an emergency department. *Journal of Paediatrics and Child Health, 40*(12), 674-677.

King, W. J., Klassen, T. P., LeBlanc, J., Bernard-Bonnin, A., Robitaille, Y., Coyle, D., et al. (2001). The effectiveness of a home visit to prevent childhood injury. *Pediatrics, 108,* 382-388.

Krieger, J. W., Takaro, T. K., Song, L., & Weaver, M. (2005). The Seattle-King Country Healthy Homes Project: A randomised, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. *American Journal of Public Health, 95,* 652-659.

Liddell, M., Barnett, T., Diallo Roost, F., & McEachran, J. (2011). Investing in our future. An evaluation of the national rollout of the Home Interaction Program for Parents and Youngsters (HIPPY). Final report to the Department of Education, Employment and Workplace Relations, Canberra. Retrieved May 2012, from http://www.hippyaustralia.org.au/file/2377/

Littell, J., Popa, M., & Forsythe, B. (2005). Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Campbell Systematic Reviews*, 2005 (1). DOI: 10.4073/csr.2005.1. Retrieved May 16, 2012, from the Campbell Collaboration Database.

Llewellyn, G., McConnell, D., Honey, A., Mayes, R., & Russo, D. (2003). Promoting health and home safety for children of parents with intellectual disability: a randomized controlled trial. *Research in Developmental Disabilities, 24*(6), 405-431.

Lui, S., Terplan, M., & Smith, E. (2008). Psychosocial interventions for women enrolled in alcohol treatment during pregnancy. *Cochrane Database of Systematic Reviews*, 2008 (3). DOI: 10.1002/14651858.CD006753.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Magarey, A. M., Perry, R. A., Baur, L. A., Steinbeck, K. S., Sawyer, M., Hills, A. P., et al. (2011). A parent-led family-focused treatment program for overweight children aged 5 to 9 years: the PEACH RCT. *Pediatrics, 127*(2), 214-222.

Markie, D. C., & Sanders, M. R. (2006). Self-directed Triple P (Positive Parenting Program) for mothers with children at-risk of developing conduct problems. *Behavioural and Cognitive Psychotherapy, 34*(3), 259-275.

Marshall, L., & Swan, P. (2010). Parents as participating partners. *Australian Primary Mathematics Classroom, 15*(3), 25-32.

Matsumoto, Y., Sofronoff, K., & Sanders, M. R. (2007). The efficacy and acceptability of the triple P-positive parenting program with Japanese parents. *Behaviour Change, 24*(4), 205-218.

Matthey, S., Kavanagh, D. J., Howie, P., Barnett, B., & Charles, M. (2004). Prevention of postnatal distress or depression: An evaluation of an intervention at preparation for parenthood classes. *Journal of Affective Disorders, 79*(1-3), 113-126.

McConnell, D., Dalziel, A., Llewellyn, G., Laidlaw, K., & Hindmarsh, G. (2009). Strengthening the social relationships of mothers with learning difficulties. *British Journal of Learning Disabilities, 37*(1), 66-75.

McDonald, E. M., Solomon, B., Shields, W., Serwint, J. R., Jacobsen, H., Weaver, N. L., et al. (2005). Evaluation of a kiosk-based tailoring to promote household safety behaviours in an urban pediatric primary care practice. *Patient Education and Counselling, 58,* 168-181.

McTaggart, P., & Sanders, M. R. (2003). The Transition to School Project: Results from the classroom. *Australian e-Journal for the Advancement of Mental Health, 2*(3).

Mildon, R. (2008). Skill acquisition in parents with an intellectual disability: The effectiveness of in-home behavioural parent training. (Doctoral Dissertation, RMIT University, 2008).

Mildon, R. & Shlonsky, A. (2011). Bridge over troubled water: using implementation science to facilitate effective services in child welfare. *Child Abuse & Neglect, 35*(9), 753-6.

Mildon, R., Wade, C., & Matthews, J. (2008). Considering the contextual fit of an intervention for families headed by parents with an intellectual disability: An exploratory study. *Journal of Applied Research in Intellectual Disabilities*, *21*(4), 377-387.

Milgrom, J., Newnham, C., Anderson, P. J., Doyle, L. W., Gemmill, A. W., Lee, K., et al. (2010). Early sensitivity training for parents of preterm infants: Impact on the developing brain. *Pediatric Research, 67*(3), 330-335.

Miller, S., Maguire, L., & Macdonald, G. (2011). Home-based child development interventions for preschool children from socially disadvantaged families. *Cochrane Database of Systematic Reviews*, 2011 (12). DOI:10.1002/14651858.CD008131.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Morawska, A., Haslam, D., Milne, D., & Sanders, M. R. (2011). Evaluation of a brief parenting discussion group for parents of young children. *Journal of Developmental and Behavioral Pediatrics, 32*(2), 136-145.

Morawska, A., & Sanders, M. (2009). An evaluation of a behavioural parenting intervention for parents of gifted children. *Behaviour Research and Therapy, 47*(6), 463-470.

Morawska, A., & Sanders, M. R. (2006). Self-administered behavioural family intervention for parents of toddlers. Part 1: efficacy. *Journal of Consulting and Clinical Psychology, 74*(1), 10-19.

Nansel, T. R., Weaver, N., Donlin, M., Jacobsen, H., Kreuter, M. W., & Simmons-Morton, B. G. (2002). Baby, Be Safe: The effect of tailored communications for pediatric injury prevention provided in a primary care setting. *Patient Education and Counselling, 46,* 175-19

Nicholson, J. M., Berthelsen, D., Abad, V., Williams, K., & Bradley, J. (2008). Impact of music therapy to promote positive parenting and child development. *Journal of Health Psychology, 13,* 226-238.

Nixon, R. D., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2004). Parent-child interaction therapy: One- and two-year follow-up of standard and abbreviated treatments for oppositional preschoolers. *Journal of Abnormal Child Psychology, 32*(3), 263-267.

Norman, E., Sherburn, M., Osborne, R. H., & Galea, M. P. (2010). An exercise and education program improves well-being of new mothers: A randomized controlled trial. *Physical Therapy, 90*(3), 348-355.

OECD. (2009). *Doing Better for Children*. ISBN: 978-92-64-05933-7.

Okely, A. D., Collins, C. E., Morgan, P. J., Jones, R. A., Warren, J. M., Cliff, D. P., et al. (2010). Multi-site randomized controlled trial of a child-centered physical activity program, a parent-centered dietary-modification program, or both in overweight children: the HIKCUPS study. *The Journal of Pediatrics, 157*(3), 388-394.

Pennington, L., Thomson, K., James, P., Martin, L., & McNally, R. (2009). Effects of it takes two to talk—The human program for parents of preschool children with cerebral palsy: Findings from an exploratory study. *Journal of Speech, Language, and Hearing Research, 52*(5), 1121-1138.

Petch, A. (2009). Guest editorial. *Evidence & Policy, 5(2)*, 117-126.

Phelan, R., Lee, L., Howe, D., & Walter, G. (2006). Parenting and mental illness: A pilot group programme for parents. *Australasian Psychiatry, 14*(4), 399-402.

Phelan, R., Howe, D., Cashamn, E., & Batchelor, S. (2012). Enhancing parenting skills for parents with mental illness: The Mental Health Positive Parenting Program. *Medical Journal of Australia,* 1, 30-33.

Phillips, J., Morgan, S., Cawthorne, K., & Barnett, B. (2008). Pilot evaluation of parent-child interaction therapy delivered in an Australian community early childhood clinic setting. *Australian and New Zealand Journal of Psychiatry, 42*(8), 712-719.

Phillips, J., Sharpe, L., & Nemeth, D. (2010). Maternal psychopathology and outcomes of a residential mother-infant intervention for unsettled infant behaviour. *Australian and New Zealand Journal of Psychiatry, 44*(3), 280-289.

Piquero, A., Farrington, D., Welsh, B., Tremblay, R., & Jennings, W. (2009). Effects of early family/parent training programs on antisocial behavior and delinquency. *Campbell Systematic Reviews*, 2008 (11). DOI: 10.4073/csr.2008.11. Retrieved May 16, 2012, from the Campbell Collaboration Database.

Plant, K. M., & Sanders, M. R. (2007). Reducing problem behavior during care-giving in families of preschool-aged children with developmental disabilities. *Research in Developmental Disabilities, 28*(4), 362-385.

Plutzer, K., & Spencer, A. J. (2008). Efficacy of an oral health promotion intervention in the prevention of early childhood caries. *Community Dentistry and Oral Epidemiology, 36*(4), 335-346.

Plutzer, K., & Keirse, M. J. (2011). Incidence and prevention of early childhood caries in one- and two-parent families. *Child: Care, Health and Development, 37*(1), 5-10.

Porter, M., & Witham, P. (2003*). HAPPI Evaluation Report. An evaluation of the Centacare Homeless and Parenting Program Initiative South Australia*. Canberra, ACT: Department of Family and Community Services. Retrieved May 2012, from http://www.fahcsia.gov.au/sa/housing/pubs/homelessfamilies/happi/Documents/HAPPI_Evaluation.pdf

Posner, J., Hawkins, L., Garcia-Espana, F., & Durbin, D. A. (2004). A randomised clinical trial of a home safety intervention based in an emergency department setting. *Pediatrics, 113,* 1603.

Priddis, L. E., & Wells, G. (2010). Improving parent-infant relationships: An innovative group approach to working with families to improve parent-infant relationships within a community setting. *Neonatal, Paediatric & Child Health Nursing, 13*(3), 20-24.

Priest, N., Roseby, R., Waters, E., Polnay, A., Campbell, R., Spencer, N., et al. (2008). Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke. *Cochrane Database of Systematic Reviews*, 2008 (4). DOI: 10.1002/14651858.CD001746.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

Quinlivan, J., Box, H., & Evans, S. (2003). Postnatal home visits in teenage mothers: a randomised controlled trial. *Lancet*, *361*, 893-900.

Ralph, A., & Sanders, M. R. (2003). Preliminary evaluation of the Group Teen Triple P Program for parents of teenagers making the transition to high school. *Australian e-Journal for the Advancement of Mental Health, 2*(3), 1-10.

Rapee, R. M., Abbott, M. J., & Lyneham, H. J. (2006). Bibliotherapy for children with anxiety disorders using written materials for parents: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 74*(3), 436-444.

Rapee, R. M., Kennedy, S., Ingram, M., Edwards, S., & Sweeney, L. (2005). Prevention and early intervention of anxiety disorders in inhibited preschool children. *Journal of Consulting and Clinical Psychology, 73*(3), 488-497.

Rapee, R. M., Kennedy, S. J., Ingram, M., Edwards, S. L., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *The American Journal of Psychiatry, 167*(12), 1518-1525.

Renzaho, A. M. N., & Vignjevic, S. (2011). The impact of a parenting intervention in Australia among migrants and refugees from Liberia, Sierra Leone, Congo, and Burundi: Results from the African Migrant Parenting Program. *Journal of Family Studies, 17*(1), 71-79.

Rhoads, G. G., Ettinger, A. S., Weisel, C. P., Buckley, T. J., Goldman, K. D., Adgate, J., et al. (1999). The effect of dust lead control on blood lead in toddlers: A randomised trial, *Pediatrics, 103,* 772-777.

Robinson, G., & Tyler, W. (2006). *Ngaripirliga'ajirri: an early intervention program on the Tiwi Islands: final evaluation report.* Darwin: School for Social and Policy Research, Charles Darwin University.

Robinson, G., Tyler, W., Jones, Y., Silburn, S., & Zubrick, S. R. (2011). Context, diversity and engagement: Early intervention with Australian Aboriginal families in urban and remote contexts. *Children and Society*, 1-13.

Rogers, H., Cann, W., Cameron, D., Littlefield, L., & Lagioia, V. (2003). Evaluation of the Family Intervention Service for children presenting with characteristics associated with Attention Deficit Hyperactivity Disorder. *Australian e-Journal for the Advancement of Mental Health, 2*(3), 1-10.

Rowe, H. J., & Fisher, J. R. W. (2010). The contribution of Australian residential early parenting centres to comprehensive mental health care for mothers of infants: Evidence from a prospective study. *International Journal of Mental Health Systems, 4*, 6-17.

Salmon, K., Dadds, M. R., Allen, J., & Hawes, D. J. (2009). Can emotional language skills be taught during parent training for conduct problem children? *Child Psychiatry and Human Development, 40*(4), 485-498.

Sanders, M. R., Pidgeon, A. M., Gravestock, F., Connors, M. D., Brown, S., & Young, R. W. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy, 35*(3), 513-535.

Sanders, M. R., Bor, W., & Morawska, A. (2007). Maintenance of treatment gains: A comparison of enhanced, standard, and self-directed Triple P-Positive Parenting Program. *Journal of Abnormal Child Psychology, 35*(6), 983-998.

Sanders, M. R., Stallman, H. M., & McHale, M. (2011). Workplace Triple P: A controlled evaluation of a parenting intervention for working parents. *Journal of Family Psychology, 25*(4), 581-590.

Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., et al. (2008). "Every Family": A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention, 29*(3), 197-222.

Sawyer, S. M., & Glazner, J. A. (2004). What follows newborn screening? An evaluation of a residential education program for parents of infants with newly diagnosed cystic fibrosis. *Pediatrics, 114*(2 part 1), 411-416.

Shelton, D., LeGros, K., Norton, L., Stanton-Cook, S., Morgan, J., & Masterman, P. (2007). Randomised controlled trial: A parent-based group education programme for overweight children. *Journal of Paediatrics and Child Health, 43*(12), 799-805.

Shortt, A. L., Hutchinson, D. M., Chapman, R., & Toumbourou, J. W. (2007). Family, school, peer and individual influences on early adolescent alcohol use: First-year impact of the Resilient Families programme. *Drug and Alcohol Review, 26*(6), 625-634.

Social Compass (2011). *Once upon a circus evaluation*. Westside Circus.

Sofronoff, K., & Farbotko, M. (2002). The effectiveness of parent management training to increase self-efficacy in parents of children with Asperger syndrome. *Autism: The International Journal of Research & Practice, 6*(3), 271-286.

Sofronoff, K., Leslie, A., & Brown, W. (2004). Parent management training and Asperger syndrome: a randomized controlled trial to evaluate a parent based intervention. *Autism: The International Journal of Research & Practice, 8*(3), 301-317.

Staiger, P., Buckingham, J., Crosbie, J., & Carr, V. (2006). *Building a relational focus into parenting education: An evaluation of the Great Kids Program*. Australian Childhood Foundation.

Stallman, H. M. R., A. (2007). Reducing risk factors for adolescent behavioural and emotional problems: a pilot randomised controlled trial of a self-administered parenting intervention. *Australian e-Journal of the Advancement of Mental Health, 6*(2), 1-13.

St James-Roberts, I., Sleep, J., Morris, S., Owen, C., & Gillham, P. (2001). Use of behavioural programme in the first 3 months to prevent infant crying and sleeping problems. *Journal of Paediatrics & Child Health, 37,* 289-297.

Stremler, R., Hodnett, E., Lee, K., MacMillan, S., Mill, C., Ongcango, L., et al. (2006). A behavioural-educational intervention to promote maternal and infant sleep: A pilot randomized, controlled trial. *Sleep, 29,* 1609-1615.

Svensson, J., Barclay, L., & Cooke, M. (2009). Randomised-controlled trial of two antenatal education programmes. *Midwifery, 25*(2), 114-125.

Swift, M. C., Roeger, L., Walmsley, C., Howard, S., Furber, G., & Allison, S. (2009). Rural children referred for conduct problems: Evaluation of a collaborative program. *Australian Journal of Primary Health, 15*(4), 335-340.

Symon, B. G., Marley, J. E., Martin, A. J., & Norman, E. R. (2005). Effect of a consultation teaching behaviour modification on sleep performance in infants: A randomised controlled trial. *Medical Journal of Australia, 182*(5), 215-218.

Thomas, R., & Zimmer-Gembeck, M. (2007). Behavioral Outcomes of Parent-Child Interaction Therapy and Triple P-Positive Parenting Program: A review and meta-analysis. *Journal of Abnormal Child Psychology*, *35*, 475-495.

Tonge, B., Brereton, A., Kiomall, M., Mackinnon, A., King, N., & Rinehart, N. (2006). Effects on parental mental health of an education and skills training program for parents of young children with autism: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(5), 561-569.

Toumbourou, J. W., & Gregg, M. E. (2002). Impact of an empowerment-based parent education program on the reduction of youth suicide risk factors. *Journal of Adolescent Health, 31*(3), 277-285.

Treyvaud, K., Rogers, S., Matthews, J., & Allen, B. (2009). Outcomes following an early parenting center residential parenting program. *Journal of Family Nursing, 15*(4), 486-501.

Turner, K. M. T., Richards, M., & Sanders, M. R. (2007). Randomised clinical trial of a group parent education programme for Australian Indigenous families. *Journal of Paediatrics and Child Health, 43*(4), 243-251.

Turner, K. M. T. S., & Matthew R. (2006). Help when it's needed first: A controlled evaluation of brief, preventive behavioral family intervention in a primary care setting. *Behavior Therapy, 37*(2), 131-142.

U.S. Department of Health and Human Services (2012). *Information Memorandum: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* (ACYF-CB-IM-12-04). Washington, DC: Author.

Van Bergen, P., Salmon, K., Dadds, M. R., & Allen, J. (2009). The effects of mother training in emotion-rich, elaborative reminiscing on children's shared recall and emotion knowledge. *Journal of Cognition and Development, 10*(3), 162-187.

Victorian Government Department of Human Services (2007). *Best Interests framework for vulnerable children and youth*. Melbourne: Victorian Government Department of Human Services.

Wake, M., Tobin, S., Girolametto, L., Ukoumunne, O. C., Gold, L., Levickis, P., et al. (2011). Outcomes of population based language promotion for slow to talk toddlers at ages 2 and 3 years: Let's learn language cluster randomised controlled trial. *British Medical Journal (Online), 343*(7821).

Wakefield, M., Banham, D., McCaul, K., Martin, J., Ruffin, R., Badcock, N., et al. (2002). Effect of feedback regarding urinary cotinine and brief tailored advice on home smoking restrictions among low-income parents of children with asthma: a controlled trial. *Preventive Medicine, 34*(1), 58-65.

Waters, E., de Silva-Sanigorski, A., Hall, B., Brown, T., Campbell, K., Gao, Y., et al. (2011). Interventions for preventing obesity in children. *Cochrane Database of Systematic Reviews*, 2011 (12). DOI: 10.1002/14651858.CD001871.pub3. Retrieved May 16, 2012, from the Cochrane Library Database.

Weiskop, S., Richdale, A., & Matthews, J. (2005). Behavioural treatment to reduce sleep problems in children with autism or fragile X syndrome. *Developmental Medicine & Child Neurology, 47*(2), 94-104.

Welsh, E., M., H., & Li, P. (2011). Home-based educational interventions for children with asthma. *Cochrane Database of Systematic Reviews*, 2011 (10). DOI: 10.1002/14651858.CD008469.pub2. Retrieved May 16, 2012, from the Cochrane Library Database.

West, F., Sanders, M. R., Cleghorn, G. J., & Davies, P. S. (2010). Randomised clinical trial of a family-based lifestyle intervention for childhood obesity involving parents as the exclusive agents of change. *Behaviour Research and Therapy, 48*(12), 1170-1179.

Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Stepping Stones Triple P: An RCT of a parenting program with parents of a child diagnosed with an autism spectrum disorder. *Journal of Abnormal Child Psychology, 37*(4), 469-480.

Wiggins, T. L., Sofronoff, K., & Sanders, M. R. (2009). Pathways Triple P-positive parenting program: Effects on parent-child relationships and child behavior problems. *Family process, 48*(4), 517-530.

Wilson, K. R., Havighurst, S. S., & Harley, A. E. (2012). Tuning in to Kids: An effectiveness trial of a parenting program targeting emotion socialization of preschoolers. *Journal of Family Psychology, 26*(1), 56-65.

Woolfenden, S., Williams, K. J., & Peat, J. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. *Cochrane Database of Systematic Reviews*, 2001 (2). DOI: 10.1002/14651858.CD003015. Retrieved May 16, 2012, from the Cochrane Library Database.

Yuen, E., & Toumbourou, J. W. (2011). Does family intervention for adolescent substance use impact parental wellbeing? A longitudinal evaluation. *Australian and New Zealand Journal of Family Therapy, 32*(3), 249-263.

6 APPENDICES

Each appendix is provided in a separate document.

Appendix 1. Family Support Program (FaHCSIA) outcomes

Appendix 2. Clearinghouse rating systems

Appendix 3. Summary of evidence for parenting programs from clearinghouse analysis

Appendix 4. Program descriptions for parenting programs identified in clearinghouse analysis

Appendix 5. REA data extraction template

Appendix 6. REA Program rating checklist template

Appendix 7. Summary of evidence of the effectiveness of each program identified in the REA

Appendix 8. Programs rated as Well Supported in the REA (data extracted from papers and program rating checklists)

Appendix 9. Programs rated as Supported in the REA (data extracted from papers and program rating checklists)

Appendix 10. Programs rated as Promising in the REA (data extracted from papers and program rating checklists)

Appendix 11. Programs rated as Emerging in the REA (data extracted from papers and program rating checklists)

Appendix 12. Programs rated as Not Effective in the REA (data extracted from papers and program rating checklists)

Parenting Research Centre
raising children well

Level 5, 232 Victoria Parade, East Melbourne, Victoria, Australia 3002

E info@parentingrc.org.au
P +61 3 8660 3500
F +61 3 8660 3599
W www.parentingrc.org.au

Appendix 1. Family Support Program (FaHCSIA) outcomes

FSP outcomes

All FSP services work towards providing integrated services for families, particularly vulnerable and disadvantaged families, to improve child wellbeing and development, safety and family functioning.

To achieve this, the following five outcomes are relevant to the FSP:

- Families function well in nurturing and safe environments
- Children and families have the knowledge and skills for life and learning
- Families, including children, especially those who are vulnerable or disadvantaged, benefit from better social inclusion and reduced disadvantage
- Organisations provide integrated services and work in collaboration with other services and the community
- Services focus on vulnerable and disadvantaged families and children

FaHCSIA also specifies other outcomes by service:

1. **Family and Children's Services**

- to improve child wellbeing and development, safety and family functioning and to help build stronger, more resilient families and communities
- to improve family functioning, safety and child wellbeing and development
- to develop social support networks
- to develop effective parenting skills, self-esteem and confidence

2. **Indigenous Parenting Services**

- to enhance the wellbeing of children
- to build culturally strong parenting skills and stronger, more sustainable Indigenous families and communities
- to address social, cultural, personal, historical, and financial and health factors that can present barriers to effective parenting

3. **Community Playgroups**

- to develop child's social, emotional, cognitive and physical skills

4. **Specialist Services**

a) Specialised Family Violence Services

– to provide support

b) Family Law Services

– child wellbeing after/during separation/divorce

– better parental conflict management

FSP outcomes
c) Indigenous Family Safety – to reduce alcohol related family violence – to reduce incidents of violence through more effective policing – to strengthen social norms against violence – to improve coordination of support services to aid the recovery of people who experience or witness violence

Note. The information above was adapted from FSP documentation.

Appendix 2. Clearinghouse ratings systems

The California Evidence-Based Clearinghouse (CEBC) for Child Welfare

Website: http://www.cebc4cw.org/ratings/scientific-rating-scale/

CEBC uses a scientific rating scale with ratings from 1 to 5 to indicate the strength of the research evidence supporting a practice or program. A rating of 1 represents a practice with the strongest research evidence, and a rating of 5 represents a concerning practice that appears to pose substantial risk to children and families. Some programs do not currently have strong enough research evidence to be rated on the CEBC's scientific rating scale and are classified as NR - (Not able to be Rated).

Specific criteria for each rating are presented below:

Well Supported by Research Evidence

a. There is no case data suggesting a risk of harm that: i) was probably caused by the treatment; and ii) the harm was severe or frequent.

b. There is no legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

c. The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it.

d. Multiple Site Replication: At least two rigorous RCTs 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.

e. In at least one RCT, the practice was shown to have a sustained effect at least one year beyond the end of treatment.

f. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

g. If multiple outcome studies have been published, the overall weight of the evidence supports the benefit of the practice.

Supported by Research Evidence

a. There is no case data suggesting a risk of harm that: i) was probably caused by the treatment; and ii) the harm was severe or frequent.

b. There is no legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

c. 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.

d. At least one rigorous RCT in usual care or a practice setting has found the practice to be

superior to an appropriate comparison practice. The RCT has been reported in published, peer-reviewed literature.

e. In at least one RCT, the practice was shown to have a sustained effect of at least six months beyond the end of treatment.

f. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

g. If multiple outcome studies have been published, the overall weight of evidence supports the benefit of the practice.

Promising Research Evidence

a. There is no case data suggesting a risk of harm that: a) was probably caused by the treatment; and b) the harm was severe or frequent.

b. There is no legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

c. 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.

d. At least one study utilising some form of control (e.g., untreated group, placebo group, matched wait list study) has established the practice's benefit over the control, or found it to be comparable to a practice rated a 1, 2, or 3 on this rating scale or superior to an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.

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

Evidence Fails to Demonstrate Effect

a. Two or more RCTs have found the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer-reviewed literature.

b. If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice. The overall weight of evidence is based on the preponderance of published, peer-reviewed studies, and not a systematic review or meta-analysis. For example, if there have been three published RCTs and two of them showed the program did not have the desired effect, then the program would be rated a "4 - Evidence Fails to Demonstrate Effect."

Concerning Practice

a. If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or

b. There is case data suggesting a risk of harm that: i) was probably caused by the

The California Evidence-Based Clearinghouse (CEBC) for Child Welfare

treatment; and ii) the harm was severe or frequent; and/or

c. There is a legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

NR. Not able to be Rated

a. There is no case data suggesting a risk of harm that: i) was probably caused by the treatment; and ii) the harm was severe or frequent.

b. There is no legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

c. 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.

d. 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.

e. The practice does not have any published, peer-reviewed study utilising some form of control (e.g., untreated group, placebo group, matched wait list study) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.

f. The practice does not meet criteria for any other level on the CEBC Scientific Rating Scale.

National Resource Center for Community-Based Child Abuse Prevention (CBCAP)

Website: http://friendsnrc.org/

Programs are rated according to the following criteria:

Emerging Programs and Practices

Programmatic Characteristics

a. The program can articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This may be represented through a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.

b. The program may have a book, manual, other available writings, training materials, OR may be working on documents that specifies the components of the practice protocol and describes how to administer it.

c. The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.

Research & Evaluation Characteristics

a. 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.

b. Programs and practices may have been evaluated using less rigorous evaluation designs that have no comparison group. This includes using "pre-post" designs that examine change in individuals from before the program or practice was implemented to afterward, without comparing to an "untreated" group. OR - an evaluation may be in process with the results not yet available.

c. The program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities. For additional information on evaluation and developing logic models, visit the FRIENDS Evaluation Toolkit and Logic Model Builder at: http://www.friendsnrc.org/outcome/toolkit/index.htm

Promising Programs and Practices

Programmatic Characteristics

a. The program can articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through presence of a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.

a. The program may have a book, manual, other available writings, and training materials that specifies the components of the practice protocol and describes how to administer it. The program is able to provide formal or informal support and guidance regarding program model.

b. The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving services child abuse prevention or family support services.

Research & Evaluation Characteristics

a. 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.

c. At least one study utilizing some form of control or comparison group (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, in reducing risk and increasing protective factors associated with the prevention of abuse or neglect. The evaluation utilised a quasi-experimental study design, involving the comparison of two or more groups that differ based on their receipt of the program or practice. A formal, independent report has been produced which documents the program's positive outcomes.

d. The local program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities. Programs continually examine long-term outcomes and participate in research that would help

solidify the outcome findings.

e. The local program can demonstrate adherence to model fidelity in program or practice implementation.

Supported Programs and Practices

Programmatic Characteristics

a. The program articulates a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through the presence of a detailed logic model or conceptual framework that depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.

b. The practice has a book, manual, training, or other available writings that specifies the components of the practice protocol and describes how to administer it.

c. The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.

Research & Evaluation Characteristics

a. 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.

b. The research supporting the efficacy of the program or practice in producing positive outcomes associated with reducing risk and increasing protective factors associated with the prevention of abuse or neglect meets at least one or more of the following criterion:

- At least two rigorous RCTs (or other comparable methodology) 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.

OR

- At least two between-group design studies using either a matched comparison or regression discontinuity have found the practice to be equivalent to another practice that would qualify as supported or well-supported; or superior to an appropriate comparison practice.

c. The practice has been 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.

d. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

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

f. The program is committed and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.

g. The local program can demonstrate adherence to model fidelity in program implementation.

Well Supported Programs and Practices

Programmatic Characteristics

a. The program articulates a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through the presence of a detailed logic model or conceptual framework that depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.

b. The practice has a book, manual, training or other available writings that specify components of the service and describes how to administer it.

c. The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.

Research & Evaluation Characteristics

a. Multiple Site Replication in Usual Practice Settings: At least two rigorous RCTs or comparable methodology 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.

b. 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.

c. The practice has been 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.

d. Outcome measures must be reliable and valid, and administered consistently and accurately cross all subjects.

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

f. The program is committed and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.

g. The local program can demonstrate adherence to model fidelity in program implementation.*

Programs and Practices Lacking Support or Positive Outcomes/ Undetermined/ Concerning/Harmful Effects

Programmatic Characteristics

National Resource Center for Community-Based Child Abuse Prevention (CBCAP)

a. The program is not able to articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes.

b. The program does not have a book, manual, other available writings, training materials that describe the components of the program.

Research & Evaluation Characteristics

a. Two or more RCTs have found the practice has not resulted in improved outcomes, or has had harmful effects when compared to usual care.

OR

b. If multiple outcome studies have been conducted, the overall weight of evidence does NOT support the efficacy of the practice.

OR

c. No evaluation has been conducted. The program may or may not have plans to implement an evaluation.

Social Programs that Work (SPW) (Coalition for Evidence-Based Policy)

Website: http://www.evidencebasedprograms.org/

Description of Rating System

The Coalition for Evidence Based Policy use a "Top Tier Evidence" system to identify and validate interventions for inclusion in their Social Programs that Work clearinghouse. For each viable program, their search the literature and contact experts to identify all well-conducted randomised trials of the intervention (in addition to those initially brought to their attention). An Advisory Panel of nationally-recognized, evidence-based researchers and former public officials, decides which interventions to identify as Top Tier or Near Top Tier.

Top Tier

The standard used to evaluate candidates for the Top Tier, based on the Congressional legislative language, is: "Interventions shown in well-conducted randomised controlled trials, preferably conducted in typical community settings, to produce sizeable, sustained benefits to participants and/or society."

In applying this standard, the Checklist For Reviewing a Randomized Controlled Trial is used, which closely tracks guidance from the U.S. Office of Management and Budget (OMB), National Academies, and other respected research organisations, and reflects well-established principles on what constitutes a high-quality trial (e.g., adequate sample size, low sample attrition, valid outcome measures, intention to treat analysis). It also addresses the importance of replication in establishing strong evidence – namely, demonstration of effectiveness in at least two well-conducted trials, or one large multi-site trial.

The main focus for each candidate intervention is on assessing whether there is strong evidence that the intervention's effects are sizeable and sustained. However, in some cases,

Social Programs that Work (SPW) (Coalition for Evidence-Based Policy)

reviewers might also take into account such factors as the intervention's cost and ease of implementation (e.g., cases where the cost is exceptionally low).

Over time, short case summaries are developed illustrating the reasoning used in applying the above standard and guidance to particular studies, thus building a body of additional guidance for reviewers and applicants that is grounded in case-by-case decisions. (This approach – using actual case decisions to grow the body of guidance over time – has been long used by the Food and Drug Administration in its well-established procedures for reviewing randomised controlled trials of pharmaceutical drugs.)

Near Top Tier

The standard used to evaluate candidates for Near Top Tier is: Interventions shown to meet all elements of the Top Tier standard in a single site, and which only need one additional step to qualify as Top Tier – a replication trial to confirm the initial findings and establishing that they generalise to other sites.

The purpose of this category is to help grow the body of Top Tier interventions, by enabling policymakers and others to identify particularly strong candidates for replication trials from among the many interventions backed by more preliminary evidence, and thereby maximise the chances of a positive replication that would qualify the intervention as Top Tier.

For each viable program, the literature is searched and experts are contacted to identify all other high quality randomised trials of the intervention (in addition to those initially brought to the attention of the reviewers). Also, for interventions being considered for Top Tier or Near Top Tier on the basis of a limited number of well-designed and implemented randomised trials, the literature of high-quality non-randomised studies of the intervention is checked, to look for any patterns of effects that differ from those in the trials (possibly suggesting problems in generalisability) or for any adverse intervention effects.

Blueprints

Website: http://www.colorado.edu/cspv/blueprints/criteria.html

The selection criteria used by Blueprints reflect the level of confidence necessary for recommending that communities use programs with reasonable assurances that they will prevent violence and other behavioural problems when implemented with fidelity. Blueprints Model Programs are not intended to be a comprehensive list of programs that work, but rather reflect a selection of programs with strong research designs for which there is good evidence of their effectiveness. There is no implication that programs not on this list are necessarily ineffective. Chances are that there are a number of good programs that have just not yet undergone the rigorous evaluations required to demonstrate effectiveness.

Selection Criteria

There are several important criteria considered by Blueprints when reviewing program effectiveness. Three of these criteria are given greater weight: evidence of deterrent effect with a strong research design, sustained effect, and multiple site replication. Blueprints Model Programs must meet all three of these criteria, while Promising Programs must meet at least the first criterion.

Blueprints

Evidence of deterrent effect with a strong research design

This is the most important of the selection criteria.

Providing sufficient quantitative data to document effectiveness in preventing or reducing targeted behaviours requires the use of evaluative designs that provide reasonable confidence in the findings (e.g., experimental designs with random assignment or quasi-experimental designs with matched control groups). When random assignment cannot be used, the Blueprints Advisory Board considers studies that use control groups matched as closely as possible to experimental groups on relevant characteristics (e.g., gender, race, age, socioeconomic status, income) and studies with control groups that use statistical techniques to control for initial differences on key variables. As carefully as experimental and control groups are matched, however, it is impossible to determine if the groups may vary on some characteristics that have not been matched or controlled for and that are related to program outcome. Random assignment, therefore, is believed to be the most rigorous of methodological approaches.

At a minimum, the following issues need to be addressed:

1. Sample sizes must be large enough to provide statistical power to detect at least moderate sized effects. Selection of participants must be made in a manner that avoids bias. For example, a self-selecting sample that relies on volunteer participants might be more motivated to make change, thus introducing a plausible alternative explanation for outcomes that are achieved. An adequate description should report the characteristics of the sample, the selection process, and pre-test differences on relevant variables between the treatment and control conditions.

2. Sample sizes and losses must be reported through all follow-up periods, and tests that rule out differential attrition should be conducted.

3. Tests to measure outcomes must be administered fairly, accurately and consistently to all study participants. The instruments used to measure outcomes should be demonstrated to be reliable and valid. Measurements of actual behaviour are required for Blueprints, not attitudes or intent. More than one report of behaviour is preferable in instances where the same person both delivers the intervention and provides a measure of the outcome. When multiple measures of outcomes are used in a study, the intervention should significantly influence the most important outcomes and influence the others in the expected direction.

4. Analyses should be appropriately designed. They should be done at the same level as the randomisation and, following an "intent to treat" approach, should include all participants originally assigned to treatment and control conditions. Secondary analyses can be performed to determine the effectiveness of a program at differing levels of implementation and dosage. Two-tailed tests of significance are preferred since they represent the most conservative of tests.

School-based evaluations

Evaluations of school-based programs, with schools as the unit of analysis, typically require multiple schools per condition to perform a main effects analysis with sufficient power to detect effects. Since meeting this criterion requires a complex and costly evaluation, it would eliminate most existing school-level studies from consideration in the Blueprints Series.

Therefore, school-based evaluations that use experimental or quasi-experimental designs with relatively few schools, but more than one in each condition, are considered in the Blueprints Series if they meet an additional burden of proof. They must demonstrate consistency across effects and across replications with multiple measures from different sources. The theoretical rationale should be well developed, and there should be a rigorous evaluation of theory with evidence that the results are consistently in line with the expectations (i.e., there are changes in the risk and protective factors which mediate the changes in outcomes). Outcomes should be robust, with at least moderate effect sizes. Evidence that the benefits of the program outweigh the costs is helpful. Evaluations with multiple schools are most desirable and should be encouraged among funders and researchers.

Sustained effect

Designation as a Blueprints Model Program requires a sustained effect at least one year beyond treatment, with no subsequent evidence that this effect is lost.

A program may be identified as promising without meeting the sustainability criterion. In some cases, programs may not have conducted longer-term follow-ups. In other cases, programs will have performed long-term follow-ups and found no enduring effects. If program effects disappear at a later time period, Blueprints may qualify the program for only the period of time in which it was found to be effective, stating the loss of enduring effects at the point at which they were found. While these programs may not show enduring effects for 12 months or longer on specifically measured outcomes, in some cases they can provide meaningful benefits to youth, schools, and communities. For example, even if benefits don't last, delaying the onset of alcohol and drug use to a later age would improve the safety of youth during a highly vulnerable period of their lives. And since early onset of youth problems often leads to more serious problems later, delaying onset with temporary improvements may have payoffs at older ages

Multiple site replications

Becoming a Blueprints Model Program requires at least one high-quality replication with fidelity demonstrating that the program continues to be effective. This criterion does not need to be met to qualify as a promising program.

Some projects may be initially implemented as a multisite single design (i.e., several sites are included in the evaluation design). Although not as valuable as independent replications, these designs can check for overall main effects and sources of variation across sites.

Replication dismantling designs will also be considered. If a program has been implemented and evaluated as a component within a number of different programs (multiple component studies) and has also been implemented and evaluated alone, it is possible that the multiple component studies might meet the replication criterion. There must be a total of three studies, including the standalone program evaluation and two additional multiple component studies. All must be well designed with positive effects and with no negative effects.

Additional Factors

In the selection of Blueprints Model Programs, two additional factors are considered: whether a program conducted an analysis of mediating factors and whether a program is cost effective.

Analysis of mediating factors

The Blueprints Advisory Board looks for evidence that change in the targeted risk or protective

Blueprints

factor(s) mediates the change in problem behaviours. This evidence clearly strengthens the claim that participation in the program is responsible for the change in behaviour, and it contributes to the theoretical understanding of the causal processes involved.

Costs versus benefits

Program costs should be reasonable and should be less or no greater than the program's expected benefits.

Strengthening America's Families (SAF): Effective Family Programs for Prevention of Delinquency

Website: http://www.strengtheningfamilies.org/

Description of Rating System

Numerous criteria were used to rate and categorise programs. The criteria included: theory, fidelity of the interventions, sampling strategy and implementation, attrition, measures, data collection, missing data, analysis, replications, dissemination capability, cultural and age appropriateness, integrity and program utility.

Each program was rated independently by reviewers, discussed and a final determination made regarding the appropriate category. The following categories were used:

Exemplary I

This indicates the program has evaluation of the highest quality with an experimental design with a randomised sample and replication by an independent investigator other than the program developer. Outcome data from the numerous research studies show clear evidence of program effectiveness.

Exemplary II

This indicates the program has evaluation of the highest quality with an experimental design with a randomised sample. Outcome data from the numerous research studies show clear evidence of program effectiveness.

Model

This indicates the program has research of either an experimental or quasi-experimental design with few or no replications. Outcome data from the research project(s) indicate program effectiveness but the data are not as strong in demonstrating program effectiveness.

Promising

This indicates the program has limited research and/or employs non-experimental designs. Evaluation data associated with the program appears promising but requires confirmation using scientific techniques. The theoretical base and/or some other aspect of the program is also sound.

Programs rated as Exemplary programs are those that are well-implemented, are rigorously evaluated, and have consistent positive findings (integrity ratings of "A4 "or "A5 "). Model programs are those that have consistent integrity ratings of "A3" and "A4" and Promising programs are those that have mixed integrity ratings but demonstrate high integrity ratings in

at least 3-4 of the following categories.

Theory: the degree to which the project findings are based in clear and well-articulated theory, clearly stated hypotheses, and clear operational relevance.

1 = no information about theory or hypotheses specified

2 = very little information about theory and hypotheses specified

3 = adequate information about theory and hypotheses specified

4 = nearly complete information about theory and hypotheses specified

5 = full and complete information about theory and hypotheses specified

Fidelity of interventions: the degree to which there is clear evidence of high fidelity implementation, which may include dosage data.

1 = no or very weak evidence that most treatment participants received the full intervention

2 = weak evidence that most treatment participants received the full intervention

3 = some evidence that most treatment participants received the full intervention

4 = strong evidence that most treatment participants received the full intervention

5 = very strong evidence that nearly all treatment participants received the full intervention

Sampling strategy and implementation: the quality of sampling design and implementation.

1 = no control group; unspecified sample size or inadequate sample size

2 = inappropriate control group included or no attempt at random assignment; inadequate sample size

3 = inappropriate control group included or no attempt at random assignment; adequate sample size

4 = control group included; random assignment at individual or other level (e.g., school); adequate sample size

5 = control group included; random assignment at individual or other level (e.g., school); more than adequate sample size

Attrition: evidence of sample quality based on information about attrition.

1 = no data on attrition or very high attrition

2 = high attrition

3 = moderate attrition

4 = acceptable retention

5 = high retention

Measures: the operational relevance and psychometric quality of measures used in the evaluation, and the quality of supporting evidence.

1 = no or insufficient information about measures

2 = poor choice of measures; low psychometric qualities

3 = adequate choice of measures; mixed quality

4 = relevant measures with good psychometric qualities

5 = highly relevant measures with excellent psychometric qualities

Missing data: the quality of implementation of data collection (e.g., amount of missing data).

1 = high quantity of missing data

2 = somewhat high quantity of missing data

3 = average amount of missing data

4 = some missing data

5 = no or almost no missing data

Data collection: way data collected in terms of bias or demand characteristics and haphazard manner.

1 = very biased manner of data collection with high demand characteristics; data collected in haphazard manner without any standardization

2 = somewhat biased manner of data collection with some demand characteristics; data collected in haphazard manner without any standardization

3 = relatively unbiased manner of data collection; standardized method of data collection

4 = anonymous or confidentiality ensured in data collection; standardized method of data collection

5 = anonymous or confidentiality ensured in data collection; standardized method of data collection; ethnic group or gender match between data collectors and participants specified

Analysis: the appropriateness and technical adequacy of techniques of analysis, primarily statistical.

1 = no analyses reported; all analyses inappropriate or do not account for important factors

2 = some but not all analyses inappropriate or left out important factors

3 = mixed in terms of appropriateness and technical adequacy

4 = appropriate analyses but not cutting edge techniques

5 = proper, state-of-the-art analyses conducted

Other plausible threats to validity (excluding attrition): the degree to which the evaluation design and implementation addresses and eliminates plausible alternative hypotheses concerning program effects. The degree to which the study design and implementation warrants strong causal attributions concerning program effects.

1 = high threat to validity or no ability to attribute program effects

2 = threat to validity and difficult to attribute program effects

3 = somewhat of threat to validity and mixed ability to attribute effects to the program

4 = low threat to validity and ability to attribute effects to the program

5 = no or very low threat to validity and high ability to attribute effects to the program

Replications: the exact or conceptual reproduction of both the intervention implementation and evaluation.

1 = no replication.

2 = one self-replication.

3 = two or more self-replications.

4 = one or two replications by independent evaluators.

5 = three or more replications by independent evaluators producing similar results.

Dissemination capability: program materials developed including training in program implementation, technical assistance, standardized curriculum and evaluation materials, manuals, fidelity instrumentation, videos, recruitment forms, etc.

1 = Materials, training and technical assistance not available; in case of model that requires no curriculum (i.e., therapeutic models), training/qualified trainers and technical assistance not available.

2 = Materials available but of low quality or very limited in scope; training/qualified trainers and technical assistance either not available or limited.

3 = Materials of sufficient quality with limited technical assistance and/or training/qualified trainers.

4 = High quality materials, limited technical assistance and/or training/qualified trainers or vise versa.

5 = High quality materials, technical assistance readily available and training/qualified trainers readily available.

Cultural and age appropriateness

1 = no claim of culturally or age appropriate materials targeted for specific populations.

2 = claim of cultural or age appropriate materials but no of validation.

3 = age specific but not culturally appropriate or vice versa with some face validation.

4 = some materials validation materials presented.

5 = specialised materials, culturally and age appropriate, developed and evaluated or existing validated materials targeting population used.

Integrity: the overall level of confidence that the reviewer can place in project findings based on research design and implementation.

1 = no confidence

2 = weak, at best some confidence in results

3 = mixed, some weak, some strong characteristics

4 = strong, fairly good confidence in results

Strengthening America's Families (SAF): Effective Family Programs for Prevention of Delinquency

5 = high confidence in results, findings fully defensible

Utility: the overall usefulness of project findings for informing prevention theory and practice. This rating is anchored according to the following categories, and combines the strength of findings and the strength of evaluation.

1 = The evaluation produced clear findings of null or negative effects for a program with well-articulated theory and program design, the study provides support for rejecting the program as a replication model.

2 = The evaluation produced findings that were predominately null or negative, though not uniform or definitive.

3 = The evaluation produced ambiguous findings because of inconsistency in result or methods weaknesses that do not provide a strong basis for programmatic or theoretical contributions.

4 = The evaluation produced positive findings that demonstrate the efficacy of the program in some areas, or support the efficacy of some components of the program.

5 = The evaluation produced clear findings supporting the efficacy of well-articulated theory and program design, the study provides support for the program as a replication model

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Website: http://www.ojjdp.gov/mpg/ratings.aspx

The evidence ratings used by the OJJDP are based on the evaluation literature of specific prevention and intervention programs. The overall rating is derived from four summary dimensions of program effectiveness:

- The conceptual framework of the program
- The program fidelity
- The evaluation design
- The empirical evidence demonstrating the prevention or reduction of problem behaviour; the reduction of risk factors related to problem behaviour; or the enhancement of protective factors related to problem behaviour.

Programs are classified into three categories that are designed to provide the user with a summary knowledge base of the research supporting a particular program. A brief description of the rating criteria is provided below.

Exemplary

In general, when implemented with a high degree of fidelity these programs demonstrate robust empirical findings using a reputable conceptual framework and an evaluation design of the highest quality (experimental).

Effective

In general, when implemented with sufficient fidelity these programs demonstrate adequate

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

empirical findings using a sound conceptual framework and an evaluation design of the high quality (quasi-experimental).

Promising

In general, when implemented with minimal fidelity these programs demonstrate promising (perhaps inconsistent) empirical findings using a reasonable conceptual framework and a limited evaluation design that requires causal confirmation using more appropriate experimental techniques.

SAMHSA's National Registry of Evidence-based Programs and Practices

Website: http://nrepp.samhsa.gov/ReviewQOR.aspx

Quality of Research

SAMHSA's National Registry of Evidence-based Programs and Practices Quality of Research ratings are indicators of the strength of the evidence supporting the outcomes of the intervention. Higher scores indicate stronger, more compelling evidence. Each outcome is rated separately because interventions may target multiple outcomes (e.g., alcohol use, marijuana use, behaviour problems in school), and the evidence supporting the different outcomes may vary.

SAMHSA uses specific standardised criteria to rate interventions and the evidence supporting their outcomes. All reviewers who conduct reviews are trained on these criteria and are required to use them to calculate their ratings.

Criteria for Rating Quality of Research

Each reviewer independently evaluates the Quality of Research for an intervention's reported results using the following six criteria:

- Reliability of measures
- Validity of measures
- Intervention fidelity
- Missing data and attrition
- Potential confounding variables
- Appropriateness of analysis

For each outcome, reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given, to rate each criterion listed above. Then a mean score is calculated, and reported as an overall rating for each outcome. It is this overall rating that is reported in the current review of parenting programs.

A more detailed description of rating criteria is provided below.

1. Reliability of Measures: Outcome measures should have acceptable reliability to be interpretable. "Acceptable" here means reliability at a level that is conventionally accepted by experts in the field.

0 = Absence of evidence of reliability or evidence that some relevant types of reliability

(e.g., test-retest, inter-rater, inter-item) did not reach acceptable levels.

2 = All relevant types of reliability have been documented to be at acceptable levels in studies by the applicant.

4 = All relevant types of reliability have been documented to be at acceptable levels in studies by independent investigators.

2. Validity of Measures: Outcome measures should have acceptable validity to be interpretable. "Acceptable" here means validity at a level that is conventionally accepted by experts in the field.

0 = Absence of evidence of measure validity, or some evidence that the measure is not valid.

2 = Measure has face validity; absence of evidence that measure is not valid.

4 = Measure has one or more acceptable forms of criterion-related validity (correlation with appropriate, validated measures or objective criteria); OR, for objective measures of response, there are procedural checks to confirm data validity; absence of evidence that measure is not valid.

3. Intervention Fidelity:- The "experimental" intervention implemented in a study should have fidelity to the intervention proposed by the applicant. Instruments that have tested acceptable psychometric properties (e.g., inter-rater reliability, validity as shown by positive association with outcomes) provide the highest level of evidence.

0 = Absence of evidence or only narrative evidence that the applicant or provider believes the intervention was implemented with acceptable fidelity.

2 = There is evidence of acceptable fidelity in the form of judgment(s) by experts, systematic collection of data (e.g., dosage, time spent in training, adherence to guidelines or a manual), or a fidelity measure with unspecified or unknown psychometric properties.

4 = There is evidence of acceptable fidelity from a tested fidelity instrument shown to have reliability and validity.

4. Missing Data and Attrition: Study results can be biased by participant attrition and other forms of missing data. Statistical methods as supported by theory and research can be employed to control for missing data and attrition that would bias results, but studies with no attrition or missing data needing adjustment provide the strongest evidence that results are not biased.

0 = Missing data and attrition were taken into account inadequately, OR there was too much to control for bias.

2 = Missing data and attrition were taken into account by simple estimates of data and observations, or by demonstrations of similarity between remaining participants and those lost to attrition.

4 = Missing data and attrition were taken into account by more sophisticated methods that model missing data, observations, or participants, OR there were no attrition or missing data needing adjustment.

5. Potential Confounding Variables: Often variables other than the intervention may account for the reported outcomes. The degree to which confounds are accounted for affects the

SAMHSA's National Registry of Evidence-based Programs and Practices

strength of causal inference.

0 = Confounding variables or factors were as likely to account for the outcome(s) reported as were the hypothesized causes.

2 = One or more potential confounding variables or factors were not completely addressed, but the intervention appears more likely than these confounding factors to account for the outcome(s) reported.

4 = All known potential confounding variables appear to have been completely addressed in order to allow causal inference between the intervention and outcome(s) reported.

6. Appropriateness of Analysis: Appropriate analysis is necessary to make an inference that an intervention caused reported outcomes.

0 = Analyses were not appropriate for inferring relationships between intervention and outcome, OR sample size was inadequate.

2 = Some analyses may not have been appropriate for inferring relationships between intervention and outcome, OR sample size may have been inadequate.

4 = Analyses were appropriate for inferring relationships between intervention and outcome. Sample size and power were adequate.

Promising Practices Network (PPN)

Website: http://www.promisingpractices.net/criteria.asp

How programs are considered

The PPN reviews any program for which there is evidence of a positive effect. A formal application is not required to submit a program for consideration. PPN relies on publicly available information for the review of a program's effectiveness. PPN are interested in programs as they were designed and evaluated — programs do not have to have been replicated or be currently in existence for inclusion. Also, even if the specific goal of the program does not address an indicator, but the evaluation shows a positive effect, PPN will include the program under the indicator for which the evidence indicates effectiveness

Evidence Levels

Proven and Promising Programs

Programs are generally assigned either a "Proven" or a "Promising" rating, depending on whether they have met the evidence criteria below. In some cases a program may receive a Proven rating for one indicator and a Promising rating for a different indicator. In this case the evidence level assigned will be Proven/Promising, and the program summary will specify how the evidence levels were assigned by indicator.

Other Reviewed Programs

Some programs on the PPN site are identified as "Other Reviewed Programs". These are programs that have not undergone a full review by PPN, but evidence of their effectiveness has been reviewed by one or more credible organizations that apply similar evidence criteria. Other Reviewed Programs may be fully reviewed by PPN in the future and identified as Proven

or Promising, but will be identified as Other Reviewed Programs in the interim.

Evidence Criteria

Proven Program

Program must meet all of these criteria to be listed as "Proven":

a. Type of Outcomes Affected - Program must directly impact one of the indicators used on the site

b. Substantial Effect Size - At least one outcome is changed by 20%, 0.25 standard deviations, or more

c. Statistical Significance - At least one outcome with a substantial effect size is statistically significant at the 5% level

d. Comparison Groups - Study design uses a convincing comparison group to identify program impacts, including randomised-control trial (experimental design) or some quasi-experimental designs

e. Sample Size - Sample size of evaluation exceeds 30 in both the treatment and comparison groups

f. Availability of Program Evaluation Documentation - Publically available.

Promising Program

Program must meet at least all of these criteria to be listed as "Promising":

a. Type of Outcomes Affected - Program may impact an intermediary outcome for which there is evidence that it is associated with one of the PPN indicators

b. Substantial Effect Size - Change in outcome is more than 1%

c. Statistical Significance - Outcome change is significant at the 10% level (marginally significant)

d. Comparison Groups - 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

e. Sample Size - Sample size of evaluation exceeds 10 in both the treatment and comparison groups

f. Availability of Program Evaluation Documentation - Publically available.

Not Listed on Site

If a program meets any of these conditions it will not be listed on the site:

a. Type of Outcomes Affected - 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)

b. Substantial Effect Size - No outcome is changed more than 1%

c. Statistical Significance - No outcome change is significant at less than the 10% level

d. Comparison Groups - Study does not use a convincing comparison group. For example, the use of before and after comparisons for the treatment group only

Promising Practices Network (PPN)

e. Sample Size - Sample size of evaluation includes less than 10 in the treatment or comparison group

f. Availability of Program Evaluation Documentation - Distribution is restricted, for example only to the sponsor of the evaluation.

Currently, PPN does not require programs to do the following:

- Be currently implemented in some location and provide technical assistance or support.
- Have been replicated numerous times. (While PPN recognise the importance of program replication and fidelity to program success, they believe there is value to including information about programs that have successfully improved outcomes for children and families but have not been replicated.)
- Have articulated as program goals the outcomes they impact. (For example, if a program was designed to reduce violence, but met the criteria for a proven program because it reduced drug use, PPN would list the program as a "proven" program under the drug use reduction indicator, even though the program did not intend to reduce drug use.)
- Evaluation to have appeared in a peer-reviewed journal. Nor do PPN count as "Proven" every evaluation that has been published in a peer-reviewed journal.

Appendix 3. Summary of evidence for parenting programs from clearinghouse analysis

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Coping Power Program	Child behaviour Family relationships Child development	Children aged 8-14 years whose aggression puts them at risk for later delinquency	Information unavailable	Well Supported					Exemplary		Other Reviewed Programs
Coping with Depression for Adolescents (CWDA)	Child behaviour Family relationships Child development	Adolescents aged 12-18 years with major depression and/or dysthymia	Information unavailable	Well Supported						3.7 - for recovery from depression; and self-reported symptoms of depression 3.8 - for interviewer-rated symptoms of depression 3.6 - for psychological level of functioning	Promising
Families and Schools Together (FAST)	Family relationships Child development Safety and physical wellbeing Child behaviour	Families with children aged 5-14 years at risk of experiencing school failure due to substance abuse by the child or other family members and poor family functioning	Yes		Well Supported			Model	Exemplary	3.7 - for child problem behaviours; and child social skills and academic competencies	Other reviewed programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Healthy Families America	Safety and physical wellbeing Family relationships Parent-child relationship Child development	Families at risk of negative birth outcomes including child abuse and neglect, low birth weight, substance abuse and criminal activity	Information unavailable	Well Supported	Promising			Model	Effective		
Incredible Years	Child development Parent-child relationship Child behaviour	Families with high-risk children aged 0-12 years and/or those displaying behaviour problems	Yes	Well Supported	Well Supported		Model	Exemplary I	Exemplary	3.7 - for positive and nurturing parenting; harsh, coercive and negative parenting; child behaviour problems; child positive behaviours, social competence and schools readiness skills; and teacher classroom management skills 3.6 - for parent bonding and involvement with teacher and school	Proven

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Multidimensional Family Therapy (MDFT)	Child behaviour Child development Parent-child relationship Family relationships	Adolescents aged 11-18 with the following symptoms or problems: substance abuse or at risk, delinquent/conduct disorder, school and other behavioural problems, and both internalising and externalising symptoms	Information unavailable	Well Supported				Exemplary II	Effective	3.2 - for substance use 3.1 - for substance use-related problem severity 3.3-for abstinence from substance use; and treatment retention 3.8 - for recovery from substance use 3.5 - for risk factors for continued substance use and other problem behaviours 2.9 - for school performance; 3.6 - for delinquency 3.5 - for cost effectiveness	Other reviewed programs
Multidimensional Treatment Foster Care-Adolescents (MTFC-A)	Child behaviour Child development Family relationships Safety and physical wellbeing	Boys and girls aged 12-18 years with severe delinquency and/or severe emotional and behavioural disorders. These youth were in need of out-of-home placement and could not be adequately served in lower levels of care.	Yes	Well Supported		Top Tier	Model	Exemplary I	Exemplary	3.1 - for days in locked settings; criminal and delinquent activities; and pregnancy rates 2.8 - for substance use; and homework completion and school attendance	Other reviewed programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Multisystemic Therapy (MST)	Child behaviour Family relationships Safety and physical wellbeing	Youth, 12-17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviours and/or youth involved with the juvenile justice system	Yes	Well Supported			Model Program	Exemplary I	Exemplary		
Multisystemic Therapy for Youth with Problem Sexual Behavior (MST-PSB)	Child behaviour Family relationships Safety and physical wellbeing	Youth (and their families) when the youth has engaged in sexually abusive behaviour toward others. The offending youth must be between 10 and 17.5 years of age. Many of these youth will have been seen by the courts, although this is not an inclusionary requirement.	Yes	Well Supported						3.8 - for problem sexual behaviour; and incarceration and other out-of-home placement 3.9 - for delinquent activities other than problem sexual behaviours; mental health symptoms; and substance use 3.6 - for family and peer relations	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Nurse Family Partnership	Safety and physical wellbeing Child development Basic child care Family relationships	First-time, low-income pregnant women. Enrolment must occur prior to 28 weeks gestation.	Yes	Well Supported	Well Supported	Top Tier	Model		Exemplary	3.5 - for maternal parental health; and childhood injuries and maltreatment 3.3 - for number of subsequent pregnancies and birth intervals 3.2 - for maternal self-sufficiency 3.4 - for school readiness	Proven
Oregon Model, Parent Management Training (PMTO)	Child behaviour Safety and physical wellbeing Child development Family relationships	Parents of children aged 2-18 years with disruptive behaviours such as conduct disorder, oppositional defiant disorder, and anti-social behaviours	Yes	Well Supported							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Parent Child Interaction Therapy	Parent-child relationship Child behaviour Safety and physical wellbeing	Children aged 3-6 and their primary parent/caregiver	Yes	Well Supported	Well Supported					3.2 - for parent-child interaction 3.3 - for child conduct disorders 3.1 - for parent distress 3.9 - for recurrence of physical abuse	**Parent Child Interaction Therapy**
Strengthening Families	Family relationships Child development Safety and physical wellbeing	The program is appropriate for any families with children aged 3-16 years	Information unavailable		Well Supported			Exemplary I		3.1 - for children's internalising and externalising behaviour; parenting practices/ parenting efficacy; and family relationships	Other reviewed programs
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	Safety and physical wellbeing Parent-child relationship Child development Child behaviour	Children with a known trauma history who are experiencing significant post-traumatic stress disorder (PTSD) symptoms. Also, children with depression, anxiety, and/or shame related to their traumatic exposure.	Yes	Well Supported					Exemplary	3.8 - for child behaviour problems; and child depression 3.6 - for child symptoms of post-traumatic stress disorder (PTSD) 3.7 - for child feelings of shame; and parental emotional reaction to child's experience of sexual abuse	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Well Supported (CEBC)											
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	Safety and physical wellbeing Parent-child relationship Child development Child behaviour	Children with a known trauma history who are experiencing significant post-traumatic stress disorder (PTSD) symptoms. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure.	Yes	Well Supported					Exemplary	3.8 - for child behaviour problems; and child depression 3.6 - for child symptoms of post-traumatic stress disorder (PTSD) 3.7 - for child feelings of shame; and parental emotional reaction to child's experience of sexual abuse	
Triple P	Child development Child behaviour Parent-child interaction	Parents and caregivers with children aged 0-18	Yes	Well Supported	Well Supported	Near Top Tier	Promising		Effective	2.9 - for negative and disruptive child behaviours; and negative parenting practices as a risk factor for later child behaviour problems 3.0 - for positive parenting practices as a protective factor for later child behaviour problems	Promising

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CEBC)											
Adolescent Community Reinforcement Approach	Safety and physical wellbeing Child behaviour Parent-child relationship	Adolescents aged 12-22 with substance abuse issues	Yes	Supported							
Building Confidence	Child development Family relationships Child behaviour Safety and physical wellbeing	Children aged 7-11 who demonstrate a clinically significant symptoms for a range of anxiety disorders and their parents	Information unavailable	Supported							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CEBC)											
Child-Parent Psychotherapy (CPP)	Parent-child relationship Safety and physical wellbeing Child behaviour	Children aged 0-5 who have experienced a trauma, and their caregivers	Information unavailable	Supported						3.7 - for child PTSD symptoms; and maternal PTSD symptoms 3.3 - for child behaviour problems; and maternal mental health symptoms other than PTSD symptoms 3.8 - for children's representational models 3.9 - for attachment security	
Children with Sexual Behaviour Problems Cognitive-Behavioral Treatment Program: School-age group	Child behaviour Safety and physical wellbeing	Children with sexual behaviour problems. Boys and girls aged 6-12 years, and their caregivers	Information unavailable	Supported							
Community Parent Education Program (COPE)	Parent-child relationship Child development Child behaviour	Families with 3-12 year-old children who have challenging behaviour. Courses specifically designed for ADHD are also available.	Information unavailable	Supported							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CEBC)											
Family Focused Treatment for Adolescents (FFT-A)	Child behaviour Family relationships Child development	Adolescents with bipolar disorder and their family members	Information unavailable	Supported							
Homebuilders	Safety and physical wellbeing Child behaviour Family relationships	Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities	Yes	Supported				Model	Promising		
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Child development Child behaviour Family relationships	Parents who have young children and have limited formal education and resources	Yes	Supported				Model			

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CEBC)											
Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)	Family relationships Child behaviour Child development Safety and physical wellbeing	Preschool foster children aged 3-6 years old who exhibit a high level of disruptive and anti-social behaviour which cannot be maintained in regular foster care or who may be considered for residential treatment	Yes	Supported							
Multi-Family Psychoeducational Psychotherapy (MF-PEP)	Child behaviour Family relationships Child development	Children aged 8-12 with major mood disorders (depressive and bipolar spectrum) and their parents	Yes	Supported							
Parenting Together Project (PTP)	Basic child care Family relationships Parent-child relationship	First-time parents	Yes	Supported							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CEBC)											
Project SUPPORT	Child behaviour Safety and physical wellbeing Parent-child relationship	Families (mothers and children) who had recently sought refuge at domestic violence shelters, with children aged 4-9 exhibiting clinical levels of elevations on externalising problems (e.g., disruptive, defiant behaviours)	Information unavailable	Supported							
Supporting Father Involvement (SFI)	Child development Safety and physical wellbeing Parent-child relationship Family relationships	Primarily low-income families	Information unavailable	Supported							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CEBC)											
Together Facing the Challenge	Parent-child relationship Child behaviour Child development Safety and physical wellbeing	Treatment foster parents and agency staff	Information unavailable	Supported							
1-2-3 Magic: Effective Discipline for Children	Child behaviour Parent-child relationship	Parents of children aged 2-12 years. The program is appropriate for universal application and for parents of special needs children.	Yes	Supported	Emerging/ Evidence-Informed						

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CBCAP)											
Guiding Good Choices	Parent-child relationship Safety and physical wellbeing Family relationships Child development Child behaviour	Families of middle-school children (ages 9-14) who reside in rural or economically stressed neighbourhoods and who are at risk of early substance use	Information unavailable		Supported		Promising		Exemplary	2.6 - for substance use; and delinquency 2.9 - for parenting behaviours and family interactions 3.1 - for symptoms of depression (adolescents)	Proven
Healthy Families New York	Safety and physical wellbeing Child development Family relationships Basic child care	Expectant parents and parents with an infant less than three months of age who are considered to be at high risk for child abuse and neglect	Information unavailable		Supported						Proven

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Supported (CBCAP)											
Infant Health and Development	Child development Family relationships Safety and physical wellbeing Basic child care	Families with infants who were born prematurely (37 or fewer weeks gestation) and at low birth weight (2500 grams or less)	Information unavailable		Supported						Proven/ Promising
Schools and Families Educating Children (SAFE Children)	Family relationships Child development	Any 5 and 6 year-old children who are entering 1st grade and their families	Information unavailable		Supported				Effective	3.6 - for reading achievement; child problem behaviours; parenting practices; and parental involvement in child's education	Other reviewed programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (Blueprints)											
Early Childhood Education and Assistance Program (ECEAP)	Safety and physical wellbeing Family relationships Child development Parent-child relationship	Low SES families with children aged 0-8 years	Information unavailable				Promising				Promising
Fast Track	Child behaviour Family relationships Child development Parent-child relationship	Children identified in kindergarten for disruptive behaviour and poor peer relations	Information unavailable				Promising		Exemplary		Other reviewed programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (Blueprints)											
Healthy Steps for Young Children	Child development Child behaviour Parent-child relationship Family relationships Safety and physical wellbeing	Families with newborns between birth and four weeks	Information unavailable				Promising				Promising
Orebro Prevention Program	Child behaviour	Targets all parents of youth between the ages of 13-16	Information unavailable				Promising				
Parents' Fair Share	Safety and physical wellbeing Family relationships	Unemployed, noncustodial parents (primarily fathers)	Information unavailable				Promising				Promising

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (Blueprints)											
Preventive Treatment Program (PTP)	Child behaviour Family relationship Child development	Boys who display early problem behaviour	Information unavailable				Promising				Other Reviewed Programs
Seattle Social Development Project (SSDP)	Child behaviour Parent-child relationship Family relationships Child development	General population and high-risk children (those with low socioeconomic status and low school achievement) attending grade school and middle school (Australian equivalent of primary school and early secondary school)	Information unavailable				Promising				Promising
Strengthening Families Program - for Parents and Youth 10-14	Child behaviour Family relationships Parent-child relationship	Any parents and youth aged 10-14 years	Information unavailable				Promising	Exemplary II	Exemplary	2.8 - for substance use 2.9 - for school success 3.0 - for aggression 3.3 - for cost effectiveness	Other Reviewed Programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (Blueprints)											
Strong African American Families (SAAF)	Parent-child relationship Child behaviour	African American youths aged 10-14 years and their primary caregivers	Information unavailable				Promising		Effective	3.6 - for alcohol use 3.8-for conduct problems	Other Reviewed Programs
Exemplary II (SAF)											
Adolescent Transitions Program	Child behaviour Child development Parent-child relationship Family relationship	Adolescents aged 11-18 years who are at risk for problem behaviour or substance use	Information unavailable					Exemplary II	Effective		

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Exemplary II (SAF)											
Raising a Thinking Child: I Can Problem Solve for Families	Child development Child behaviour Parent-child relationship	Parents of children up to age seven and has been expanded to include middle and upper-middle income populations in the normal behavioural range as well as those displaying early high-risk behaviours. These include those diagnosed with ADHD and other special needs.	Information unavailable					Exemplary II	Effective		
Exemplary (OJJDP)											
The Prenatal and Early Childhood Nurse Home Visitation Program	Safety and physical wellbeing Child development Basic child care Child behaviour Family relationships	Low income first-time mothers experiencing substance abuse and their infants at risk of child maltreatment, childhood injuries, developmental delay and behavioural problems	Information unavailable					Exemplary II			

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Exemplary (OJJDP)											
Linking the Interests of Families and Teachers (LIFT)	Child behaviour Parent-child relationship Family relationships	Elementary school children at risk of developing aggressive and antisocial behaviours	Information unavailable						Exemplary		Other Reviewed Programs
Promising (CEBC)											
Attachment and Biobehavioral Catch-up (ABC)	Child behaviour Child development Safety and physical wellbeing Parent-child relationship	Foster parents of infants who have experienced early maltreatment and/or disruptions in care	Information unavailable	Promising							
AVANCE Family Support and Education Program (AVANCE)	Child development	Low income Hispanic families	Information unavailable	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Child-Parent Centers	Child development Parent-child relationship Family relationships	Low-income children and families from preschool to early elementary school	Information unavailable	Promising					Effective		Proven
Children with Sexual Behavior Problems Cognitive-Behavioural Treatment Program: Preschool Program	Child behaviour Safety and physical wellbeing	Children with sexual behaviour problems. Boys and girls aged 3-6 years of age and their caregivers.	Information unavailable	Promising							
Circle of Security (COS)	Child behaviour Parent-child relationship Basic child care Child development	High-risk populations such as having a child enrolled in Early Head Start or Head Start programs, incarcerated women, or having an irritable baby	Yes	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Common Sense Parenting CSP	Child behaviour	Any parents and other caregivers of children aged 6-16 years	Information unavailable	Promising					Promising		
Cool Kids	Family relationships Safety and physical wellbeing Child behaviour Child development	Children and adolescents suffering anxiety disorders	Yes	Promising							
Cools Kids Outreach Program	Safety and physical wellbeing Child development Family relationships Child behaviour	Children with anxiety disorders of any type and their parents	Yes	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Domestic Violence Home Visit Intervention (DVHVI)	Safety and physical wellbeing Child behaviour Family relationships	Families with children from birth to 18 years old that have reported incidents of intimate partner violence (IPV) to police	Information unavailable	Promising							
Effective Black Parenting Program (EBPP)	Family relationships Child development Safety and physical wellbeing Child behaviour	African-American families at risk for child maltreatment	Information unavailable	Promising				Model			

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Family Connections (FC)	Basic child care Safety and physical wellbeing Family relationships Child development	Families at risk for child emotional and physical neglect	Yes	Promising							
Foster Parent College (FPC)	Child behaviour Parent-child relationship Safety and physical wellbeing Family relationships	Foster, adoptive, and kinship parents, as well as social workers and other mental health professionals who work with resource parents	Yes	Promising							
Helping the Noncompliant Child	Parent-child relationship Child behaviour	The program is designed for parents of children aged 3-8 who have noncompliance or other conduct problems	Yes	Promising	Supported			Exemplary I	Promising		

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Interaction Guidance (IG)	Child development Child behaviour Basic child care Family relationships Parent-child relationship	Infants with a variety of early regulation disorders including feeding, sleeping and excessive crying	Information unavailable	Promising							
KEEP (Keeping Foster and Kin Parents Supported and Trained)	Child behaviour Family relationships Parent-child relationships Child development	Chidren aged 4-12 years who are in foster or kinship care placements and are experiencing behavioural and emotional problems	Information unavailable	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Kids Club & Moms Empowerment	Child development Child behaviour Safety and physical wellbeing Family relationships	Children aged 6-12 and their mothers exposed to intimate partner violence in the last year. Children may also have been abused.	Information unavailable	Promising							
Neighbor to Neighbor	Parent-child relationship Safety and physical wellbeing Family relationships Child behaviour	Sibling groups of 4 or more children from infancy through to 14 years of age or older who are in the custody of the state. The program is targeted to serve children and families who are newly involved in the foster care system.	Information unavailable	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Parenting Wisely	Parent-child relationship Child behaviour Family relationships	Parents with children aged 3-18 years with behaviour problems	Yes	Promising	Supported			Exemplary II	Promising	2.7 - for child problem behaviours; and parental knowledge, beliefs and behaviours 2.8 - for parental sense of competence	Other Reviewed Programs
Parents Anonymous (PA)	Child development Basic child care Child behaviour Family relationships	General population, but can accommodate specific population types such as teen parents or parents of children with special needs	Yes	Promising				Promising			
Nurturing Parenting Program	Basic child care Child behaviour Child development Family relationships Parent-child relationship	All families with children birth to 18 years	Yes	Promising	Promising			Model		3.1 - for parenting attitudes, knowledge, beliefs and behaviours 2.9 - for recidivism of child abuse and neglect 3.0 - for children's behaviour and attitudes toward parenting 3.2 - for family interaction	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Parents as Teachers	Family relationships Child development	All families with young children from birth to age 5, as well as families who are expecting the birth of a child	Yes	Promising	Supported			Model	Promising	3.4 - for cognitive development 3.0 - for mastery motivation 3.1 - for school readiness 3.2 - for third-grade achievement	Promising
Participation Enhancement Intervention (PEI)	Child behaviour Family relationships	Parents participating with their child or adolescent in treatment. PEI can be easily modified for any psychosocial treatment	Information unavailable	Promising							
Period of PURPLE Crying	Child behaviour Safety and physical wellbeing	All mothers of new infants and society in general in their understanding of early infant crying and shaken baby syndrome	Yes	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Project Connect	Safety and physical wellbeing	High-risk, substance-affected families involved in the child welfare system. Family risks may include the following: Poly-substance abuse and dependence, domestic violence, child abuse and neglect, criminal involvement and behaviour, poverty, inappropriate housing, lack of education, poor employment skills, and impaired parenting.	Information unavailable	Promising							
Project Safe Care	Safety and physical wellbeing Parent-child relationship Child behaviour Basic child care	Families at risk for child maltreatment with children aged 0-5 years	Information unavailable	Promising	Promising						

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Self-Motivation (SM Group)	Safety and physical wellbeing	Child-welfare involved parents and other caregivers of children from birth through to age 12	Information unavailable	Promising							
STEP: Systematic Training for Effective Parenting	Basic child care Child behaviour Child development	All parents of children 0-18 years	Yes	Promising	Supported					2.1 - for child behaviour 2.6 - for parent potential to physically abuse child 3.2 - for general family functioning; parenting stress; and parent-child interaction	
Teaching-Family Model (TFM)	Parent-child relationship Family relationships Child development Child behaviour Safety and physical wellbeing	Youth who are at-risk, juvenile delinquents, in foster care, mentally retarded/developmentally disabled, or severely emotionally disturbed. Families at risk of having children removed.	Yes	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
The Parent-Child Home Program	Parent-child relationship Child development Child behaviour	Two and three-year-olds who face multiple obstacles to educational and economic success. Risk factors include, living in poverty, being a single or teen-age parent, low parental education status, illiteracy/limited literacy, and families who are challenged by language barriers (e.g., immigrant families).	Information unavailable	Promising							
The Upstate New York Shaken Baby Syndrome Education Program (SBS)	Safety and physical wellbeing	All mothers, fathers, or father figures	Information unavailable	Promising							
Theraplay	Parent-child relationship Child behaviour Child development	Children ages 0-18 who exhibit behavioural problems and their caregiver (biological, adoptive, or foster)	Yes	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CEBC)											
Watch, Wait and Wonder (WWW)	Child development Parent-child relationship Child behaviour	Parents and their children aged 0-4 years who are experiencing relational and developmental difficulties	Yes	Promising							
Wraparound	Child behaviour Safety and physical wellbeing Family relationships	Designed for children and youth with severe emotional, behavioural, or mental health difficulties and their families. Most often these are young people who are in, or at risk for, out of home, institutional, or restrictive placements, and who are involved in multiple child and family-serving systems.	Information unavailable	Promising							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (CBCAP)											
Creating Lasting Family Connections	Safety and physical wellbeing Family relationships Child behaviour Child development	Families with children aged 9-17 years with substance abuse and violence issues	Information unavailable		Promising			Model Programs	Effective	3.0 - for use of community services; and parent knowledge and beliefs about AOD 2.9 - for onset of youth AOD use; and frequency of youth AOD use	
Dare to Be You	Family relationships Child development	Families with children 2-5 years old, including high-risk families	Information unavailable		Promising			Model Programs	Exemplary	2.8 - for parental self-efficacy; use of harsh punishment; and satisfaction with social support systems 2.7 - for child's developmental level	Proven
Syracuse Family Development Research Program	Child development Basic child care Child behaviour	African-American, single-parent, economically disadvantaged families with children from birth through to preschool years	Information unavailable		Promising				Effective		Promising

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Model (SAF)											
Focus on Families	Safety and physical wellbeing Child behaviour Child development	Families with parents who are addicted to drugs. The program is most appropriate for parents enrolled in methadone treatment who have children between 3 and 14 years of age.	Information unavailable					Model			
MELD	Family relationships	Parents of preschool children; has been adapted to meet the needs of young, single mothers or single fathers, Hispanic and Southeast Asian parents, deaf and hard of hearing parents, first-time adult parents, and parents of children with special needs	Information unavailable					Model			

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Model (SAF)											
Parents Who Care	Child behaviour Family relationships Child development	Families with children between the ages of 12-16 years at risk of later alcohol and other drug use, delinquency, violent behaviour and other behavioural problems in adolescence	Information unavailable					Model			
The NICASA Parent Project	Family relationships Parent-child relationship Child behaviour Child development	Working parents with children of the following ages: birth to 3, 3-5, 5-10, and 11-17	Information unavailable					Model			
Effective (OJJDP)											
First Step to Success	Child behaviour Child development	At-risk kindergarten children who show early signs of an antisocial pattern of behaviour	Information unavailable						Effective		

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Effective (OJJDP)											
Staying Connected with Your Teen	Child behaviour Family relationships Parent-child relationship Child development	Adolescents at risk of substance abuse and problem behaviours, and their parents	Information unavailable						Effective		
Proven (PPN)											
Attachment-Based Family Therapy	Child behaviour Parent-child relationship Family relationships Child development	Adolescents aged 13-18 at risk of adolescent depression or suicide, and their parents	Yes								Proven
Family Thriving Program	Parent-child relationship Safety and physical wellbeing	Parents with young children experiencing relationship difficulties	Information unavailable								Proven

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Proven/Promising (PPN)											
Family Support and Parenting Education in the Home	Child development Parent-child relationship	Low SES families with children aged 0-18 months	Information unavailable								Proven/ Promising
Promising (SAF)											
Make Parenting a Pleasure (MPAP)	Child development Parent-child relationship Safety and physical wellbeing Family relationships	Parents with children 0-6 years of age at risk of child abuse and neglect and family dysfunction	Information unavailable					Promising			
Nurturing Program for Families in Substance Abuse Treatment and Recovery	Child behaviour Parent-child relationship Family relationships	Families affected by parental substance abuse	Information unavailable					Promising			

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (SAF)											
Strengthening Multi-Ethnic Families and Communities	Child behaviour Safety and physical wellbeing Family relationships Parent-child relationship	Ethnic and culturally diverse parents of children aged 3-18 years who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle	Yes					Promising			
Promising (OJJDP)											
Children in Between	Family relationships Parent-child relationship	Families experiencing divorce	Information unavailable						Promising	2.2 - parental conflict 2.1 - for awareness of effects of divorce on the children 2.4 - for rate of relitigation 2.3 - for communication skills 2.0 - for child-reported stress	Other reviewed programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (OJJDP)											
Families Unidas	Child behaviour Family relationships Parent-child relationship Safety and physical wellbeing	Hispanic families with children aged 12-17 years at risk of conduct disorders, use of illicit drugs, alcohol and cigarettes and risky sexual behaviours	Information unavailable						Promising	3.9 - for behaviour problems; family functioning; substance use; and risky sexual behaviours 3.8 - for externalising disorders	
Gang Resistance Is Paramount (GRIP)	Child behaviour Family relationships	Any adolescents and their parents at risk of gang involvement	Information unavailable						Promising		
Parenting Partnership	Family relationships Child behaviour Child development Safety and physical wellbeing	Employed Parents	Information unavailable						Promising		

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Promising (OJJDP)											
Peace Works	Child behaviour Family relationships Parent-child relationship	All children in prekindergarten through 12th grade experiencing conflict issues	Information unavailable						Promising		
Rural Education Achievement Project (REAP)	Child behaviour Child development	REAP targets fourth grade students enrolled in elementary school	Information unavailable						Promising		
3.1 - for parental perceptions; and parental attitudes and beliefs 3.3 - for parent-child relationship problems 2.2 - for positive and negative child behaviours (SAMHSA)											
Active Parenting Now	Parent-child relationship Child behaviour	Any parents of children aged 2-12	Information unavailable							3.1 - for parental perceptions; and parental attitudes and beliefs 3.3 - for parent-child relationship problems 2.2 - for positive and negative child behaviours	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
2.6 - for positive attachment to family, school and peers; and attitudes towards alcohol use 2.2 - for participation in counselling 2.7 - for self-esteem (SAMHSA)											
Active Parenting of Teens: Families in Action	Child behaviour Safety and physical wellbeing Family relationships Parent-child relationship Child development	Middle school-aged youth at risk of alcohol, tobacco and other drug use, irresponsible sexual behaviour and violence	Information unavailable							2.6 - for positive attachment to family, school and peers; and attitudes towards alcohol use 2.2 - for participation in counselling 2.7 - for self-esteem	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
			2.3 - for parenting skills 2.4 - for parent tobacco and substance use 2.6 - for parent depressive symptoms 2.1 - for family environment; child behaviours and family reunification (SAMHSA)								
Celebrating Families!	Child behaviour Family relationships Safety and physical wellbeing Parent-child relationship	Families in which one or both parents are in early stages of recovery from substance addiction and/or domestic violence and/or child abuse	Information unavailable							2.3 - for parenting skills 2.4 - for parent tobacco and substance use 2.6 - for parent depressive symptoms 2.1 - for family environment; child behaviours and family reunification	
			3.5 - for child-related behaviours and attitudes toward parental illness as reported by parents 3.3- children's understanding of parental illness 3.7 - for internalising symptomology 3.5 - for family functioning (SAMHSA)								
Clinician-Based Cognitive Psychoeducational Intervention for Families	Parent-child relationship Family relationship	Families with parents with significant mood disorder	Information unavailable							3.5 - for child-related behaviours and attitudes toward parental illness as reported by parents 3.3- children's understanding of parental illness 3.7 - for internalising symptomology 3.5 - for family functioning	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
3.2 - for children's PTSD symptoms; and parenting skills (SAMHSA)											
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families Who Are at Risk for Physical Abuse	Safety and physical wellbeing Child behaviour Parent-child relationship Child development Family relationships	Families with children aged 3-17 years who are at risk for physical abuse	Information unavailable							3.2 - for children's PTSD symptoms; and parenting skills	
3.6 - for co-parenting; and parent-child interaction 3.7 - for parental adjustment; and child adjustment (SAMHSA)											
Family Foundations	Basic child care Child development Family relationships Parent-child relationship Child behaviour	Adult couples expecting their first child	Information unavailable							3.6 - for co-parenting; and parent-child interaction 3.7 - for parental adjustment; and child adjustment	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
3.2 - for prevalence of adolescent cigarette use; prevalence of adolescent alcohol use; and onset of adolescent cigarette use (SAMHSA)											
Family Matters	Child behaviour Family relationships	Adolescents aged 12-14 years at risk of using tobacco and alcohol and their families	Information unavailable							3.2 - for prevalence of adolescent cigarette use; prevalence of adolescent alcohol use; and onset of adolescent cigarette use	
3.7 - for abstinence from substance use; and recovery from substance use 3.5 - for cost effectiveness (SAMHSA)											
Family Support Network (FSN)	Child behaviour Family relationships	Youth aged 10-18 years with substance abuse problems	Information unavailable							3.7 - for abstinence from substance use; and recovery from substance use 3.5 - for cost effectiveness	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
2.9 - for posttreatment arrest rates 3.0 - for long-term arrest rates; alcohol and drug use; and perceived family-functioning cohesion 3.1 - for long-term incarceration rates; and peer aggression 3.2 - for self-reported criminal activity (SAMHSA)											
Multisystemic Therapy (MST) for Juvenile Offenders	Child behaviour Family relationships Safety and physical wellbeing	Juvenile offenders and their families	Yes			No rating				2.9 - for posttreatment arrest rates 3.0-for long-term arrest rates; alcohol and drug use; and perceived family-functioning cohesion 3.1 - for long-term incarceration rates; and peer aggression 3.2 - for self-reported criminal activity	
3.6 - for internalising behaviours; and delinquency 3.4 - for externalising behaviours; and noncompliance with mother's directives 3.8 - for academic functioning (SAMHSA)											
Parenting through Change	Child behaviour Child development Parent-child relationships	Separated single mothers and their children who are at risk of internalising and externalising conduct behaviours and associated problems	Information unavailable							3.6 - for internalising behaviours; and delinquency 3.4 - for externalising behaviours; and noncompliance with mother's directives 3.8 - for academic functioning	

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
2.5 - for interpersonal violence within families; parenting stress; child behaviour problems; caregiver-child attachment 2.4 - for service access (SAMHSA)											
Partners with Families and Children: Spokane	Safety and physical wellbeing Parent-child relationship Family relationship Child behaviour	Families with children under 30 months old who are referred by child protective services, law enforcement, or other public health agencies due to chronic child neglect or risk of child maltreatment	Information unavailable							2.5 - for interpersonal violence within families; parenting stress; child behaviour problems; caregiver-child attachment 2.4 - for service access	
Not able to be rated (CEBC)											
Advocacy for Women and Kids In Emergencies (AWAKE)	Safety and physical wellbeing Family relationships	Battered women with abused and neglected children	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Behaviour Analysis Services Program (BASP)	Basic child care Child behaviour Family relationships Safety and physical wellbeing	Foster, adoptive, and biological caregivers and their children with challenging behaviours	Information unavailable	Not able to be rated							
Behaviour Tools	Child behaviour Safety and physical wellbeing	Foster, adoptive and biological parents; caseworkers; care managers; and direct care staff of residential and group home facilities; and caregivers and teachers of children and adults with disabilities	Information unavailable	Not able to be rated							
Boot Camp for New Dads (BCND)	Parent-child relationship	Dads-to-be in the months surrounding their baby's birth	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Caring Dads: Helping Fathers Value their Children	Parent-child relationship Safety and physical wellbeing Child development Family relationships	Fathers (including biological, step, and common-law) who have who have physically abused, emotionally abused, or neglected their children; exposed their children to domestic violence; or who are deemed to be at high risk for these behaviours	Information unavailable	Not able to be rated							
Child Protective Services Reintegration Project (CRP)	Safety and physical wellbeing Parent-child relationship	Children/adolescents aged 5-17 who reside in therapeutic or residential placement facilitated by child welfare and have an Axis I diagnosis (i.e., a clinical disorder(s), including major mental disorders, learning disorders, and substance use disorders)	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Child Welfare Organising Project-Parent Leadership Curriculum (CWOP)	Safety and physical wellbeing Family relationships	Anyone who has had personal experience with the child welfare system (could be as a parent, child, foster parent, etc.)	Information unavailable	Not able to be rated							
Child Witness to Violence Project	Safety and physical wellbeing Child-parent relationship Child behaviour	Children aged 8 and younger, with the majority being under age six, from a racially diverse urban area who have been exposed to domestic violence	Information unavailable	Not able to be rated							
Circle of Parents	Safety and physical wellbeing Family relationships Child development	Any parent or individual in a parenting role for children aged 0-18	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Confident Parenting: Survival Skills Training Program	Child behaviour Parent-child relationship Safety and physical wellbeing Family relationships	Parents of children aged 2-12 years who are experiencing behaviour or emotional problems	Information unavailable	Not able to be rated							
DADS Family Project	Basic child care Parent-child relationship	Any fathers	Information unavailable	Not able to be rated							
Early Steps to School Success (ESSS)	Child development Family relationships Basic child care	Pregnant women and children from birth to age 5 living in rural and geographically isolated communities	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Families First of Michigan	Safety and physical wellbeing Family relationships	Children who are at high risk of removal from their families due to abuse or neglect	Information unavailable	Not able to be rated							
Father's Time Fatherhood Academy	Basic child care Family relationships	Fathers from age 14 to 80 in any aspect of fatherhood: married with children, non custodial, single, addicted, impoverished, incarcerated, teenage, military, step, stand-in, or about to become a father	Information unavailable	Not able to be rated							
Fundamentals of Foster and Adoptive Parenting	Basic child care Parent-child relationship	The target populations of this program are prospective foster and adoptive parents and kinship providers	Information unavailable	Not able to be rated							
Individual Family-Psycheducational Psychotherapy (IF-PEP)	Child behaviour Family relationships Child development	Children aged 8-12 with major mood disorders (depressive and bipolar spectrum) and their parents	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
InsideOut Dad	Parent-child relationship	Fathers with children 18 years old and younger. It is designed specifically for the issues/challenges faced by incarcerated fathers (e.g., challenge of successful re-entry)	Information unavailable	Not able to be rated							
Kids in Transition to School (KITS)	Child development Child behaviour Parent-child relationship	Foster children and other children at high risk for school difficulties who are entering kindergarten	Information unavailable	Not able to be rated							
Los Ninos Bien Educados (LNBE)	Child behaviour Parent-child relationship	For parents of Latino descent who are raising children in the United States, both Spanish and English speakers	Information unavailable	Not able to be rated							
Love and Logic	Child development Parent-child relationship	Any parents, grandparents, teachers, and other caretakers working with children	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Minority Youth and Family Initiative for African-Americans (MYFI)	Safety and physical wellbeing Family relationships	African American children and families involved with the child welfare system	Information unavailable	Not able to be rated							
Parent and Child Together Project (PACT)	Safety and physical wellbeing Basic child care Family relationships Child development	Mothers referred by Social Services. Priority is given to mothers who are 16-24 years old with children aged 9-3 who have risk factors associated with neglect	Information unavailable	Not able to be rated							
Parent Partners-Iowa	Safety and physical wellbeing Family relationships	Parents involved with Department of Human Services' Child Protective Services	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Parent Support Outreach Program (PSOP)	Safety and physical wellbeing Family relationships	Families at risk of child maltreatment as identified by screened out child maltreatment reports, community referrals, or self-referral	Information unavailable	Not able to be rated							
Parenting with Love and Limits (PLL)	Child behaviour Safety and physical wellbeing Family relationships Child development	Children and adolescents aged 10-18 who have severe emotional and behavioural problems and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation	Yes	Not able to be rated					Exemplary	2.9 - for conduct disorder 2.3 - for readiness for change and parent-teen communication 2.2 - for youth attitudes and behaviour 2.7 - for self-perception of substance abuse	Other reviewed Programs

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Parents as Tender Healers (PATH)	Child behaviour Safety and physical wellbeing Family relationship Child development Parent-child relationship	Prospective foster parents	Information unavailable	Not able to be rated							
Parents Engagement and Self-Advocacy (PESA)	Child behaviour	Birth parents, foster parents, and caseworkers of children aged 10-17 who are in foster care and candidates for reunification	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Positive Discipline	Parent-child relationship Child behaviour	Parents and teachers of children who are typically developing (infants through teens). Parents, teachers, and service providers of children with special needs (infants through teens), including children with disorders of attachment, children on the autism spectrum and children exposed to trauma	Information unavailable	Not able to be rated							
Project Fatherhood	Parent-child relationship Family relationships	Any fathers, significant others, and at-risk children	Information unavailable	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Shared Family Care (SFC)	Family relationships Safety and physical wellbeing	Families with an infant or young child in the child welfare system who are at risk of having their children removed or who are in the process of reunifying with them	Information unavailable	Not able to be rated							Not able to be rated (CEBC)
SPIN Video Training (SPIN VHT)	Safety and physical wellbeing Parent-child relationship	At-risk children and their families, families in conflict, foster parents/children, and adoptive families	Information unavailable	Not able to be rated							
Steps to Effective Enjoyable Parenting (STEEP)	Parent-child relationship Child development Safety and physical wellbeing	All parents and their infants	Yes	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
Strengthening Families through Early Care and Education	Safety and physical wellbeing Child development Family relationships	All families with young children; families under stress	Information unavailable	Not able to be rated							
The FATHER (Fostering Actions to Help Earnings and Responsibility) Project	Family relationships Safety and physical wellbeing Child development Parent-child relationship	Low-income fathers, primarily non-custodial	Information unavailable	Not able to be rated							
The Happiest Baby (THB)	Parent-child relationship Child behaviour Safety and physical wellbeing	All new parents, grandparents, teachers and healthcare professionals	Yes	Not able to be rated							

Parenting Program	Outcomes	Target population	Used in Australia?	Ratings from clearinghouses							
				CEBC	CBCAP	SPW	Blueprints	SAF	OJJDP	SAMHSA	PPN
Not able to be rated (CEBC)											
24/7 Dad	Basic child care Parent-child relationship	Fathers with children aged 18 or younger. It is designed for custodial and non-custodial fathers with instructions on how to deliver it most effectively to non-custodial and unemployed and underemployed fathers	Yes	Not able to be rated							
No rating (SPW)											
Health Care Program for First-Time Adolescent Mothers and their Infants	Basic child care	Teen mothers	Information unavailable			No rating					
Recovery Coaches	Safety and physical wellbeing Family relationships	Parents who have temporarily lost custody of their children to the state, and are suspected substance abuses	Information unavailable			No rating					

Appendix 4. Program descriptions for parenting programs identified in clearinghouse analysis

Coping Power Program		Source	Year
Program description	"The Coping Power Program is based on an empirical model of risk factors for potential antisocial behavior. For high-risk children, it addresses deficits in social cognition, self-regulation, peer relations, and positive parental involvement. The Coping Power Program, which has both a child and parent intervention component, is designed to be presented in an integrated manner. The Coping Power Child Component consists of 34 group sessions. The Coping Power Parent Component consists of 16 sessions offered during the same time frame. The child component focuses on anger management, social problem solving, and practicing skills to resist peer pressure. The parent component of the program focuses on supporting involvement and consistency in parenting, which also contributes to better adjustment. Improvement in all these areas, particularly around times of change such as going to middle school, can reduce the number of problem behaviors that can arise during these transitional times."	CEBC	2009
Outcomes	• Child behaviour • Family relationships • Child development		
Population	Children aged 8-14 years whose aggression puts them at risk for later delinquency.	CEBC	2009
Setting	Coping Power Program was designed to be conducted in a group setting, Recommended group size: 4-6 children. This program is typically conducted in a(n): outpatient clinic or school.	CEBC	2009
Dose	"Recommended intensity: Weekly 50-minute sessions. Recommended duration: 34 weekly sessions for the full program."	CEBC	2009
Evidence rating	Well Supported	CEBC	2009
	Exemplary	OJJDP	Not indicated
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Information unavailable		

Coping with Depression for Adolescents (CWDA)		Source	Year
Program description	"CWDA is a group cognitive-behavioral therapy (CBT) program for depressed adolescents ages 12 to 18. The intervention focuses on self-monitoring one's mood, increasing pleasant activities, decreasing anxiety, and decreasing cognitions that foster depression. It also addresses interpersonal factors such as social skills, improving communications, and conflict resolution. A parallel course allows parents to address the same interpersonal issues."	CEBC	2009
Outcomes	• Child behaviour • Family relationships • Child development		
Population	"Adolescents aged 12-18 years with major depression and/or dysthymia."	CEBC	2009
Setting	"Coping with Depression for Adolescents was designed to be conducted in a group setting. Recommended group size: between 4 and 10 youth with one therapist; if two therapists the maximum size may be increased to youth aged 12-16 years. This program is typically conducted in a(n): Community Agency; or Outpatient Clinic."	CEBC	2009
Dose	"Recommended intensity: Two-hour sessions, twice a week. Recommended duration: Typically 16 sessions in 8 weeks, but it can and has been configured with more frequent meetings per week (e.g., 3 x per week instead of the usual 2 x) for shorter total duration."	CEBC	2009
Evidence rating	Well Supported	CEBC	2009
	3.7 - for recovery from depression; and self-reported symptoms of depression 3.8 - for interviewer-rated symptoms of depression 3.6 - for psychological level of functioning	SAMHSA	2007
	Promising	PPN	2006
Used in Australia	Information unavailable		

Families and Schools Together (FAST)		Source	Year
Program description	"Families and Schools Together (FAST) is a group-based intervention implemented in a school setting. It consists of whole-family support group session for families with children 5-14. Stated goals are to 1)enhance family functioning; 2) prevent the target child from experiencing school failure; 3) prevent substance abuse by the child and other family members; and 4) reduce the stress that parents and children experience from daily life situations. Families are recruited through structured outreach, participate in a core program of support groups, and are offered on-going "reunion" groups on a less frequent basis. The program focuses on activities that promote healthy family functioning, positive communication, and increased social support."	CBCAP	2009
Outcomes	• Family relationships • Child development • Safety and physical wellbeing • Child behaviour		
Population	Families with children 5-14 years of age	CBCAP	2009
Setting	Delivered in a group setting	CBCAP	2009
Dose	"Multifamily 2.5 hour support groups of 5-25 families weekly for 8-12 weeks, depending on the age of the designated youth. Family support group meeting activities are sequential; each session includes • A family meal and family communication games • A self-help parent support group occurring while children engage in supervised play and organised activities • One-to-one parent-mediated play therapy • Opening and closing routines, which model the effectiveness of family rituals for children Multi-family meetings are held monthly for 21 months after families graduate from the 8-week FAST program. One dedicated half-time staff person, per school, is recommended."	CBCAP	2009
Evidence rating	Well Supported	CBCAP	2009
	Model Programs	SAF	1999
	Exemplary	OJJDP	Not indicated
	3.7 - for child problem behaviours; and child social skills and academic competencies	SAMHSA	2008
	Other reviewed programs	PPN	Not indicated
Used in Australia	Yes		

Healthy Families America		Source	Year
Program description	"Healthy Families America (HFA) provides home visits to families identified as at risk, with children ages prenatal to 5. The program goals include prevention of negative birth outcomes (low birth weight, substance abuse, criminal activity, child abuse and neglect), increased parenting skills, healthy pregnancy practices, and the use of social systems. Program services must begin prenatally or at birth. The long-term services, ideally 3 to 5 years, are provided at an intensity based on family need. The service format is designed to support parents and to promote healthy parent-child interaction and child development. Families are linked to medical services and other resources as needed."	CBCAP	2009
Outcomes	• Safety and physical wellbeing • Family relationships • Parent-child relationship • Child development		
Population	At risk families identified by a standard assessment. Enrolment must occur before child reaches three months of age.	CBCAP	2009
Setting	Delivered through home visiting	CBCAP	2009
Dose	"Recommended intensity: Families are to be offered weekly home visits for a minimum of six months after the birth of the baby. Home visits typically run 50-60 minutes. Upon meeting the defined criteria for family functioning, visit frequency is reduced to biweekly visits, monthly visits, and quarterly visits and services are tapered off over time. Typically, during pregnancy, families receive 2-4 visits per month. During times of crisis families may be seen 2 or more times in a week. Recommended duration: Services are offered prenatally or at birth until the child is at least three years of age and can be offered until he/she is five years of age."	CEBC	2011
Evidence rating	Well Supported	CEBC	2011
	Promising	CBCAP	2009
	Model Programs	SAF	1999
	Effective	OJJDP	Not indicated
Used in Australia	Information unavailable		

Incredible Years		Source	Year
Program description	"The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations. Incredible Years Training for Parents. The Incredible Years parenting series includes three programs targeting parents of high-risk children and/or those displaying behavior problems. The BASIC program emphasises parenting skills known to promote children's social competence and reduce behavior problems such as: how to play with children, helping children learn, effective praise and use of incentives, effective limit-setting and strategies to handle misbehavior. The ADVANCE program emphasises parent interpersonal skills such as: effective communication skills, anger management, problem-solving between adults, and ways to give and get support. The SUPPORTING YOUR CHILD'S EDUCATION program (known as SCHOOL) emphasises parenting approaches designed to promote children's academic skills such as: reading skills, parental involvement in setting up predictable homework routines, and building collaborative relationships with teachers. Incredible Years Training for Teachers. This series emphasises effective classroom management skills such as: the effective use of teacher attention, praise and encouragement, use of incentives for difficult behavior problems, proactive teaching strategies, how to manage inappropriate classroom behaviors, the importance of building positive relationships with students, and how to teach empathy, social skills and problem-solving in the classroom. Incredible Years Training for Children. The Dinosaur Curriculum emphasises training children in skills such as emotional literacy, empathy or perspective taking, friendship skills, anger management, interpersonal problem-solving, school rules and how to be successful at school. The treatment version is designed for use as a "pull out" treatment program for small groups of children exhibiting conduct problems. The prevention version is delivered to the entire classroom by regular teachers, 2-3 times a week."	CEBC Blueprints	2011 2007
Outcomes	• Child development • Parent-child relationship • Child behaviour		
Population	Families with children aged 0-12	CBCAP	2009
Setting	Delivered in a group setting	CBCAP	2009
Dose	"Recommended intensity: One 2-hour session per week (parent and child component). Classroom program offered 2-3 times weekly for 60 lessons. Teacher sessions can be completed in 4-5 full-day workshops or 14 x 2-hour sessions. Recommended duration: The Basic Parent Training Program is 14 weeks for prevention populations, and 18-20 weeks for treatment. The Child Training Program is 18-22 weeks. For treatment version, the Advance Parent Program is recommended as a supplemental program. Basic plus Advance takes 26-30 weeks. The Child Prevention Program is 20-30 weeks and may be spaced over two years. The Teachers Program is 4-6 full-day workshops spaced over 6-8 months."	CEBC	2011

Incredible Years (continued)		Source	Year
Evidence rating	Well Supported	CEBC	2011
	Well Supported	CBCAP	2009
	Model Program	Blueprints	2007
	Exemplary I	SAF	1999
	Exemplary	OJJDP	Not indicated
	3.7 - for positive and nurturing parenting; harsh, coercive and negative parenting; child behaviour problems; child positive behaviours, social competence and schools readiness skills; and teacher classroom management skills 3.6 - for parent bonding and involvement with teacher and school	SAMHSA	2007
	Proven	PPN	2006
Used in Australia	Yes		

Multidimensional Family Therapy (MDFT)		Source	Year
Program description	"MDFT is a family-based treatment system for adolescent substance use, delinquency, and related behavioral and emotional problems. Therapists work simultaneously in four interdependent domains: the adolescent, parent, family, and extra-familial. Once a therapeutic alliance is established and youth and parent motivation is enhanced, the MDFT therapist focuses on facilitating behavioral and interactional change. In the adolescent domain, adolescents are helped to develop coping, emotion regulation, and problem solving skills; improve social competence; and establish alternatives to substance use and delinquency. In the parent domain, the focus is on enhancing parental teamwork and improving parenting practices. Decreasing family conflict, deepening emotional attachments, and improving family communication and problem solving skills are the key goals within the family domain. In the extrafamilial domain, MDFT fosters family competency in interactions with social systems (e.g., justice, educational, social welfare). The final stage of MDFT works to solidify behavioral and relational changes and launch the family successfully so that treatment gains are maintained."	CEBC	2010
Outcomes	• Child behaviour • Child development • Parent-child relationship • Family relationships		
Population	"Adolescents 11 to 18 with the following symptoms or problems: substance abuse or at risk, delinquent/conduct disorder, school and other behavioral problems, and both internalising and externalising symptoms."	CEBC	2010
Setting	"This program is typically conducted in a(n):Adoptive Home; Birth Family Home; Community Agency; Day Treatment Program; Foster Home; Hospital; Residential Care Facility and School. MDFT was not designed to be conducted in a group setting and has not been tested for use in a group setting."	CEBC	2010
Dose	"Recommended intensity: For at-risk and early intervention, therapists typically provide 1-2 sessions per week, with sessions lasting between 60 and 90 minutes. More severe cases will require 2-3 sessions per week (average of 2) with each session lasting 60-90 minutes. Recommended duration: 3- 4 months for at-risk and early intervention youth and families; 5- 6 months for youth with a substance abuse and/or conduct disorder diagnosis."	CEBC	2010

Multidimensional Family Therapy (MDFT) (continued)		Source	Year
Evidence rating	Well Supported	CEBC	2010
	Exemplary II	SAF	1999
	Effective	OJJDP	Not indicated
	3.2 - for substance use 3.1 - for substance use-related problem severity 3.3 - for abstinence from substance use; and treatment retention 3.8 - for recovery from substance use 3.5 - for risk factors for continued substance use and other problem behaviours 2.9 - for school performance 3.6 - for delinquency 3.5 - for cost effectiveness	SAMHSA	2008
	Other reviewed programs	PPN	Not indicated
Used in Australia	Information unavailable		

Multidimensional Treatment Foster Care-Adolescents (MTFC-A)		Source	Year
Program description	"MTFC-A is a model of foster care treatment for children 12-18 years old with severe emotional and behavioral disorders and/or severe delinquency. MTFC-A aims to create opportunities for youths to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents (or other long-term placement) to provide them with effective parenting. Four key elements of treatment are (1) providing youths with a consistent reinforcing environment where he or she is mentored and encouraged to develop academic and positive living skills, (2) providing daily structure with clear expectations and limits, with well-specified consequences delivered in a teaching-oriented manner, (3) providing close supervision of youths' whereabouts, and (4) helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships. MFTC-A also has versions for preschoolers and children. MFTC-P (for preschoolers) is rated separately on this website. MTFC-C (for children) has not been tested separately, but has the same elements as MFTC-A except it includes materials more developmentally appropriate for younger children."	CEBC	2011
Outcomes	• Child behaviour • Child development • Family relationships • Safety and physical wellbeing		
Population	"Boys and girls, 12-18 years old with severe delinquency and/or severe emotional and behavioral disorders. These youth were in need of out-of-home placement and could not be adequately served in lower levels of care."	CEBC	2011
Setting	"Multidimensional Treatment Foster Care – Adolescents (MTFC-A) was designed to be conducted in a group setting. Recommended group size: one component of the foster parent support is designed to be delivered in a group format. The recommended group size is 10 or fewer foster parents. This program is typically conducted in a(n): Birth Family Home; Community Agency; Foster Home; Outpatient Clinic; or School"		
Dose	"Recommended intensity: For foster parent(s), there is typically a minimum of seven contacts per week which consist of five 10-minute contacts, one 2-hour group, and additional contacts based on the amount of support or consultation required. For the youth in treatment, two contacts per week which consist of a weekly individual therapy for one hour and weekly individual skills training in a 2-hour session. For the biological family or other long-term placement resource, one contact per week in the form of a 1-hour family therapy session. Recommended duration: Designed with an overall treatment duration of 6-9 months."		

Multidimensional Treatment Foster Care-Adolescents (MTFC-A) (continued)		Source	Year
Evidence rating	Well Supported	CEBC	2011
	Top Tier	SPW	2009
	Model	Blueprints	2007
	Exemplary I	SAF	1999
	Exemplary	OJJDP	Not indicated
	3.1 - for days in locked settings; criminal and delinquent activities; and pregnancy rates 2.8 - for substance use; and homework completion and school attendance	SAMHSA	2009
	Other reviewed programs	PPN	Not indicated
Used in Australia	Yes		

Multisystemic Therapy (MST)		Source	Year
Program description	"Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change."	CEBC	2011
Outcomes	• Child behaviour • Family relationships • Safety and physical wellbeing		
Population	"Youth, 12-17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system."	CEBC	2011
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Foster Home; and School	CEBC	2011
Dose	"Recommended intensity: Services are intensive, with intervention sessions being conducted from three times per week to daily. However, there is no expectation on a specific number of contact hours as staff contact is based on the clinical needs of the families. Session length also depends on the treatment needs of the family and may range from 50 minutes to 2 hours. Multiple types of sessions may be conducted in one day (e.g., parental drug screening and session; family communication and problem solving). Recommended duration: Treatment duration ranges from 3-5 months."	CEBC	2011
Evidence rating	Well Supported	CEBC	2011
	Model	Blueprints	2006
	Exemplary I	SAF	1999
	Exemplary	OJJDP	Not indicated
	Proven	PPN	2011
Used in Australia	Yes		

Multisystemic Therapy for youth with problem sexual behaviors (MST-PSB)		Source	Year
Program description	"Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB) is a clinical adaptation of Multisystemic Therapy (MST) that has been specifically designed and developed to treat youth (and their families) for problematic sexual behavior. Building upon the research and dissemination foundation of standard MST, the MST-PSB model represents a practice uniquely developed to address the multiple determinants underlying problematic juvenile sexual behavior. MST-PSB is delivered in the community, occurs with a high level of intensity and frequency, incorporates treatment interventions from MST, and places a high premium on approaching each client and family as unique entities. Treatment incorporates intensive family therapy, parent training, cognitive-behavioral therapy, skills building, school and other community system interventions, and clarification work. Ensuring client, victim, and community safety is a paramount mission of the model."	CEBC	2011
Outcomes	• Child behaviour • Family relationships • Safety and physical wellbeing		
Population	"Youth (and their families) when the youth has engaged in sexually abusive behavior toward others. The offending youth must be between 10 and 17.5 years of age. Many of these youth will have been seen by the courts, although this is not an inclusionary requirement."	CEBC	2011
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Foster Home; or School	CEBC	2011
Dose	"Recommended intensity: Frequency and intensity of treatment are dependent on the unique needs of the youth and family. In general, families receive three or more contacts per week with the average contact lasting 1-2 hours. However, if the family is in crisis or urgent needs arise, the amount of contact will likely be even greater. During the latter stages of treatment, session frequency may lessen to promote more autonomy and generalisation of treatment effects. Recommended duration: 5-7 months."	CEBC	2011
Evidence rating	Well Supported	CEBC	2011
	3.8 - for problem sexual behaviour; and incarceration and other out-of-home placement 3.9 - for delinquent activities other than problem sexual behaviours; mental health symptoms; and substance use 3.6 - for family and peer relations	SAMHSA	2009
Used in Australia	Yes		

Nurse Family Partnership		Source	Year
Program description	"The Nurse Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. The program content focuses on developing a healthy, supportive relationship between the mother and home visitor. The primary goals which drive program content include: 1) to improve pregnancy outcomes by promoting health-related behaviors; 2)to improve child health, development and safety by promoting component care-giving; 3) to enhance parent life-course development by promoting pregnancy planning, educational achievement and employment. The program also provides links to other community resources and encourages the development of healthy social support for the family."	CBCAP	2009
Outcomes	• Safety and physical wellbeing • Child development • Basic child care • Family relationships		
Population	First-time, low-income pregnant women. Enrolment must occur prior to 28 weeks gestation	CBCAP	2009
Setting	Home visitation	CBCAP	2009
Dose	"Recommended intensity: Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. Last four visits are monthly until the child is two years old. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on client's needs. Recommended duration: Clients are able to participate in the program for 2.5 years and the program is voluntary."	CEBC	2011

Nurse Family Partnership (continued)		Source	Year
Evidence rating	Well Supported	CEBC	2011
	Well Supported	CBCAP	2009
	Top Tier	SPW	2012
	Model Program	Blueprints	2006
	Exemplary	OJJDP	Not indicated
	3.5 - for maternal parental health; and childhood injuries and maltreatment 3.3 - for number of subsequent pregnancies and birth intervals 3.2 - for maternal self-sufficiency 3.4 - for school readiness	SAMHSA	2008
	Proven	PPN	2009
Used in Australia	Yes		

Oregon Model, Parent Management Training (PMTO)		Source	Year
Program description	"PMTO refers to a set of parent training interventions developed over forty years, originating with the theoretical work, basic research, and intervention development of Gerald Patterson and colleagues at Oregon Social Learning Center. PMTO can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent led, and foster families. PMTO can be used as a preventative program and a treatment program. It can be delivered in many formats, including parent groups, individual family treatment, books, audiotapes and video recordings. PMTO interventions have been tailored for specific clinical problems, such as antisocial behavior, conduct problems, theft, delinquency, substance abuse, and child neglect and abuse."	CEBC	2012
Outcomes	• Child behaviour • Safety and physical wellbeing • Child development • Family relationships		
Population	Parents of children 2-18 years of age with disruptive behaviours such as conduct disorder, oppositional defiant disorder, and anti-social behaviours.	CEBC	2012
Setting	"This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Community Agency; Community Daily Living Settings; Foster Home or Outpatient Clinic Oregon Model, Parent Management Training (PMTO™) was designed to be conducted in a group setting, and has been tested for use in a group setting. Recommended group size: 12-15 parents."	CEBC	2012
Dose	"Recommended intensity: 1.5-2-hour weekly parent group sessions and 60-minute weekly individual/family sessions Recommended duration: 14 group sessions and 20-25 individual/family sessions, depending on severity; individual family treatment is not typically provided together with group treatment. The time frame can be 5-6 months or longer, depending on circumstances."	CEBC	2012
Evidence rating	Well Supported	CEBC	2012
Used in Australia	Yes		

Parent Child Interaction Therapy		Source	Year
Program description	"Parent Child Interaction Therapy (PCIT) is a prevention program that focuses on improving the quality of the parent-child relationship through skill-building and promoting positive parent-child interaction. It was developed specifically for conduct-disordered young children and includes use of a one-way mirror and 'bug in the ear'. The treatment on two basic interactions: • Child Directed Interaction (CDI), which is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship • Parent Directed Interaction (PDI), which resembles clinical behavior therapy in that parents learn to use specific behavior management techniques with their child."	CBCAP	2009
Outcomes	• Parent-child relationship • Child behaviour • Safety and physical wellbeing		
Population	Children aged 3-6 and their primary parent/caregiver. Adaption is available for physically abusive parents with children aged 4-12, which has been tested and achieved positive results.	CBCAP	2009
Setting	Delivered in a one-on-one coaching environment "PCIT was not designed to be conducted in a group setting; but has been tested for use in a group setting. When delivered in a group format, small groups of 3 or 4 families in 90-minute sessions are recommended. This will allow adequate time for individual coaching of each parent-child dyad while other parents observe, code, and provide feedback in each session."	CBCAP CEBC	2009 2009
Dose	"Recommended intensity: One or two 1-hour sessions per week. Recommended duration: The average number of sessions is 14, but varies from 10 to 20 sessions. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behavior has improved to within normal limits."	CEBC	2009
Evidence rating	Well Supported	CEBC	2009
	Well Supported	CBCAP	2009
	3.2 - for parent-child interaction 3.3 - for child conduct disorders 3.1 - for parent distress 3.9 - for recurrence of physical abuse	SAMHSA	2009
Used in Australia	Yes		

Strengthening Families		Source	Year
Program description	"The Strengthening Families Program (SFP) is a prevention program focusing on increasing family skills to support healthy child development. The program includes parenting skills sessions that address positive communication, family functioning, and discipline and guidance topics. The children's sessions focus on social-emotional development, communication skills, and healthy behavior. The family sessions include structured activities and the opportunity to practice new skills presented in the curriculum. Ongoing family support groups and booster sessions are also recommended."	CBCAP	2009
Outcomes	• Family relationships • Child development • Safety and physical wellbeing		
Population	"The program is appropriate for families with children aged 3-16. There are four different curricula: • Preschool children, SFP 3-5 years, higher risk • Elementary school children, SFP 6-11 years, higher risk • Junior high students, SFP 10-14, general/universal population • Early teens and high school, SFP 12-16, higher risk"	CBCAP	2009
Setting	"Delivered in a group setting"	CBCAP	2009
Dose	"The Strengthening Families Program is a 14-session course, generally delivered in weekly 2-hour sessions. There are separate sessions for adults and children and combined family sessions."	CBCAP	2009
Evidence rating	Well Supported	CBCAP	2009
	Exemplary I	SAF	1999
	3.1 - for children's internalising and externalising behaviour; parenting practices/ parenting efficacy; and family relationships	SAMHSA	2007
	Other reviewed programs	PPN	Not indicated
Used in Australia	Information unavailable		

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)		Source	Year
Program description	"TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family and humanistic principles. The overall goal of TF-CBT is to address symptoms resulting from a specific traumatic experience or experiences. This includes: • Improving child Post Traumatic Stress Disorder (PTSD), depressive and anxiety symptoms • Improving child externalising behavior problems (including sexual behavior problems if related to trauma) • Improving parenting skills and parental support of the child, and reducing parental distress • Enhancing parent-child communication, attachment and ability to maintain safety • Improving child's adaptive functioning • Reducing shame and embarrassment related to the traumatic experiences."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Parent-child relationship • Child development • Child behaviour		
Population	"Children with a known trauma history who are experiencing significant PTSD symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment"	CEBC	2011
Setting	"This program is typically conducted in a(n): Birth Family Home; Community Agency; Community Daily Living Settings; Outpatient Clinic; or Residential Treatment Center" Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) was not designed to be conducted in a group setting; but has been tested for use in a group setting. Recommended group size: 6-10 children and their caregivers."	CEBC	2011
Dose	"Recommended intensity: Sessions are conducted once a week. Recommended duration: For each session: 30-45 minutes for child; 30-45 minutes for parent. The program model also includes conjoint child-parent sessions toward the end of treatment that last approximately 30-45 minutes. Treatment lasts 12-18 sessions."	CEBC	2011
Evidence rating	Well Supported	CEBC	2011
	Exemplary	OJJDP	Not indicated
	3.8 - for child behaviour problems; and child depression 3.6 - for child symptoms of Post Traumatic Stress Disorder (PTSD) 3.7 - for child feelings of shame; and parental emotional reaction to child's experience of sexual abuse	SAMHSA	2008
Used in Australia	Yes		

Triple P		Source	Year
Program description	"The Triple P Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13 to 16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies used at previous levels: • Level 1 (Universal Triple P) is a media-based information strategy designed to increase community awareness of parenting resources, encourage parents to participate in programs and communicate solutions to common behavioral developmental concerns • Level 2 (Selected Triple P) provides specific advice on how to solve common child developmental issues (e.g., toilet training) and minor child behavior problems (e.g., bedtime problems). Include are parenting tip sheets and videotapes that demonstrate specific parenting strategies. Level 2 is delivered mainly through one or two brief face-to-face 20-minute consultations. • Level 3 (Primary Care Triple P) targets children with mild to moderate behavior difficulties (e.g., tantrums, fighting with siblings) and includes active skills training that combines advice with rehearsal and self-evaluation to teach parents how to manage these behaviors. Level 3 is delivered through brief and flexible consultation, typically in the form of four 20-minute sessions. • Level 4 (Standard Triple P and Group Triple P), an intensive strategy for parents of children with more severe behavior difficulties (e.g., aggressive or oppositional behavior), is designed to teach positive parenting skills and their application to a range of target behaviors, settings and children. Level 4 is delivered in 10 individual or 8 group sessions totalling about 10 hours. • Level 5 (Enhanced Triple P) is an enhanced behavioral family strategy for families win which parenting difficulties are complicated by other sources of family distress (e.g., relationship conflict, parental depression or high levels of stress). Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills. Enhance Triple P extends Standard Triple P by adding 3-5 sessions tailored to the needs of the family. Variations of some Triple P levels are available for parents of young children with developmental disabilities (Stepping Stones Triple P) and for parents who have abused (Pathways Triple P)."	SAMHSA	2008
Outcomes	• Child development • Child behaviour • Parent-child interactions		
Population	Parents and caregivers with children aged 0-18.	CBCAP	2009
Setting	The Triple P can be delivered in a range of settings including group based and home visiting. Recommended group size: 10-12 parents.	CBCAP CEBC	2009 2009

Triple P (continued)		Source	Year
Dose	"Recommended intensity: Sessions last up to one hour. The number of sessions varies according to the level of the intervention required by the family: • Level 2: approximately 1-2 weekly sessions delivered via individual brief consultations (or in large-group parenting seminars) • Level 3: up to 4 brief 20-minute weekly consultation sessions • Level 4: 8 to 10 weekly sessions • Level 5: on average an additional 3 weekly sessions per family. Recommended duration: This varies by the level of the intervention required by the family. For example, Level 2 is 1-2 weeks in duration, while Level 5 can be up to 12 weeks."	CEBC	2009
Evidence rating	Well Supported	CEBC	2009
	Well Supported	CBCAP	2009
	Near Top Tier	SPW	2010
	Promising (NB: Blueprints only rated Triple P when it was implemented as a total system in a community. Evaluations of individual levels of Triple P implemented alone, such as the Level 4 Standard, Group, or Self-Directed formats, have not met Blueprints criteria)	Blueprints	2009
	Effective	OJJDP	Not indicated
	2.9 - for negative and disruptive child behaviours; and negative parenting practices as a risk factor for later child behaviour problems 3.0 - for positive parenting practices as a protective factor for later child behaviour problems	SAMHSA	2008
	Promising	PPN	2011
Used in Australia	Yes		

Adolescent Community Reinforcement Approach (A-CRA)		Source	Year
Program description	"A-CRA is a behavioral intervention that seeks to increase the family, social, and educational/vocational reinforcers of an adolescent to support recovery from substance abuse and dependence. The manual outlines an outpatient program that targets youth 12-22 years old with Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) cannabis, alcohol, and/or other substance use disorders. A-CRA also has been implemented in intensive outpatient and residential treatment settings and the adult model, Community Reinforcement Approach (CRA), has been found effective with adults. A-CRA includes guidelines for three types of sessions: adolescents alone, caregivers alone, and adolescents and caregivers together. According to the adolescent's needs and self-assessment of happiness in multiple areas of functioning, therapists choose from among 17 A-CRA procedures that address, for example, problem-solving skills to cope with stressors, communication skills, and participation in positive social and recreational activities with the goal of improving life satisfaction and eliminating substance use problems."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Child behaviour • Parent-child relationship		
Population	Adolescents aged 12-22 years with substance abuse issues	CEBC	2011
Setting	This program is typically conducted in a(n): Community Agency; Outpatient Clinic; Residential Care Facility; or School	CEBC	2011
Dose	"Recommended intensity: Once per week for 50-90 minutes. It is not unusual for family sessions to last up to 90 minutes. Recommended duration: Three months."	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Yes		

Building Confidence		Source	Year
Program description	"Building Confidence is a cognitive-behavioral therapy (CBT) that is provided to school-aged children who demonstrate clinically significant symptoms of a range of anxiety disorders (e.g., separation anxiety disorder). The format consists of individual child therapy combined with parent-training and involvement. The goal is to enhance the learning and maintenance of treatment strategies via child and parent involvement in treatment. Both children and their parents are taught fundamental CBT principles and techniques as well as integrating ways to build confidence through graduated learning and practice of age-appropriate self-independence skills. In-session exposures are extended into the home where parents assist children complete home-based exposures in the community by providing coaching in CBT strategies and naturalistic opportunities to practice and maintain treatment goals and effects. In line with these overarching treatment goals, the intervention program also works closely with the children's schools and teachers to promote the practice and generalization of treatment goals in the school (e.g., social anxiety). This program involves the family or other support systems in the individual's treatment: Parents are provided with psychoeducation about anxiety, independence skills, and CBT strategies to both help coach children during home-based exposures and provided opportunities to target treatment goals with the natural setting of the home, community, etc. The school system is also elicited as a support system so that key school personnel (e.g., teachers) can provide opportunities for treatment goals and monitoring of the child with the school environment."	CEBC	2011
Outcomes	• Child development • Family relationships • Child behaviour • Safety and physical wellbeing		
Population	Children aged 7-11 who demonstrate a clinically significant symptoms for a range of anxiety disorders and their parents	CEBC	2011
Setting	"The program is typically conduced in community daily living settings, outpatient clinics and schools"	CEBC	2011
Dose	"Recommended intensity: Weekly 1.5-hour session. Recommended duration: 16 weeks."	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Information unavailable		

Child-Parent Psychotherapy (CPP)		Source	Year
Program description	"CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect."	CEBC	2009
Outcomes	• Parent-child relationship • Safety and physical wellbeing • Child behaviour		
Population	Children aged 0-5, who have experienced a trauma, and their caregivers	CEBC	2009
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Community Agency; Foster Home; Outpatient Clinic; or School	CEBC	2009
Dose	"Recommended intensity: Weekly sessions lasting 1-1.5 hours. Recommended duration: 52 weeks (one year)."	CEBC	2009
Evidence rating	Supported	CEBC	2009
	3.7 - for child Post Traumatic Stress Disorder (PTSD) symptoms; and maternal PTSD symptoms 3.3 - for child behaviour problems; and maternal mental health symptoms other than PTSD symptoms 3.8 - for children's representational models 3.9 - for attachment security	SAMHSA	2010
Used in Australia	Information unavailable		

Children with Sexual Behavior Problems Cognitive-Behavioural Treatment Program: School-age group		Source	Year
Program description	"Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: School-Age Group is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems: • The program is an outpatient group treatment program for children ages 6 to 12 years and their parents or other caregivers. • Program can be provided to individual families when group is not an option. • The treatment is provided as an open-ended group, with children able to graduate in 4-5 months. • Collaboration with child protective services, juvenile court personnel, school personnel, and others involved is highly recommended. The children acknowledge the previous breaking of sexual behavior rules, learn coping and self-control strategies, and develop a plan of how they were going to keep these rules in the future. Caregivers were taught how to supervise the children, teach and implement rules in the home, communicate about sex education, and reduce behavior problems utilizing behavior parent training strategies."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing		
Population	Children with sexual behaviour problems. Boys and girls ages 6 to 12 years of age and their caregivers	CEBC	2011
Setting	"Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: School-Age Group was designed to be conducted in a group setting. Separate 6-9-year-olds from 10-12-year-olds. Five to eight children in each group. One caregiver group for these two groups can be used – or separate caregiver group depending on program decisions. This program is typically conducted in a(n):Outpatient clinic."	CEBC	2011
Dose	"Recommended intensity: 60-90 minute weekly session. Recommended duration: 4-5 months depending on meeting graduation criteria."	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Information unavailable		

Community Parent Education Program (COPE)		Source	Year
Program description	"COPE is designed to help all parents develop proven skills to strengthen their relationships with their children, increase cooperation, and solve problems. COPE is a cost-effective large group program. Sessions typically include groups of 15 to 25 parents working to together in a combination of small group and large group exercises. COPE uses a coping modeling problem solving process. Leaders help groups of parents develop solutions to common problems. This helps parents develop skills which are culturally and developmentally relevant, strengthens problems solving skills, and builds parental confidence. COPE is designed to be conducted in convenient community locations such as schools and recreation centers. When possible, child care is provided. This reduces barriers which may prevent parents from participating in parenting programs. COPE uses readings, videotapes, small group problem solving discussions, demonstrations, practice exercises, and homework projects to help parents develop new skills."	CEBC	2011
Outcomes	• Parent-child relationship • Child development • Child behaviour		
Population	Not specified	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Information unavailable		

Family Focused Treatment for Adolescents (FFT-A)		Source	Year
Program description	"FFT-A is a psychosocial treatment for youth with bipolar disorder, consisting of family psychoeducation, communication enhancement training, and problem-solving skills training. It is given alongside of medications in the period just after an episode of bipolar disorder. The clients are the adolescent, mother/father, and where possible, siblings and extended relatives."	CEBC	2010
Outcomes	• Child behaviour • Family relationships • Child development		
Population	"Adolescents with bipolar disorder and their family members."	CEBC	2010
Setting	"This program is typically conducted in an outpatient clinic" "FFT-A was not designed to be conducted in a group setting"	CEBC	2010
Dose	"Recommended intensity: 21 x 1-hour sessions: 12 weekly, 6 biweekly, and 3 monthly. Recommended duration: 9 months."	CEBC	2010
Evidence rating	Supported	CEBC	2010
Used in Australia	Information unavailable		

Homebuilders		Source	Year
Program description	"Homebuilders® is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems; and to teach families the skills they need to prevent placement or successfully reunify with their children. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Child behaviour • Family relationships		
Population	"Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities."	CEBC	2011
Setting	Adoptive home; birth family home	CEBC	2011
Dose	"Recommended intensity: Three to five 2-hour sessions contacts per week; an average of 8-10 hours per week of face-to-face contact, with telephone contact between sessions. Recommended duration: An average of 4-6 weeks. Two aftercare 'booster sessions' totaling up to five hours are available in the six months following referral."	CEBC	2011
Evidence rating	Supported	CEBC	2011
	Model Programs	SAF	1999
	Promising	OJJDP	Not indicated
Used in Australia	Yes		

Home Instruction for Parents of Preschool Youngsters (HIPPY)		Source	Year
Program description	"HIPPY is a home-based and parent-involved school readiness program that helps parents prepare their children aged 3-4 years for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books, and materials designed to strengthen their child's cognitive and early literacy skills, as well as their social, emotional, and physical development. The HIPPY Curriculum contains 30 weekly activity packets, a set of storybooks, and a set of 20 manipulative shapes for each year. In addition to these basic materials, supplies such as scissors and crayons are provided for each participating family. The program uses trained coordinators and community-based home visitors who go into the home. These coordinators and home visitors role-play the activities with the parents and support each family throughout its participation in the program. HIPPY believes that parents play a critical role in their children's education. The HIPPY program seeks to support parents who may not feel sufficiently confident to prepare their children for school, and is designed to remove barriers to participation in education. HIPPY's primary goal is to increase vulnerable children's success in school and, ultimately, in life."	CEBC	2011
Outcomes	• Child development • Child behaviour • Family relationships		
Population	Parents who have young children and have limited formal education and resources.	CEBC	2011
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; or Foster Home	CEBC	2011
Dose	"Recommended intensity: Home visitors engage their assigned parents on a weekly basis. Service delivery is primarily through home visits. A home visit consists of a 1-hour, one-on-one interaction between the home visitor and their assigned parents. Parents then engage their children in educational activities for five days per week for 30 weeks. At least six times per year, one or more cohorts of parents meet in a group setting with the coordinator and their assigned home visitor(s). Group meetings feature an enrichment activity and last approximately two hours. Recommended duration: A minimum of 30 weeks of interaction with the home visitor."	CEBC	2011
Evidence rating	Supported	CEBC	2011
	Model Programs	SAF	1999
Used in Australia	Yes		

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)		Source	Year
Program description	"MTFC-P is a foster care treatment model specifically tailored to the needs of 3-6-year-old foster children. MTFC-P is effective at promoting secure attachments in foster care and facilitating successful permanent placements. MTFC-P is delivered through a treatment team approach in which foster parents receive training and ongoing consultation and support. Children receive individual skills training and participate in a therapeutic playgroup, and birth parents (or other permanent placement caregivers) receive family therapy. MTFC-P emphasises the use of concrete encouragement for pro-social behavior; consistent, non-abusive limit-setting to address disruptive behavior; and close supervision of the child. In addition, the MTFC-P intervention employs a developmental framework in which the challenges of foster preschoolers are viewed from the perspective of delayed maturation."	CEBC	2009
Outcomes	• Family relationships • Child behaviour • Child development • Safety and physical wellbeing		
Population	Preschool foster children aged 3-6 years who exhibit a high level of disruptive and anti-social behaviour which cannot be maintained in regular foster care or who may be considered for residential treatment.	CEBC	2009
Setting	"Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) was designed to be conducted in a group setting. Recommended group size: There are two main components that are conducted in group environment: Therapeutic Playgroup and Foster Parent Support Meeting. The Therapeutic Playgroup is conducted with approximately 10 children. The Foster Parent Support Meeting occurs with 10 caregivers This program is typically conducted in a(n): Birth Family Home; Community Agency; Foster Home; or School."	CEBC	2009
Dose	"Recommended intensity: For foster parent(s), there is typically a minimum of seven contacts per week which consist of five 10-minute contacts, one 2-hour group and additional contacts based on the amount of support or consultation required. For the child in treatment, two contacts per week which consist of a 2-hour therapeutic playgroup and a 2-hour skills training session. For the biological family or other long-term placement resource, one contact per week in the form of a 1-hour skill-building session. Recommended duration: Designed with an overall treatment duration of 6-9 months."	CEBC	2009
Evidence rating	Supported	CEBC	2009
Used in Australia	Yes		

Multi-Family Psychoeducational Psychotherapy (MF-PEP)		Source	Year
Program description	"MF-PEP is a manual-based treatment for children aged 8-12 with mood disorders (depressive and bipolar spectrum disorders). MF-PEP is based on a biopsychosocial framework and utilises cognitive-behavioral and family-systems based interventions. MF-PEP is an 8-session, 90-minutes-per-session treatment that begins and ends with children and parents together; the bulk of each session is run separately for parents and children. MF-PEP's goals are to help parents and children learn about, then effectively manage, symptoms of mood disorders via improved communication, problem solving, and emotion regulation. It is the intention of MF-PEP that by giving the parents and child a better understanding of the disorder, family tension will decrease and consumer skills will improve; resulting in reduced symptom severity and improved functioning."	CEBC	2010
Outcomes	• Child behaviour • Family relationships • Child development		
Population	Children aged 8-12 years with major mood disorders (depressive and bipolar spectrum) and their parents.	CEBC	2010
Setting	This program is typically conducted in a community agency or outpatient clinic	CEBC	2010
Dose	"Recommended intensity: Weekly 90 minute sessions. Recommended duration: 8 weeks."	CEBC	2010
Evidence rating	Supported	CEBC	2010
Used in Australia	Yes		

Parenting Together Project (PTP)		Source	Year
Program description	"PTP is an educational intervention for first-time parents that focuses on the development of fathers' knowledge, skills, and commitment to the fatherhood role. The programs goals are to increase mothers' support and expectations for the fathers' involvement; to foster co-parental teamwork in the couple; and to have the couple deal more constructively with contextual factors such as work and cultural expectations. The intervention consists of eight 2-hour sessions that are spread out between the second trimester of pregnancy and five months post-partum."	CEBC	2011
Outcomes	• Basic child care • Family relationships • Parent-child relationship		
Population	Not specified	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Yes		

Project SUPPORT		Source	Year
Program description	"Project SUPPORT was developed to address child conduct problems (i.e., disruptive, oppositional behaviors). Specifically, it was designed for individual families (mother and child(ren)) in which the mother had sought refuge at a woman's shelter because of domestic violence and at least one of her children was exhibiting clinical levels of conduct problems. The intervention includes two main components: providing instrumental and emotional support to the mother during her transition from the women's shelter and teaching the mother to implement a set of child management and nurturing skills that have been shown to be effective in the treatment of clinical levels of conduct problems."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing • Parent-child relationship		
Population	Families (mothers and children) who had recently sought refuge at domestic violence shelters, with children aged 4-9 exhibiting clinical levels of elevations on externalising problems (e.g., disruptive, defiant behaviours).	CEBC	2011
Setting	Birth family home	CEBC	2011
Dose	"Recommended intensity: Weekly 1-1.5 hour sessions with flexibility in scheduling to address crises that emerge. Recommended duration: 26 weeks."	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Information unavailable		

Supporting Father Involvement (SFI)		Source	Year
Program description	"SFI is a preventive intervention designed to enhance fathers' positive involvement with their children. The curriculum is based on an empirically-validated family risk model. This model predicts that children's development is predicted by risks and buffers in five interconnected domains: • family members' characteristics • 3-generational expectations and relationship patterns • quality of parent-child relationship • quality of parents' relationship • balance of stressors versus social support for the family. The curriculum highlights the potential contributions fathers make to the family. The program is aimed at strengthening fathers' involvement in the family, promoting healthy child development, and preventing key factors implicated in child abuse."	CEBC	2011
Outcomes	• Child development • Safety and physical wellbeing • Parent-child relationships • Family relationships		
Population	Primarily low-income families	CEBC	2011
Setting	Conducted in a group setting in community agencies and schools	CEBC	2011
Dose	"Recommended intensity: Two-hour long weekly group meetings. Case management contact advisable. Recommended duration: 16 weeks."	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Information unavailable		

Together Facing the Challenge		Source	Year
Program description	"Together Facing the Challenge is a training/consultation approach to improving practice in treatment foster care (TFC). The intervention was built from a naturalistic study of "usual care" TFC to determine what practice components were related to improved outcomes for youth. It also incorporates elements from existing evidence-based treatments to fill identified gaps in usual care practice. The resulting model includes training/consultation for TFC supervisors as well as training for treatment foster parents. Together Facing the Challenge is designed as a train-the-trainer approach, so that TFC administrative/supervisory personnel can learn the training and model and train treatment foster parents. This program will provide training on practical parenting and supervisory skills and techniques. The goal of the program is that, at the end, both therapeutic foster parents and supervisors alike will: • Build therapeutic relationships • Perform and teach cooperation skills • Implement effective parenting techniques (communicate effectively, set expectations, reinforce positive behavior, avoid power struggles, etc.) • Prepare youth for their future by teaching independence skills • Create a positive home environment through family fun time, taking care of self, family meetings, etc. The program strives to improve outcomes for youth served in therapeutic foster care settings."	CEBC	2011
Outcomes	• Parent-child relationship • Child behaviour • Child development • Safety and physical wellbeing		
Population	Treatment foster parents and agency staff	CEBC	2011
Setting	This program is typically conducted in a(n): Community Agency or Departments of Social Service. Together Facing the Challenge was designed to be conducted in a group setting. Recommended group size: 15-20	CEBC	2011
Dose	"Recommended intensity: Training for treatment foster parents occurs as a 6-week course (one 2-hour session per week). Recommended duration: Training for treatment foster parents occurs over 6 weeks. Follow-up booster sessions for foster parents at 6 and 12 months post-training."	CEBC	2011
Evidence rating	Supported	CEBC	2011
Used in Australia	Information unavailable		

1-2-3 Magic: Effective Discipline for Children		Source	Year
Program description	"The 1-2-3 Magic curriculum focuses on developing positive discipline strategies for parents of children approximately 2-12 years of age. The program is appropriate for universal application and for parents of special needs children. 1-2-3 Magic describes parenting activities in three general categories: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to improve discipline and guidance skills in parents and reduce arguing, yelling, or spanking."	CBCAP	2009
Outcomes	• Child behaviour • Parent-child relationship		
Population	Parents of children aged 2-12	CBCAP	2009
Setting	Delivered in a group setting or in a one-on-one coaching environment. Recommended group size: 6-25.	CBCAP CEBC	2009 2011
Dose	Eight 1.5 hour sessions delivered in one or two sessions a week for 4-8 weeks.	CBCAP	2009
Evidence rating	Supported	CEBC	2011
	Emerging/Evidence-Informed	CBCAP	2009
Used in Australia	Yes		

Guiding Good Choices		Source	Year
Program description	"The Guiding Good Choices (GGC) program (formerly known as Preparing for the Drug-Free Years) promotes healthy, protective parent-child interactions and reduces children's risk for early substance use. The curriculum is delivered through group sessions with content focused on strengthening parenting techniques, parent-child bonding, and children's peer resistance skills. Children are required to attend one session that concentrates on peer pressure. The program begins with increasing parents' knowledge of the risk factors associated with substance abuse. It then presents skills that help mitigate these risk factors, such as how to clearly communicate expectations for behavior, how to reduce family conflict, and how to encourage the expression of positive feelings and love. One of the sessions teaches both parents and children various ways to resist peer and social pressures to engage in inappropriate behavior."	CBCAP	2009
Outcomes	• Parent-child relationship • Safety and physical wellbeing • Family relationships • Child development • Child behaviour		
Population	Families of middle school children (ages 9-14) who reside in rural or economically stressed neighbourhoods.	CBCAP	2009
Setting	Delivered in a group setting.	CBCAP	2009
Dose	The program is divided into five x 2-hour sessions or 10 x 1-hour sessions and includes homework.	CBCAP	2009
Evidence rating	Supported	CBCAP	2009
	Promising	Blueprints	2006
	Exemplary I	SAF	1999
	Exemplary	OJJDP	Not indicated
	2.6 - for substance use; and delinquency 2.9 - for parenting behaviours and family interactions 3.1 - for symptoms of depression (adolescents)	SAMHSA	2007
	Proven	PPN	2009
Used in Australia	Information unavailable		

Healthy Families New York		Source	Year
Program description	"Healthy Families New York (HFNY) is a community-based prevention program based on the Healthy Families American model. It focuses on the health and well-being of children at risk for abuse and neglect by providing intensive home visitation services. The program is geared specifically towards young, first time mothers who enrol in the program during pregnancy. The program is centred on home visitation services provided by trained paraprofessionals from the community who help promote positive parenting, healthy pregnancy and child health and development, as well as improve parent self-sufficiency. Home visitors provide families with support, education and referrals to achieve these goals."	CBCAP	2009
Outcomes	• Safety and physical wellbeing • Child development • Family relationships • Basic child care		
Population	"Expectant parents and parents with an infant less than three months of age who are considered to be at high risk for child abuse and neglect. A thorough screening is conducted, measuring risk factors that determine program eligibility."	CBCAP	2009
Setting	Home visitation program	CBCAP	2009
Dose	"HFNY participants may receive home visiting services until the child reaches the age of 5 or is enrolled in Head Start or kindergarten. Families are served at different service levels based on families' needs- the greater the need, the greater frequency of home visits. Home visits are scheduled one or more times per week during pregnancy (Level 1), and families usually remain on Level 1 until the child is at least six months old. As families progress through the service levels, home visits occur on a diminishing schedule, from biweekly (Level 2), to monthly (Level 3), and then quarterly (Level 4)."	CBCAP	2009
Evidence rating	Supported	CBCAP	2009
	Proven	PPN	2011
Used in Australia	Information unavailable		

Infant Health and Development		Source	Year
Program description	"The Infant Health and Development Program (IHDP) was a comprehensive early intervention program for low birth-weight, premature infants designed to promote child health and development. The curriculum and protocols were adapted for the specific target population from the Carolina Abcedarian Project. The program was operated in eight medical institutions from 1985 to 1988. The IHDP was designed as a randomized clinical trial, and the participating sites were selected through a national competitive review. The IHDP combined early child development and family support services with pediatric follow-up. The program began at the infant's discharge from the neonatal nursery and continued until 36 months of age. The intervention consisted of three components: home visits, attendance by the child at a child development centre and parent group meetings. Infants also participated in pediatric follow-up, which included medical, developmental and social assessments, with referral for pediatric care and other services as needed. The home visitor provided parents with health and developmental information, along with family support. In addition, the home visitor implemented two specific curricula, the first of which emphasised cognitive, linguistic and social development through games and activities for the parent to use with the child, while the second involved a systematic approach to help parents manage self-identified problems. The component at the child development centre continued learning activities used by the home visitors and tailored the program to each child's needs and developmental levels. The parent groups provided parents with information on child rearing, health and safety and other parenting concerns, along with increasing social support."	CBCAP	2009
Outcomes	• Child development • Family relationships • Safety and physical wellbeing • Basic child care		
Population	Families with infants who were born prematurely (37 or fewer weeks' gestation) and at low birth weight (2500 grams or less).	CBCAP	2009
Setting	Home visits, parent groups and child attendance at an early childhood centre.	CBCAP	2009
Dose	"Home visits occurred weekly during the first year and biweekly for the next two years. Attendance at the child development centre began at age 12 months and lasted until age 36 months; the children attended the centre five days per week. Teacher-child ratios were 1-to-3 for children aged 12-23 months and 1-to-4 for those aged 24-36 months. Class sizes were six children for those under 24 months of age and eight children for those 24-36 months of age. Each site provided children with (optimal) transportation in IHDP-operated vans. Parent groups met every two months beginning when children were 12 months old."	CBCAP	2009
Evidence rating	Supported	CBCAP	2009
	Proven/Promising	PPN	2009
Used in Australia	Information unavailable		

Schools and Families Educating Children (SAFE Children)		Source	Year
Program description	"Schools and Families Educating Children (SAFE Children) is a comprehensive family-based prevention program for children who live in inner-city neighbourhoods and are entering 1st grade. The goal of the program is to improve parenting and family management skills that support successful academic and healthy social development in children. The program provides multiple family group sessions combined with individual tutoring in reading. The small group meetings for 4-6 families per group address parenting skills, including healthy communication, problem solving and family involvement in the child's education. All family members are invited to attend these meetings. The one-on-one tutoring program focuses on developing reading skills through activities, games and reading time."	CBCAP	2009
Outcomes	• Family relationships • Child development		
Population	Children aged 5 and 6 years who are entering 1st grade and their families.	CBCAP	2009
Setting	Delivered in a group setting and through individualised coaching and home visits in collaboration with a school.	CBCAP	2009
Dose	"SAFE Children is a manualised program, but the materials are not sufficient to implement the program and should be used only in consultation with the program developers. The SAFE children program has two components: • A 20-week series of group meetings of 4-6 families. Families meet weekly for 90 minute sessions led by Family Group Leaders • Twice-weekly, 20-30-minute individual tutoring sessions."	CBCAP	2009
Evidence rating	Supported	CBCAP	2009
	Effective	OJJDP	Not indicated
	3.6 - for reading achievement; child problem behaviours; parenting practices; and parental involvement in child's education	SAMHSA	2007
	Other reviewed programs	PPN	Not indicated
Used in Australia	Information unavailable		

Early Childhood Education and Assistance Program (ECEAP)		Source	Year
Program description	"ECEAP is composed of four interactive components: education, health and nutrition, parent involvement, and family support. These components collectively identify problems that hinder learning; provide health screenings and immunizations for children; encourage parental involvement in the classroom and in the program itself through local parent-run policy councils; assess family needs and refer families to community resources; and provide adults with training to improve their parenting, leadership, and self-sufficiency skills. ECEAP is a community-based, family-focused, comprehensive, pre-kindergarten program designed to help children and their families who are in poverty. The program focuses on helping three- and four-year-olds prepare for and succeed in school while helping their parents progress toward self-sufficiency."	PPN	2004
Outcomes	• Safety and physical wellbeing • Family relationships • Child development • Parent-child relationship		
Population	Early childhood (0-8 years)	PPN	2004
Setting	Type of setting: child care/preschool; community-based service provider; health care provider; home visiting	PPN	2004
Evidence rating	Promising	PPN	2004
Used in Australia	Information unavailable		

Fast Track		Source	Year
Program description	"FAST Track is a comprehensive and long-term prevention program that aims to prevent chronic and severe conduct problems for high-risk children. It is based on the view that antisocial behavior stems from the interaction of multiple influences, and it includes the school, the home, and the individual in its intervention. FAST Track's main goals are to increase communication and bonds between these three domains, enhance children's social, cognitive, and problem-solving skills, improve peer relationships, and ultimately decrease disruptive behavior in the home and school. The Program spans grades 1 through 6, but is most intense during the key periods of entry to school (first grade) and transition from grade school to middle school. It is multidimensional, including the following components: • Parent Training occurs in first grade and emphasises fostering children's academic performance, communicating with the school, controlling anger, and using effective discipline. • Home Visitations occur biweekly to reinforce parenting skills, promote parents' feelings of efficacy and empowerment, and foster parent's problem-solving skills. • Social Skills Training enhances children's social-cognitive and problem-solving skills, peer relations, anger control, and friendship maintenance. • Academic Tutoring is offered three times per week to improve children's reading skills. • Classroom Intervention utilises the PATHS curriculum, a program designed to be used in grades 1-5 to help children develop emotional awareness skills, self-control and problem-solving skills, foster a positive peer climate, incorporate home activities to allow parents' participation, and improve teachers' classroom management skills."	Blueprints	2006
Outcomes	• Child behaviour • Family relationships • Child development • Parent-child relationship		
Population	"FAST Track is an intervention that can be implemented in rural and urban areas for boys and girls of varying ethnicity, social class, and family composition (i.e., the primary intervention is designed for all youth in a school setting). It specifically targets children identified in kindergarten for disruptive behavior and poor peer relations."	Blueprints	2006
Dose	The Program spans grades 1 through 6, but is most intense during the key periods of entry to school (first grade) and transition from grade school to middle school.	Blueprints	2006
Evidence rating	Promising Program	Blueprints	2006
	Exemplary	OJJDP	Not indicated
	Other reviewed programs	PPN	Not indicated
Used in Australia	Information unavailable		

Healthy Steps for Young Children		Source	Year
Program description	"Healthy Steps for Young Children is a national initiative that incorporates developmental specialists into primary care pediatric visits with the aim of meeting families' needs related to their young children's development and behavior. The program also aims to improve the relationships between parents and children, between parents and pediatric practices, and between pediatric practice members. The program targets families with newborns between birth and four weeks. Participating families receive up to six home visits and extended developmental services provided by a Healthy Steps Specialist (HSS) from birth to age three. The HSSs participate in the well-child office visits with the child's health care provider, answer parents' questions about child development, assess the children's developmental status, and identify family health risks. Participating families are also provided with written materials on preventative safety measures and community resources, and the families are given access to a child development telephone information line staffed by an HSS and parent groups facilitated by an HSS."	PPN	2011
Outcomes	• Child development • Child behaviour • Parent-child relationship • Family relationships • Safety and physical wellbeing		
Population	Families with newborns between birth and four weeks	PPN	2011
Setting	Home care provider; home visiting	PPN	2011
Dose	Participating families receive up to six home visits and extended developmental services provided by a Healthy Steps Specialist (HSS) from birth to age three	PPN	2011
Evidence rating	Promising	PPN	2011
Used in Australia	Information unavailable		

Orebro Prevention Program		Source	Year
Program description	"The Orebro Prevention Program (OPP) is a universal prevention program to decrease underage drunkenness by maintaining parents' restrictive attitudes and expectations towards underage drunkenness. The goal is to maintain parents' restrictive attitudes towards underage drinking, even when their child is in their teens."	Blueprints	2011
Outcomes	• Child behaviour		
Population	OPP targets all parents of youth between the ages of 13-16	Blueprints	2011
Setting	School	Blueprints	2011
Dose	OPP is delivered to the parents through structured 20 minute presentations during parent meetings in school, once each semester	Blueprints	2011
Evidence rating	Promising Program	Blueprints	2011
Used in Australia	Information unavailable		

Parents' Fair Share		Source	Year
Program description	"The Parents' Fair Share (PFS) demonstration program, implemented from 1994 through 1996 (with an initial pilot phase from 1992 to 1994), was a national demonstration project authorised by the Family Support Act of 1988. PFS was designed and evaluated by the Manpower Demonstration Research Corporation (MDRC). The goals of the program included helping unemployed, noncustodial parents (primarily fathers) to secure employment, pay child support, and participate more fully and responsibly as parents. The PFS program was designed as an alternative to standard child support enforcement. The program offered services in four areas: employment and training, modified child-support enforcement, peer support, and voluntary mediation services with the custodial parent. PFS services were provided through newly developed coalitions of governmental child-support enforcement agencies, employment and training agencies at the state and community level, and private community service organisations. The PFS program was originally implemented in seven states, including Dayton (OH), Grand Rapids (MI), Jacksonville (FL), Los Angeles (CA), Memphis (TN), Springfield (MA), and Trenton (NJ). Most of the sites that continued the PFS program through to the end of the demonstration project adapted the original program model based on their initial experiences."	PPN	2007
Outcomes	• Safety and physical wellbeing • Family relationships		
Population	Unemployed, noncustodial parents (primarily fathers)	PPN	2007
Setting	Community-based service provider	PPN	2007
Evidence rating	Promising	PPN	2007
Used in Australia	Information unavailable		

Preventive Treatment Program (PTP)		Source	Year
Program description	"The program is designed to prevent antisocial behavior of boys who display early, problem behavior. It provides training for both parents and youth to decrease delinquency, substance use, and gang involvement. The Preventive Treatment Program combines parent training with individual social skills training. Parents receive an average of 17 sessions that focus on monitoring their children's behavior, giving positive reinforcement for prosocial behavior, using punishment effectively, and managing family crises. The boys receive 19 sessions aimed at improving prosocial skills and self-control. The training is implemented in small groups containing both disruptive and non-disruptive boys, and it utilises coaching, peer modeling, self-instruction, reinforcement contingency, and role playing to build skills."	Blueprints	2006
Outcomes	• Child behaviour • Family relationship • Child development		
Population	Boys who display early, problem behaviour	Blueprints	2006
Setting	School		
Dose	Parents receive an average of 17 sessions and boys 19 sessions	Blueprints	2006
Evidence rating	Promising Program	Blueprints	2006
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Information unavailable		

Seattle Social Development Project (SSDP)		Source	Year
Program description	"This universal, multidimensional intervention decreases juveniles' problem behaviors by working with parents, teachers, and children. It incorporates both social control and social learning theories and intervenes early in children's development to increase prosocial bonds, strengthen attachment and commitment to schools, and decrease delinquency. SSDP's success lies in its combination of parent and teacher training. Teachers receive instruction that emphasises proactive classroom management, interactive teaching, and cooperative learning. When implemented, these techniques minimise classroom disturbances by establishing clear rules and rewards for compliance; increase children's academic performance; and allow students to work in small, heterogeneous groups to increase their social skills and contact with prosocial peers. In addition, 1st grade teachers teach communication, decision-making, negotiation, and conflict resolution skills; and 6th grade teachers present refusal skills training. Parents receive optional training programs throughout their children's schooling. • When children are in 1st and 2nd grade, 7 sessions of family management training help parents monitor children and provide appropriate and consistent discipline. • When children are in 2nd and 3rd grade, 4 sessions encourage parents to improve communication between themselves, teachers, and students; create positive home learning environments; help their children develop reading and math skills, and support their children's academic progress. • When children are in 5th and 6th grade, 5 sessions help parents create family positions on drugs and encourage children's resistance skills."	Blueprints	2006
Outcomes	• Child behaviour • Parent-child relationship • Family relationships • Child development		
Population	General population and high-risk children (those with low socioeconomic status and low school achievement) attending grade school and middle school	Blueprints	2006
Setting	School		
Evidence rating	Promising Program	Blueprints	2006
	Promising	PPN	2006
Used in Australia	Information unavailable		

Strengthening Families Program: For Parents and Youth 10-14		Source	Year
Program description	"The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) is a family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10-14-year-olds. It is theoretically based on several etiological and intervention models including the biopsychosocial vulnerability, resiliency, and family process models. The program includes seven x 2-hour sessions and four optional booster sessions in which parents and youth meet separately for instruction during the first hour and together for family activities during the second hour. The sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences to use substances. Sessions, which are typically held once a week, can be taught effectively by a wide variety of staff."	SAMHSA	2008
Outcomes	• Child behaviour • Family relationships • Parent-child relationships		
Population	Parents, and youth aged 10-14 years	SAMHSA	2008
Setting	School	SAMHSA	2008
Dose	Seven 2-hour sessions and four optional booster sessions	SAMHSA	2008
Evidence rating	Promising Program	Blueprints	2006
	Exemplary II	SAF	1999
	Exemplary	OJJDP	Not indicated
	2.8 - for substance use 2.9 - for school success 3.0 - for aggression 3.3 - for cost effectiveness	SAMHSA	2008
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Information unavailable		

Strong African American Families (SAAF)		Source	Year
Program description	"Strong African American Families (SAAF) is a parental training and family therapy program grounded in social bonding and control theories. The program works to strengthen the attachment between parent and child to reduce the likelihood of youth involvement in various problem behaviors, particularly alcohol and substance abuse. SAAF targets African American families with children 10-14 years of age. SAAF aims to strengthen parenting practices related to monitoring and supporting youth, articulating parental expectations for alcohol use, communicating with youth about sex, and promoting positive racial socialization. It also works to promote youths' ability to focus on goals for the future, resist involvement in risk behaviors, maintain negative images of risk behaviors and peers who engage in them, and accept parental influences. Caregivers and their children attend seven consecutive weekly sessions at a venue in their community (e.g., local community centers, schools, and churches). Caregiver session topics address monitoring, communication, limit setting, parental school involvement, racial socialization, and clear expectations about alcohol use. The youth sessions address goal setting, attitudes about substance use and people who use substances, risk behavior, resistance skills, racial socialisation, understanding of parental perspectives, and acceptance of parental influences. The family sessions build upon these topics while supporting efforts to strengthen family relationships, as well as cultural pride and values."	OJJDP	Not indicated
Outcomes	• Parent-child relationship • Child behaviour		
Population	African American youths aged 10-14 years and their primary caregivers	SAMHSA	2011
Setting	School and other community settings	SAMHSA	2011
Dose	Facilitators administer SAAF through seven 2-hour sessions using separate skill-building curricula for youths and primary caregivers. Sessions can be implemented at any time during the week, including weekends. During the first hour of each session, youths and primary caregivers meet separately with facilitators	SAMHSA	2011
Evidence rating	Promising Program	Blueprints	2006
	Effective	OJJDP	Not indicated
	3.6 - for alcohol use 3.8 - for conduct problems	SAMHSA	2011
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Information unavailable		

Adolescent Transitions Program		Source	Year
Program description	"The Adolescent Transitions Program (ATP) is a multilevel, family-centered intervention targeting children who are at risk for problem behavior or substance use. Designed to address the family dynamics of adolescent problem behavior, it is delivered in the middle school setting to parents and their children. The parent-focused curriculum concentrates on developing family management skills such as making requests, using rewards, monitoring, making rules, providing reasonable consequences for rule violations, problem-solving, and active listening. Strategies targeting parents are based on evidence about the role of coercive parenting strategies in the development of problem behaviors in youth. The curriculum for teens takes a social learning approach to behavior change and concentrates on setting realistic goals for behavior change, defining reasonable steps toward goal achievement, developing and providing peer support for prosocial and abstinent behavior, setting limits, and learning problem-solving. The long-term goals of the program are to arrest the development of teen antisocial behaviors and drug experimentation. Intermediate goals are to improve parents' family management and communication skills. To accomplish these goals, the intervention uses a "tiered" strategy with each level (universal, selective, and indicated) building on the previous level. The universal level is directed to the parents of all students in a school. Program goals at this level include engaging parents, establishing norms for parenting practices, and disseminating information about risks for problem behavior and substance use. At the selective level of intervention, the Family Check-Up, assessment, and support are provided to identify those families at risk for problem behavior and substance use. At the indicated level, direct professional support is provided to parents based on the results of the Family Check-Up through services including behavioral family therapy, parenting groups, or case management services."	OJJDP	Not indicated
Outcomes	• Child behaviour • Child development • Parent-child relationship • Family relationship		
Population	Adolescents aged 11-18 years	OJJDP	Not indicated
Setting	Rural	OJJDP	Not indicated
Dose	Program activities are led by group leaders and include parent group meetings, individual family meetings, and teen group sessions, as well as monthly booster sessions for at least 3 months following completion of the group.	OJJDP	Not indicated
Evidence rating	Exemplary II	SAF	1999
	Effective	OJJDP	Not indicated
Used in Australia	Information unavailable		

Raising a Thinking Child: I Can Problem Solve for Families		Source	Year
Program description	"Raising a Thinking Child: I Can Problem Solve for Families aims to develop a set of interpersonal cognitive problem-solving (ICPS) skills that relate to overt behaviors as early as preschool. By enhancing ICPS skills, the goal is to decrease future serious problems by addressing the behavioral predictors early in life. In addition, the parent intervention is designed to help parents use a problem-solving style of communication that guides young children to think for themselves. The program consists of 10-12 weekly sessions, though a minimum of 6 weeks is sufficient to convey the approach. The first section concentrates on learning a problem-solving vocabulary in the form of games. The second section teaches children how to listen. It also teaches them how to identify their own and others' feelings and to realise that people can feel different ways about the same thing. In the last section, children are given hypothetical problems and asked to think about people's feelings, consequences to their acts, and different ways to solve problems. During the course of the program, parents are given exercises to help them think about their own feelings and become sensitive to their children's feelings. Parents also learn how to find out their children's view of the problem and how to engage their children in the process of problem solving."	OJJDP	Not indicated
Outcomes	• Child development • Child behaviour • Parent-child relationship		
Population	The program now includes parents of children up to age seven and has been expanded to include middle and upper-middle income populations in the normal behavioural range as well as those displaying early high-risk behaviours. These include those diagnosed with ADHD and other special needs.	SAF	1999
Dose	The program consists of 10-12 weekly sessions, though a minimum of 6 weeks is sufficient to convey the approach	OJJDP	Not indicated
Evidence rating	Exemplary II	SAF	1999
	Effective	OJJDP	Not indicated
Used in Australia	Information unavailable		

The Prenatal and Early Childhood Nurse Home Visitation Program		Source	Year
Program description	"The Prenatal and Early Childhood Nurse Home Visitation Program is a well-tested model that improves the health and social functioning of low-income first-time mothers and their babies. Nurse home visitors develop a supportive relationship with the mother and family which emphasises education, mutual goal setting, and the development of the parents' own problem-solving skills and sense of self-efficacy. Beginning in pregnancy, the nurses help women to improve their health behaviors related to substance abuse (smoking, drugs, alcohol) and nutrition, significant risk factors for pre-term delivery, low birth weight, and infant neuro-developmental impairment. After delivery, the emphasis is on enhancing qualities of care-giving for infants and toddlers, thereby preventing child maltreatment, childhood injuries, developmental delay, and behavioral problems. Among the mothers, the program also focuses on preventing unintended subsequent pregnancies, school drop out, and failure to find work resulting in ongoing welfare dependence - factors that conspire to enmesh families in poverty and that increase the likelihood that women will have poor subsequent pregnancies and increase the likelihood for sub-optimal care of children. In order to achieve maximum outcomes in the preceding domains of functioning, nurses work to improve environmental contexts by enhancing informal support and by linking families with needed health and human services."	SAF	1999
Outcomes	• Safety and physical wellbeing • Child development • Basic child care • Child behaviour • Family relationships		
Population	Low income first time mothers and their infants	SAF	1999
Setting	Home	SAF	1999
Dose	Using developmentally established protocols, nurses visit families as follows: (a) weekly during the first month following enrollment, (b) every other week throughout the remainder of the woman's pregnancy, (c) weekly for the first six weeks postpartum, (d) every other week thereafter through the child's 21st month, and (e) then monthly until the child reaches age two.	SAF	1999
Evidence rating	Exemplary II	SAF	1999
Used in Australia	Information unavailable		

Linking the Interests of Families and Teachers (LIFT)		Source	Year
Program description	"Linking the Interests of Families and Teachers (LIFT) is an intervention designed to prevent the development of aggressive and antisocial behaviors in children within the elementary school setting (particularly first graders and fifth graders). LIFT was informed by scientific research on the development of delinquency—specifically coercion theory (for more details, see Patterson, 1982, or Patterson, Reid, and Dishion, 1992). As such, LIFT is designed to decrease the likelihood of two major factors that put children at risk for subsequent antisocial behavior and delinquency: 1) aggressive and other socially incompetent behaviors with teachers and peers at school and 2) ineffective parenting, including inconsistent and inappropriate discipline and lax supervision. LIFT has three main components: 1) classroom-based child social skills training, 2) the playground Good Behavior Game, and 3) parent management training. These efforts are fortified by systematic communication between teachers and parents. To facilitate communication, a "LIFT line" is implemented in each classroom. The LIFT line is a phone and an answering machine in each classroom that families are encouraged to use if they have any questions for the teachers or have concerns that they wish to share. Child social skills training sessions are held during the regular school day and are broken into distinct segments. The first segment includes 1) classroom instruction and discussion about specific social and problem-solving skills, 2) skills practice in small and large groups, 3) free play in the context of a group cooperation game, and 4) review and presentation of daily rewards. The second segment includes a formal class problem-solving session and free play and rewards. The curriculum is similar for all elementary school students, but delivery format, group exercises, and content emphasis are modified to address normative developmental issues depending on the grade level of the participants. The playground Good Behavior Game takes place during the middle of the free-play portion of the social skills training and is used to actively encourage positive peer relations on the playground. During the game, rewards are earned by individual children for demonstrating positive problem-solving skills and other prosocial behaviors with peers as well as for the inhibition of negative behaviors. Parent Management Training in LIFT is conducted in groups of 10-15 parents and consists of six weekly 2.5-hour sessions. Sessions can provide training either after school or in the evenings. Session content concentrates on positive reinforcement, discipline, monitoring, problem solving, and parent involvement in the school. Communication is fostered throughout the school year."	OJJDP	Not indicated
Outcomes	• Child behaviour • Parent-child relationship • Family relationships		
Population	Elementary school children	OJJDP	Not indicated
Evidence rating	Exemplary	OJJDP	Not indicated
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Information unavailable		

Attachment and Biobehavioral Catch-up (ABC)		Source	Year
Program description	"ABC targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the second intervention component helps caregivers provide nurturing care even if it does not come naturally. Third, many children who have experienced early adversity are dysregulated behaviorally and biologically. The third intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities."	CEBC	2012
Outcomes	• Child behaviour • Child development • Safety and physical wellbeing • Parent-child relationship		
Population	Foster parents of infants	CEBC	2012
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; or Foster Home	CEBC	2012
Dose	"Recommended intensity: Weekly 1-hour sessions. Recommended duration: 10 sessions."	CEBC	2012
Evidence rating	Promising	CEBC	2012
Used in Australia	Information unavailable		

AVANCE Family Support and Education Program (AVANCE)		Source	Year
Program description	"AVANCE is program to support low-income Hispanic families. The program includes a 9-month center-based component, as well as monthly home visits. Mothers are provided transportation to centers, where they make educational toys and receive training on child development and a curriculum aimed at helping them see themselves as effective role models and teachers. This curriculum is supported by the home visits. Children participate in and educational day-care setting during mothers' classes. During a second year, mothers may attend courses in English as a Second Language and take college or GED classes or courses in vocational skills."	CEBC	2011
Outcomes	• Child development		
Population	Low income Hispanic families	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Child-Parent Centers		Source	Year
Program description	"The Child-Parent Centers program is a center-based early intervention that provides educational and family support services. The program is designed for low-income children and families from preschool to early elementary school. Class sizes are kept small and teachers are given in-service training. The Child-Parent Centers focus on five areas: early intervention; parent involvement; a structured language and basic skills approach; health and social services; and continuity between preschool and early elementary school. The parent component includes a full-time parent resource teacher; parent educational activities and GED classes; and support for parent-child interactions and interactions among parents. The program also includes home visitation and parent conferences to support their five focus areas."	CEBC	2011
Outcomes	• Child development • Parent-child relationship • Family relationships		
Population	Children aged 3-9 years	OJJDP	Not indicated
Setting	Urban	OJJDP	Not indicated
Evidence rating	Promising	CEBC	2011
	Effective	OJJDP	Not indicated
	Proven	PPN	2008
Used in Australia	Information unavailable		

Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: Preschool Program		Source	Year
Program description	"Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: Preschool Program is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems: • The program is an outpatient group treatment program for children ages 3-6 years and their parents or other caregivers. • The program can be provided to individual families when group is not an option. • The treatment is provided as a closed-ended group. • The group is 12-14 sessions long. • Collaboration with child protective services, school personnel, and others involved is highly recommended. Caregivers are taught about sexual development, how to supervise the children, teach and implement rules in the home, communicate about sex education, and reduce behavior problems utilizing behavior parent training strategies. Children are taught private part rules and abuse prevention skills in the context of safety rules. Boundaries, emotional regulation, coping skills, and basic impulse control strategies are taught and practiced during and between sessions."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing		
Population	Children with sexual behaviour problems. Boys and girls aged 3-6 years and their caregivers.	CEBC	2011
Setting	Children with Sexual Behaviour Problems Cognitive-Behavioural Treatment Program: Preschool Program was designed to be conducted in a group setting. The size depends in part on the number of co-therapists available. We recommend having 5-7 children in each group.	CEBC	2011
Dose	Recommended intensity: 90-minute weekly session. Recommended duration: 12-14 sessions.	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Circle of Security (COS)		Source	Year
Program description	"The COS protocol is an early intervention program designed to prevent insecure attachment and child mental disorders. It uses a user-friendly, visually based approach (utilising extensive use of both graphics and video clips) to help parents better understand the needs of their children. It is based extensively upon attachment theory and current affective neuroscience. All of the learning is informed around the following themes: • Teaching the basics of attachment theory via the Circle of Security™ • Increasing parent skills in observing parent/child interactions • Increasing capacity of the caregiver to recognise and sensitively respond to children's needs • Supporting a process of reflective dialogue between clinician and parent to explore both strengths and areas of parent difficulties (i.e., being 'Bigger, Stronger, Wiser, and Kind,' supporting exploration, and supporting attachment) • Introducing parent to a user-friendly way to explore defensive process."	CEBC	2011
Outcomes	• Child behaviour • Parent-child relationship • Basic child care • Child development		
Population	High-risk populations such as having a child enrolled in Early Head Start or Head Start programs, incarcerated women, or having an irritable baby	CEBC	2011
Setting	Birth family home	CEBC	2011
Dose	"Recommended intensity: A 2-hour lab visit for the dyad (caregiver and child) for assessment and three hour-long home visits reviewing video tape of the dyad with the parent and a fourth visit at the end for follow-up and ending. The visits took place about once every three weeks. Recommended duration: 3-4 months."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

Common Sense Parenting (CSP)		Source	Year
Program description	"Common Sense Parenting[SM] (CSP) is a group-based class for parents comprised of 6 weekly, 2-hour sessions led by a certified trainer who focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior. Each class is formatted to include a review of the prior session, instruction of the new skill, modeled examples, skill practice/feedback, and a summary."	CEBC	2010
Outcomes	• Child behaviour		
Population	Parents and other caregivers of children aged 6-16 years	CEBC	2010
Setting	This program is typically conducted in a(n): Community Agency; Community Daily Living Settings; Hospital; or School. Common Sense Parenting (CSP) was designed to be conducted in a group setting. Recommended group size: Approximately 9-10 parents.	CEBC	2010
Dose	"Recommended intensity: One 2-hour weekly session. Recommended duration: 6 weeks."	CEBC	2010
Evidence rating	Promising	CEBC	2010
	Promising	OJJDP	Not indicated
Used in Australia	Information unavailable		

Cool Kids		Source	Year
Program description	"Cool Kids is a program that teaches children and their parents how to better manage the child's anxiety. It can be run either individually or in groups and involves the participation of both children and their parents. The program aims to teach clear and practical skills to both the child and parents. The program is aimed at young people 7-17 years, is fully supported by manuals, and has slightly different versions for children and teenagers. Variations of the program also exist for children with comorbid autism, adolescents with comorbid depression, and for delivery in school settings. The goals of Cool Kids are to reduce the symptoms and amount of life interference caused by anxiety, including reducing avoidance and family distress and increasing confidence, peer relationships, and engagement in extra-curricular activities. This program involves the family or other support systems in the individual's treatment: For children under 12, parents attend every session. For adolescents, parents attend most sessions. Parents learn how to manage children differently, how to manage their own anxieties, and how to help their child implement their new skills outside the therapy sessions."	CEBC	2011
Outcomes	• Family relationships • Safety and physical wellbeing • Child behaviour • Child development	CEBC	2011
Population	"Children and adolescents suffering anxiety disorders"	CEBC	2011
Setting	"This program is typically conducted in a(n): Community Agency; Outpatient Clinic; or School" "Cool Kids was designed to be conducted in a group setting (recommended group size: 6-8)"	CEBC	2011
Dose	"Recommended intensity: • Individual format: 8 hour-long weekly sessions followed by two hour-long biweekly sessions • Group format: 8 x 2-hour long sessions followed by two x 2-hour long sessions. Recommended duration: 12 weeks."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

Cool Kids Outreach Program		Source	Year
Program description	"Cool Kids Outreach Program is a version of Cool Kids, a program that teaches children and their parents how to better manage the child's anxiety. The program aims to teach clear and practical skills to both the child and parents. The program is supported by manuals and has slightly different versions for children (7-12) and teenagers (13-17). The outreach version is designed to be conducted without any personal contact between client and therapist. For younger children, parents act as the "therapist" and receive detailed instructions to help their child. For teenagers, the young person receives detailed instructions and parents are encouraged to participate as a support. The goals of Cool Kids Outreach are to reduce the symptoms and amount of life interference caused by anxiety, including reducing avoidance and family distress and increasing confidence, peer relationships, and engagement in extra-curricular activities This program involves the family or other support systems in the individual's treatment: For children under 13, primary materials are aimed at helping the parent/ caregiver run the program with the child (i.e., the parent becomes the therapist). For adolescents, parents receive some information to enable them to assist and support the young person."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Child development • Family relationships • Child behaviour		
Population	Children with anxiety disorders of any type and their parents	CEBC	2011
Setting	Delivery settings include adoptive homes, birth family homes, foster homes and schools. "Cool Kids Outreach Program was not designed to be conducted in a group setting, and has not been tested for use in a group setting."	CEBC	2011
Dose	"Recommended intensity: Number of contacts varies depending on therapist availability and personal need. Weekly 30-minute sessions by telephone is recommended. Recommended duration: It is an individual program and so length is personal. However, standard is 12 weeks with phone contact during the first 10."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

Domestic Violence Home Visit Intervention (DVHVI)		Source	Year
Program description	"The DVHVI is a joint project of the Yale Child Study Center and the New Haven Police Department. The project provides enhanced law enforcement, community-based advocacy, and mental health services to families affected by domestic violence, in an effort to increase children's safety and decrease negative psychological effects of exposure to domestic violence. The project conducts outreach home visits by teams of advocates and patrol officers. At the initial home visit, the team and non-offending parent identify issues affecting family safety. The team provides information related to judicial processes, available community resources, and children's responses to violence and trauma. Ongoing intervention, including referrals for child-focused clinical treatment, is determined by the unique needs of each family."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Child behaviour • Family relationships		
Population	"Families with children from birth to 18 years old that have reported incidents of intimate partner violence (IPV) to police. Children need not have been physically present at the violent event, but there must be children living in the home for the family to be eligible for the service. All levels of violence are targeted, with specific interventions determined by the level of ongoing danger."	CEBC	2011
Setting	Birth family home	CEBC	2011
Dose	"Recommended intensity: This program provides a single initial home visit to all referred families. The number of visits ranges from 1 to 15. Most families receive 1 or 2 visits, with the initial home visits ranging in length from 5 minutes to 2 hours, with a median of 20 minutes. For those families that do engage in ongoing services, frequency of contact with program advocates ranges from daily to monthly. Recommended duration: Individual service plans are determined by specific family needs and wishes. Duration of contact ranges from a single visit to more than a year of advocacy service with the total time spent ranging from 10 minutes to more than 100 hours. Most families receive less than 1 hour of total service."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Effective Black Parenting Program (EBPP)		Source	Year
Program description	"Effective Black Parenting (EBPP), a cognitive-behavioral program, was created to meet the specific needs of African-American parents. It seeks to foster effective family communication, healthy African-American identity, extended family values, child growth and development, and healthy self-esteem. In addition, it facilitates efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances. The program is grounded in basic parenting strategies and information appropriate for all socio-economic status levels but especially for parents of children aged 2-12 years old."	SAF	1999
Outcomes	• Family relationships • Child development • Safety and physical wellbeing • Child behaviour		
Population	African-American families at risk for child maltreatment	CEBC	2010
Setting	"Effective Black Parenting Program (EBPP) was designed to be conducted in a group setting. The program is typically conducted in a(n): Birth Family Home; Community Agency; Foster Home' or Outpatient Clinic."	CEBC	2010
Dose	"Recommended intensity: Weekly 3-hour sessions or a 1-day abbreviated seminar version of 6.5 hours. Recommended duration: 15 weeks total including a session for graduation and testifying or just one-day for the abbreviated seminar version."	CEBC	2010
Evidence rating	Promising	CEBC	2010
	Model Program	SAF	1999
Used in Australia	Information unavailable		

Family Connections (FC)		Source	Year
Program description	"FC is a multi-faceted, community-based service program that works with families in their homes and in the context of their neighborhoods. The goal of FC is to help these families meet the basic needs of their children and reduce the risk of child neglect. Nine practice principles guide FC interventions: community outreach; individualised family assessment; tailored interventions; helping alliance; empowerment approaches; strengths perspective; cultural competence; developmental appropriateness; and outcome-driven service plans. Individualised family intervention is geared to increase protective factors, decrease risk factors, and target child safety and well-being outcomes. The core components of FC include: (a) emergency assistance/concrete services; (b) home-based family intervention (e.g., family assessment, outcome-driven service plans, individual and family counseling); (c) service coordination with referrals targeted toward risk (e.g., substance abuse treatment) and protective factors (e.g., mentoring program); and (d) multi-family supportive recreational activities (e.g., theme-based gatherings such as Black History month, trips to museums, etc.). Family Connections (FC) was designed with a parent/caregiver component that addresses the following presenting problems and symptoms: Poor Household Conditions, Poor Financial Conditions, Inadequate Supports to Caregivers, Unsafe Caregiver/Child Interactions, Abusive Interactions Between Caregivers, Dysfunctional Outcomes from Caregiver History, and Dysfunctional Caregiver Personal Characteristics and Behaviors."	CEBC	2011
Outcomes	• Basic child care • Safety and physical wellbeing • Family relationships • Child development		
Population	"Families at risk for child emotional and physical neglect."	CEBC	2011
Setting	"This program is typically conducted in a(n): Birth Family Home; or Community Agency"	CEBC	2011
Dose	"Recommended intensity: A minimum of one hour of face-to-face contact between the social worker and clients weekly. Recommended duration: 3-9 months."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Unclear		

Foster Parent College (FPC)		Source	Year
Program description	"FPC is an online training venue for foster, adoptive, and kinship parents. Interactive multimedia courses offered through the site provide resource parents with both pre-service and in-service training on clinical aspects of and parent interventions for their child's behavior problems. Instructional content is based on social learning theory and attachment theory. There are currently 31 courses on FPC, 15 of which address specific child behavioral and emotional problems. Course topics in the area of parenting strategies include safe parenting, positive parenting, resource parents' marriage relationships, working with schools and birth parents, house safety, child safety and supervision, kinship care, culturally competent parenting, grief and loss in the care system, and substance-exposed infants. The first three courses in a planned series of pre-service training courses are now available, covering the topics of child abuse and neglect, the child welfare team, and parent-child attachment. Most FPC courses can be taken individually via computer or in groups via DVD. Two newer online courses are advanced parenting workshops that were designed to be conducted in a group setting, with a discussion board and homework assignments. In addition, agencies can adapt any of the self-paced individual courses for delivery as group workshops with a discussion board, adding their own homework assignments. The goal of FPC is to strengthen agency efforts to support and retain foster parents by providing quick and easy access to expert help on specific parenting and behavioral challenges through online training."	CEBC	2011
Outcomes	• Child behaviour • Parent-child relationship • Safety and physical wellbeing • Family relationships		
Population	Foster, adoptive, and kinship parents, as well as social workers and other mental health professionals who work with resource parents	CEBC	2011
Setting	This program is typically conducted in a(n): Adoptive Home; Community Agency; or Foster Home	CEBC	2011
Dose	"Recommended intensity: The average time it takes to complete an individual course, including completion of interactive exercises, reading handouts, and completing a review questionnaire, is 1-2 hours. Recommended duration: Each course can be completed in 1-2 hours. Courses need not be completed in one session, but most people complete them in 1 or 2 days. Once purchased, courses are available to individuals for 30 days. Workshops are scheduled to be completed over a 3-week period."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

Helping the Noncompliant Child		Source	Year
Program description	"Helping the Noncompliant Child (HNC) is a focused prevention program that seeks to improve parent-child interaction. The program consists of teaching parenting skills designed to promote healthy interaction. Specific techniques include ignoring minor inappropriate behavior, providing clear instructions to the child, and providing appropriate consequences for compliance (positive attention) and noncompliance (time out). HNC strives to help parents feel competent and comfortable with the various parenting skills taught in the program. The coaching relationships allows for role modelling and extensive practice of skills. Skills are taught until mastery is achieved."	CBCAP	2009
Outcomes	• Parent-child relationship • Child behaviour		
Population	The program is designed for parents of children ages 3-8 who have noncompliance or other conduct problems.	CBCAP	2009
Setting	Delivered in the home and through one-on-one coaching. HNC was not designed to be conducted in a group setting; but has been tested for use in a group setting. Recommended group size: 10-15 parents.	CBCAP CEBC	2009 2009
Dose	"Parents and children participate in weekly sessions of 60-90 minutes each. The average number of sessions is 10. This is a mastery-based program, so families can repeat sessions until mastery is achieved. In an ideal setting, sessions occur in clinic playrooms equipped with one-way mirrors for observation, sound systems and sound devices by which the therapist can communicate unobtrusively with the parent. However, these are not mandatory for the successful implementation of the program."	CBCAP	2009
Evidence rating	Promising	CEBC	2009
	Supported	CBCAP	2009
	Exemplary I	SAF	1999
	Promising	OJJDP	Not indicated
Used in Australia	Yes		

Interaction Guidance (IG)		Source	Year
Program description	"IG treats infants with a variety of early regulation disorders including feeding, sleeping, and excessive crying. The program was developed for families who have been difficult to engage in treatment due to risk factors such as poverty, substance abuse, mental illness, or other family stressors. IG uses observation of interactions between the baby and caregiver as representations of family structure. Therapeutic techniques include reviewing videotaped interactions to reinforce positive aspects and enhance caregivers' understanding of infant behavior and development."	CEBC	2009
Outcomes	• Child development • Child behaviour • Basic child care • Family relationships • Parent-child relationship		
Population	Infants with a variety of early regulation disorders including feeding, sleeping and excessive crying.	CEBC	2009
Evidence rating	Promising	CEBC	2009
Used in Australia	Information unavailable		

KEEP (Keeping Foster and Kin Parents Supported and Trained)		Source	Year
Program description	"The objective of KEEP (Keeping Foster and Kin Parents Supported and Trained) is to give parents effective tools for dealing with their child's externalising and other behavioral and emotional problems and to support them in the implementation of those tools. Curriculum topics include framing the foster/kin parents' role as that of key agents of change with opportunities to alter the life course trajectories of the children placed with them. Foster/kin parents are taught methods for encouraging child cooperation, using behavioral contingencies and effective limit setting, and balancing encouragement and limits. There are also sessions on dealing with difficult problem behaviors including covert behaviors, promoting school success, encouraging positive peer relationships, and strategies for managing stress brought on by providing foster care. There is an emphasis on active learning methods; illustrations of primary concepts are presented via role-plays and videotapes."	CEBC	2009
Outcomes	• Child behaviour • Family relationships • Parent-child relationships • Child development		
Population	Children aged 4-12 years who are in foster or kinship care placements.	CEBC	2009
Setting	This program is typically conducted in a(n): Community Agency; Departments of Social Service	CEBC	2009
Dose	"Recommended intensity: One 90-minute meeting per week plus one 10-minute telephone call per week for foster/kin parents. Recommended duration: 16 weeks."	CEBC	2009
Evidence rating	Promising	CEBC	2009
Used in Australia	Information unavailable		

Kids Club & Moms Empowerment		Source	Year
Program description	"The Kids' Club & Moms Empowerment are two programs designed to coincide with each other and are most effective when both the mother and child participate in the intervention. Kids Club is a preventive intervention program that targets children's knowledge about family violence; their attitudes and beliefs about families and family violence; their emotional adjustment; and their social behavior in the small group. The program is phase-based, such that early sessions are designed to enhance the child's sense of safety, to develop the therapeutic alliance, and to create a common vocabulary of emotions for making sense of violence experiences. Later sessions address responsibility for violence, managing emotions, family relationship paradigms, and conflict and its resolution. Activities rely on displacement and group lessons are reviewed and repeated, as needed, each week. Moms Empowerment is a parenting program that provides support to mothers by empowering them to discuss the impact of the violence on their child's development; to build parenting competence; to provide a safe place to discuss parenting fears and worries; and to build connections for the mother in the context of a supportive group. In essence, this 10-session intervention is aimed at improving mothers' repertoire of parenting and disciplinary skills, and enhancing social and emotional adjustment, thereby reducing the children's behavioral and adjustment difficulties."	CEBC	2011
Outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Family relationships		
Population	Children ages 6-12 and their mothers exposed to intimate partner violence in the last year. Children may also have been abused	CEBC	2011
Setting	This program is typically conducted in a(n): Community Agency or Outpatient Clinic	CEBC	2011
Dose	"Recommended intensity: Groups for children and the mothers meet concurrently for a 1-hour session once a week. Recommended duration: Ten weeks."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Neighbor to Neighbor		Source	Year
Program description	"Neighbor to Neighbor, developed by The Jane Addams Hull House Association, is a unique child-centered, family-focused foster care model. The program is designed to keep large (4 or more) sibling groups together in stable foster care placements while working intensively on reunification or permanency plans that keep the siblings together. Neighbor to Neighbor began in 1994 serving targeted communities in Chicago where the majority of children came into foster care. The program uses a community-based, team-oriented approach, including foster caregivers and birth parents as part of the treatment team. Trained and supported foster caregivers are key to the model's success. Neighbor to Neighbor has professionalized this key role by placing these trained foster caregiver on the payroll of Jane Addams Hull House Association complete with salaries and benefits. Foster families, birth families, and children receive comprehensive and intensive services including individualised case management, advocacy, and clinical services on a weekly basis. Neighbor to Neighbor was designed with a parent/caregiver component that addresses the following presenting problems and symptoms: Substance or alcohol abuse, mental health challenges, domestic violence, unemployment, parent-child relational and interaction issues, anger management, deficits in parenting skills or child management, and adult survivors of childhood abuse and neglect."	CEBC	2011
Outcomes	• Parent-child relationship • Safety and physical wellbeing • Family relationships • Child behaviour		
Population	"Sibling groups of 4 or more children from infancy through fourteen years of age who are in the custody of the state. Youth who are older than 14 may be accepted if they are part of a sibling group. The program is targeted to serve children and families who are newly involved in the foster care system. If the siblings are at risk for separation and the program can meet their needs, the program will serve sibling groups of 4 or more who have re-entered the foster care system due to disrupted adoptions or who are transferred from another agency."	CEBC	2011
Setting	This program is typically conducted in a(n): Birth Family Home; Community Agency; or Foster Home	CEBC	2011
Dose	"Recommended intensity: Weekly foster home visits for at least one hour. Recommended duration: As long as it takes for reunification to occur. If reunification is not an option and the foster parent(s) become potential adoptive parents or guardians, the number or visits usually decrease per month. The amount of times visits occur is then determined on a family-by-family basis. However, at minimum foster home visits must occur once every 30 days until the family case is closed with the state agency and the juvenile court."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Parenting Wisely		Source	Year
Program description	"Parenting Wisely is a curriculum teaching parents and their 9-18 year old children skills to improve their relationships and decrease conflict through support and behavior management. The program uses interactive multimedia to present scenarios of common family problems. Parents can participate in a group or individually through a computer program. The program instructs parents in effective parenting skills through the use of demonstration, quizzing, repetition, rehearsal, recognition, and feedback for correct and incorrect answers. The target population is families with parents who do not usually seek or complete mental health or parent education treatment for children's problem behaviors. Single-parent families and stepfamilies with children who exhibit behavior problems constitute most of the families targeted."	CBCAP	2009
Outcomes	• Parent-child relationship • Child behaviour • Family relationships		
Population	Parents with children aged 3-18.	CBCAP	2009
Setting	"Delivered in a group setting or through self-directed interactive media. Recommended group size: 10-16."	CBCAP CEBC	2009 2008
Dose	"There are 9 case studies. Parents need 2-3 x 3-hour sessions to work through the computer program for 9 case studies. In a group format, it takes 6-10 x 1 hour sessions. When practitioners work with individual families, they show 1-2 family sceneries from Parenting Wisely each session, for a total of 4-6 sessions."	CBCAP	2009
Evidence rating	Promising	CEBC	2008
	Supported	CBCAP	2009
	Exemplary II	SAF	1999
	Promising	OJJDP	Not indicated
	2.7 - for child problem behaviours; and parental knowledge, beliefs and behaviours 2.8 - for parental sense of competence	SAMHSA	2008
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Yes		

Parents Anonymous (PA)		Source	Year
Program description	"PA is a family-strengthening program of community-based weekly mutual support groups, based on national standards of practice and free to all participants. This culturally responsive model is open to any parent or caregiver in a parenting role seeking support and positive parenting strategies regardless of the age or special challenges of their children. Groups for parents/caregivers are co-facilitated by a trained Group Facilitator and Parent Group Leader to address any issue the group participants wish to discuss, including topics such as child development, communication skills, positive discipline, parental roles, age appropriate expectations, effective parenting strategies, anger management techniques, and self-care. While parents/caregivers are meeting, their infants, children and older youth participate in complementary standards-based Children and Youth Programs conducted by trained Children & Youth Program Workers and designed to build self-esteem, teach emotions management, change behavior, and strengthen family relationships based on the child/youth's developmental stage. Parents/caregivers participating in PA groups engage in meaningful leadership roles in the planning, implementation and evaluation of all aspects of the Parents Anonymous® Group and Children and Youth Program."	CEBC	2011
Outcomes	• Child development • Basic child care • Child behaviour • Family relationships		
Population	"General population, but can accommodate specific population types such as teen parents or parents of children with special needs."	CEBC	2011
Setting	"This program is typically conducted in a(n): Child Abuse & Family Reunification Programs; Child Care Center; Community Agency; Community Daily Living Settings; Day Treatment Program; Departments of Social Service; Homeless Shelter; Prison; Religious Organisation; Residential Care Facility; Residential Treatment Center; or School. Parents Anonymous (PA) was designed to be conducted in a group setting. Recommended group size: 10-15 adult participants and 8-10 children/youth participants per program."	CEBC	2011
Dose	"Recommended intensity: 1.5-2 hours per week. Recommended duration: None; groups are open-ended and ongoing; parents/caregivers attend whenever they want for as long as they want."	CEBC	2011
Evidence rating	Promising	CEBC	2011
	Promising Programs	SAF	1999
Used in Australia	Yes		

Nurturing Parenting Program		Source	Year
Program description	"The Nurturing Parenting Program is universal, curriculum-based parenting program. The approach is to teach age-specific parenting skills along with addressing the need to nurture oneself. A variety of curricula are available for parents and their children aged 0-18. The curricula may be delivered in a group-based setting or through individual home visits. The program focuses on developing nurturing skills as alternatives to punitive parenting practices. The sessions, either group-based or in-home, include parenting instruction on discipline, nurturing, communication and child development. Self-nurturing instruction is always included. Role playing, discussions, skills practice, and role modelling are methods employed as teaching strategies."	CBCAP	2009
Outcomes	• Basic child care • Child behaviour • Child development • Family relationships • Parent-child relationship		
Population	Families with children from birth to 18 years	CBCAP	2009
Setting	"Delivered in a group setting or with at-risk families through home visits." "Recommended group size: Dependent on the functioning levels of the parents, between 8 to 12 adults and their children meeting in a separate group. Adults: 12-15. Children: 12 (depending on age and abilities)."	CBCAP CEBC	2009 2007
Dose	"Recommended intensity: Four sessions per month. Group-based sessions range from 2.5 to 3 hours. Home-based sessions generally run 90 minutes. Recommended duration: 12-48 weeks."	CEBC	2007
Evidence rating	Promising	CEBC	2007
	Promising	CBCAP	2009
	Model Programs	SAF	1999
	3.1 - for parenting attitudes, knowledge, beliefs and behaviours 2.9 - for recidivism of child abuse and neglect 3.0 - for children's behaviour and attitudes toward parenting 3.2 - for family interaction	SAMHSA	2010
Used in Australia	Yes		

Parents as Teachers		Source	Year
Program description	"Parents as Teachers (PAT) is an early childhood, parent education and family support program serving families from pregnancy until their children enter kindergarten. PAT is a universal program that focuses on promoting child development and school achievement through parent education. The age-specific parent education curriculum is delivered through weekly or monthly home visits, depending on the needs of the family. Parent groups are offered monthly to discuss parenting topics and build social networks. The program also provides developmental screening and links to community resources."	CBCAP	2009
Outcomes	• Family relationships • Child development		
Population	All families with young children birth to age 5, as well as families who are expecting the birth of a child.	CBCAP	2009
Setting	"Home visiting with an additional parent group component." "There are no set recommendations of the group size. Group connections are one of the four main model components. However, the program was designed so that the personal visits are held in conjunction with group connections."	CBCAP CEBC	2009 2011
Dose	"Recommended intensity: Personal visits are delivered weekly, every two weeks, or monthly, depending on family needs. Families with two or more high needs characteristics receive at visits at least twice monthly (24 visit/year). Families with fewer then two high needs characteristics receive at least monthly visits (12 visits/year). Visits last approximately 60 minutes with more time allocated for families with more than one child. At least 12 group connections should also be provided across the program year. Length of the group connection varies by topic, but are typically between one and two hours in length. Recommended duration: The program is designed so that it can be implemented with each family from the child's birth or prenatally until age 3. Services are offered to families for a minimum of two years duration. If parent educators are trained in delivering the Born to Learn Curriculum: 3 Years to Kindergarten Entry, then services ideally would continue until Kindergarten entry. Children may be enrolled at any time within those age windows. This allows siblings to be served by the program, and does not limit participation to children enrolled in infancy or prenatally."	CEBC	2011

Parents as Teachers (continued)		Source	Year
Evidence rating	Promising	CEBC	2011
	Supported	CBCAP	2009
	Model Programs	SAF	1999
	Promising	OJJDP	Not indicated
	3.4 - for cognitive development 3.0 - for mastery motivation 3.1 - for school readiness 3.2 - for third-grade achievement	SAMHSA	2010
	Promising	PPN	2008
Used in Australia	Yes		

Participation Enhancement Intervention (PEI)		Source	Year
Program description	"The PEI is a brief intervention composed of selected motivational enhancement techniques. PEI is designed to increase parents' motivation for treatment and their ability to identify and overcome potential barriers to treatment participation. For 5 to 15 minutes during the 1st, 5th, and 7th sessions (i.e., a total of 15-45 minutes), clinicians help parents create self-motivational statements about their plans for changing their parenting behaviors, for attending the treatment sessions, and for adhering to the treatment regimen (e.g., "What steps can you take to help change your child's behavior?"). During these brief discussions, clinicians also inquire about a range of potential barriers to participating in treatment, such as problems with transportation, a lack of support from others, or the perception that treatment is too demanding or irrelevant. Through the use of a Change Plan Worksheet, clinicians help parents develop specific plans to overcome each barrier should it arise or exacerbate."	CEBC	2011
Outcomes	• Child behaviour • Family relationships		
Population	Parents participating with their child or adolescent in treatment. PEI can be easily modified for any psychosocial treatment	CEBC	2011
Setting	This program is typically conducted in a(n): Community Agency or Outpatient Clinic	CEBC	2011
Dose	"Recommended intensity: 5-15 minutes during the 1st, 5th and 7th sessions." "Recommended duration: Within the first 8 weeks of their child's treatment."	CEBC CEBC	2011 2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Period of PURPLE Crying		Source	Year
Program description	"It is a shaken baby syndrome prevention program that educates parents and caretakers on normal infant crying, the most common trigger for shaking an infant. It was designed to be used primarily in primary prevention settings, but is applicable to secondary prevention as well. The letters in PURPLE stand for the common properties of crying, including unsoothable crying, in infants during the first few months: • Peak pattern (crying peaks around 2 months, then decreases) • Unpredictable (crying for long periods can come and go for no reason) • Resistant to soothing (the baby may keep crying for long periods) • Pain-like look on face • Long bouts of crying (crying can go on for hours) • Evening crying (baby cries more in the afternoon and evening). The program also contains a public media component aimed at changing cultural attitudes about crying, especially inconsolable crying."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing		
Population	All mothers of new infants and society in general in their understanding of early infant crying and shaken baby syndrome	CEBC	2011
Setting	This program is typically conducted in a(n): Birth Family Home or Hospital	CEBC	2011
Dose	"Recommended intensity: Three 5-10 minute "doses:" 1. In the maternity ward, given separately from other materials; 2. Either pre or post-birth as a second "dose" (e.g., in prenatal classes, and in the first pediatric office visit); 3. Via media campaign. Recommended duration: Through the three contacts, the duration of the program is at least a week and can last much longer since a key element of the program is that each parent receives a copy of the DVD and booklet to take home with them. This way they can refer to the DVD again when the infant is crying, and show it to other temporary caregivers."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

Project Connect		Source	Year
Program description	"Project Connect works with high-risk families who are affected by parental substance abuse and are involved in the child welfare system. The program offers home-based counseling, substance abuse monitoring, nursing, and referrals for other services. The program also offers home-based parent education, parenting groups, and an ongoing support group for mothers in recovery. While the goal for most Project Connect families is maintaining children safely in their homes, when this is not possible, the program works to facilitate reunification."	CEBC	2011
Outcomes	• Safety and physical wellbeing		
Population	"High-risk, substance-affected families involved in the child welfare system. Family risks may include the following: Poly-substance abuse and dependence, domestic violence, child abuse and neglect, criminal involvement and behavior, poverty, inappropriate housing, lack of education, poor employment skills, and impaired parenting. Most of the families served are ethnically diverse, have a low household income, and are headed by single mothers."	CEBC	2011
Setting	This program is typically conducted in a(n): Birth Family Home; Community Agency; or Foster Home	CEBC	2011
Dose	"Recommended intensity: At least 2 home visits a week. Intensity is determined by the family's needs and the level of risk to the children. Recommended duration: Program services last an average of 13 months for families that complete the program. Home visits are typically 1-2 hours per visit, adding up to 4-6 hours of services per week."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Project Safe Care		Source	Year
Program description	"Project SafeCare is a home visitation program for families experiencing child maltreatment or at risk for child abuse and neglect. The program addresses three specific areas: home safety, child health, and parent-child interaction. The in-home eco-behavioral model provides direct skill-training to parents in child behavior management using activities training, home safety training, and teaching child health-care skills to prevent child maltreatment. Each component includes assessment and focus on areas of concern. Home visitors work with parents by providing information, role modelling, and coaching in each component."	CBCAP	2009
Outcomes	• Safety and physical wellbeing • Parent-child relationship • Child behaviour • Basic child care		
Population	Families at risk for child maltreatment with children aged 0-5 years	CBCAP	2009
Setting	Delivered through home visits	CBCAP	2009
Dose	The program is implemented through weekly home visits of approximately 1.5 hours each for approximately 18-20 weeks.	CBCAP	2009
Evidence Rating	Promising	CEBC	2012
	Promising	CBCAP	2009
Used in Australia	Information unavailable		

Self-Motivation (SM Group)		Source	Year
Program description	"The SM Group protocol is a short-term (six-session) orientation or pre-treatment protocol for child-welfare involved parents. The SM Group is designed to help parents engage in a parenting intervention program by increasing their readiness to begin the intervention and helping them recognise problems when they arise. The protocol is based on Motivational Interviewing principles, similar to those used in substance abuse treatment, but adapted for child-welfare involved parents entering parenting programs."	CEBC	2010
Outcomes	• Safety and physical wellbeing		
Population	Child-welfare involved parents and other caregivers of children from birth through age 12.	CEBC	2010
Setting	This program is typically conducted in a(n): Community Agency; Outpatient Clinic; or School	CEBC	2010
Dose	"Recommended intensity: Weekly sessions that last one hour. Recommended duration: Six sessions."	CEBC	2010
Evidence rating	Promising	CEBC	2010
Used in Australia	Information unavailable		

STEP: Systematic Training for Effective Parenting		Source	Year
Program description	"STEP (Systematic Training for Effective Parenting) is a multi-component parenting education curriculum delivered to parents in discussion focused group sessions. Parents learn effective communication and positive discipline skills. The three curricula cover various parenting strategies that focus on the age of the child. The program includes videos and discussion guides. Videos serve as the basis for presenting information."	CBCAP	2009
Outcomes	• Basic child care • Child behaviour • Child development		
Population	Parents of children 0-18 years	CBCAP	2009
Setting	"Systematic Training for Effective Parenting (STEP) was designed to be conducted in a group setting, and has been tested for use in a group setting. Recommended group size: There is no set minimum/maximum size, but is recommended to break large groups into smaller discussion groups o f 12-15 for better interaction."	CEBC	2011
Dose	60-90-minute weekly sessions for 7 weeks.	CBCAP	2009
Evidence rating	Promising	CEBC	2011
	Supported	CBCAP	2009
	2.1 - for child behaviour 2.6 - for parent potential to physically abuse child 3.2 - for general family functioning; parenting stress; and parent-child interaction	SAMHSA	2010
Used in Australia	Yes		

Teaching-Family Model (TFM)		Source	Year
Program description	"TFM is a unique approach to human services characterized by clearly defined goals, integrated support systems, and a set of essential elements. TFM has been applied in residential group homes, home-based services, foster care and treatment foster care, schools, and psychiatric institutions. The model uses a married couple or other "teaching parents" to offer a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children's parents, teachers, and other support network to help maintain progress."	CEBC	2011
Outcomes	• Parent-child relationship • Family relationships • Child development • Child behaviour • Safety and physical wellbeing	CEBC	2011
Population	"Youth who are at risk, juvenile delinquents in foster care, mentally retarded/developmentally disabled, or severely emotionally disturbed. Families at risk of having children removed."	CEBC	2011
Setting	"This program is typically conducted in a(n): Birth Family Home; Community Agency; Foster Home; Hospital; Outpatient Clinic; Residential Care Facility; or School."	CEBC	2011
Dose	"Recommended intensity: For all residential settings, it is a 24/7 arrangement. For home-based interventions, it is a 10-15 sessions per week arrangement. Recommended duration: Ideally 9 months however program has been applied in emergency care settings as well, Duration for home-based is typically 6-10 weeks."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

The Parent-Child Home Program		Source	Year
Program description	"The PCHP, a national early childhood program, promotes parent-child interaction and positive parenting to enhance children's cognitive and social-emotional development. The program prepares children for academic success and strengthens families through intensive home visiting. Twice weekly home visits are designed to stimulate the parent-child verbal interaction, reading, and educational play critical to early childhood brain development. Each week the home visitors bring a new book or educational toy that remains with the families permanently. Using the book or toy, home visitors model for parents and children reading, conversation, and play activities that stimulate quality verbal interaction and age-appropriate developmental expectations."	CEBC	2011
Outcomes	• Parent-child relationship • Child development • Child behaviour		
Population	"Two and three-year-olds who face multiple obstacles to educational and economic success. These risk factors include, living in poverty, being a single or teen-age parent, low parental education status, illiteracy/limited literacy, and families who are challenged by language barriers (e.g., immigrant families)."	CEBC	2011
Setting	Adoptive home; birth family home	CEBC	2011
Dose	"Recommended intensity: Twice a week for 30 minutes each visit. Recommended duration: Two years, and the model requires that at least 46 visits, 23 per year, are offered to the dad."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

The Upstate New York Shaken Baby Syndrome Education Program (SBS)		Source	Year
Program description	"The Upstate New York SBS Education Program is a research study begun in December 1998 with the purpose of educating both parents of all infants about the dangers of violent infant shaking. The premise was that parents needed to be reminded at the correct time and, if educated, could be effective advocates in disseminating this information to all who care for their child. The parents receive both written and video materials about SBS before leaving the hospital. Both parents are then asked to voluntarily sign a commitment statement affirming their receipt and understanding of this material; these commitment statements are returned and tracked by the investigators. The Upstate New York SBS Education Program formed a partnership with the pediatric care providers. Additional educational materials are provided at the first doctor's office visit. The program has demonstrated a sustained and consistent reduction of over 50% in incidence of SBS."	CEBC	2011
Outcomes	• Safety and physical wellbeing		
Population	Mothers, fathers, or father figures	CEBC	2011
Setting	Hospital	CEBC	2011
Dose	"Recommended intensity: One contact with parents by the RN in the maternity unit. Parents see video, receive brochure on Shaken Baby Syndrome (SBS), and discuss material just seen with the RN so she/he can answer any questions about SBS. This contact lasts an average of 15 minutes per family. The nurse does not, however, need to be present during parents' viewing of the 8-minute video. Recommended duration: Typically one contact."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Theraplay		Source	Year
Program description	"Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, Theraplay has been used for many years with foster and adoptive families."	CEBC	2011
Outcomes	• Parent-child relationship • Child behaviour • Child development		
Population	"Children aged 0-18 who exhibit behavioral problems and their caregiver (biological, adoptive, or foster)."	CEBC	2011
Setting	This program is typically conducted in a(n): Adoptive Home; Community Agency; Foster Home; Hospital; Outpatient Clinic; Residential Care Facility; or School. Theraplay was designed to be conducted in a group setting. Recommended group size: 4-10	CEBC	2011
Dose	"Recommended intensity: Families typically receive 30-45 minute weekly sessions (shorter for younger children). Recommended duration: Approximately a year and a half (weekly for 18-24 weeks then four follow-up sessions."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Yes		

Watch, Wait, and Wonder (WWW)		Source	Year
Program description	"WWW is aimed at parents and their children who are experiencing relational and developmental difficulties. It was designed for children 0 to 4 years of age, but has been used with older children. The focus of the approach is on strengthening the attachment relationship between caregiver and child, in order to improve the child's self-regulating abilities and sense of efficacy and enhance the caregiver's sensitivity. A unique feature of the approach is the use of infant-led play sessions in which mothers are encouraged to observe their infants and allow them to initiate activities."	CEBC	2009
Outcomes	• Child development • Parent-child relationship • Child behaviour		
Population	Parents and their children aged 0-4 years who are experiencing relational and developmental difficulties	CEBC	2009
Evidence rating	Promising	CEBC	2009
Used in Australia	Yes		

Wraparound		Source	Year
Program description	"Wraparound is a team-based planning process intended to provide individualised and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed. The values associated with Wraparound require that the planning process itself, as well as the services and supports provided, should be individualised, family driven, culturally competent and community-based. Additionally, the Wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, Wraparound should be "strengths-based", helping the child and family recognise, utilize, and build talents, assets, and positive capacities."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing • Family relationships		
Population	"Designed for children and youth with severe emotional, behavioral, or mental health difficulties and their families. Most often these are young people who are in, or at risk for, out of home, institutional, or restrictive placements, and who are involved in multiple child and family-serving systems (e.g., child welfare, mental health, juvenile justice, special education, etc.) Wraparound is widely implemented in each of these various settings; however, because the youth have multi-system involvement, wraparound participants have many similarities across settings."	CEBC	2011
Setting	"This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Community Agency; Foster Home; or Residential Care Facility	CEBC	2011
Dose	"Recommended intensity: This can vary. Usually there is an intensive engagement and initial planning process that may require two 60-90 minute sessions with the family and two team sessions during the first three weeks to a month. The team continues to meet thereafter, usually with increased intensity in the early phases (often once per month or even more) and decreasing thereafter. The care coordinator, facilitator, and parent partner could have other contacts with the youth and family as necessary. Services and supports called for in the plan are provided by other team members or by people not included on the team. Recommended duration: Well-established programs provide services for an average of 14 months or so."	CEBC	2011
Evidence rating	Promising	CEBC	2011
Used in Australia	Information unavailable		

Creating Lasting Family Connections		Source	Year
Program description	"Creating Lasting Family Connections (CLFC) is a family-based program whose primary goal is to reduce substance abuse and violence in teens. The program is primarily implemented in faith-based organisations. The program's approach is intended to develop healthy parenting and family resilience, increase positive communication, and provide direct information of substance abuse. Community connections are improved by including congregation and community members and schools in outreach and implementation activities. The curriculum is implemented through parent and youth training sessions and an optional parent-youth combined component. Parent trainings focus on knowledge of substance abuse, family management and communication skills, and healthy community involvement. Youth trainings teach positive communication skills and refusal skills and encourage family cohesion. CLFC also provides early intervention and case management services for six months following training completion to encourage integration of skills."	CBCAP	2009
Outcomes	• Safety and physical wellbeing • Family relationships • Child behaviour • Child development		
Population	Families with children aged 9-17 years	CBCAP	2009
Setting	Delivered in a group setting	CBCAP	2009
Dose	"The Creating Lasting Family Connections program consists of six modules, three each for parents and youth. The parent modules are 'Developing Positive Parental Influences', 'Raising Resilient Youth', and 'Getting Real'. The youth modules are 'Developing a Positive Response', 'Developing Independence and Responsibility', and 'Getting Real1. Each parent module includes 5-6 sessions, with each session lasting 1.5 to 2.5hours, depending on breaks and possibly including a meal. Each youth module includes 5-6 sessions, with each session lasting 1 to 2.5 hours, again depending on snacks, breaks and/or a meal. An optional combined module for parents and youths, 'Getting Real', usually requires an additional 2 or 3 sessions. For maximum effectiveness, parents and youth are involved simultaneously in separate three-module tracks lasting for 15-18 sessions."	CBCAP	2009
Evidence rating	Promising	CBCAP	2009
	Model Programs	SAF	1999
	Effective	OJJDP	Not indicated
	3.0 - for use of community services; and parent knowledge and beliefs about AOD 2.9 - for onset of youth AOD use; and frequency of youth AOD use	SAMHSA	2007
Used in Australia	Information unavailable		

Dare to Be You		Source	Year
Program description	"DARE to Be You (DTBY) is a universal parent and child program for families with children 2-5. The program includes three main components: 1) family program; 2) preschool teacher and day-care provider workshops; and 3) community training. Program objectives focus on promoting healthy child development through improved parenting practices, social support and skills for children. Parent sessions focus on stress management, parental resilience, effective communication, knowledge of child development, and increasing informal social supports."	CBCAP	2009
Outcomes	• Family relationships • Child development		
Population	Families with children 2-5 years old, including high-risk families.	CBCAP	2009
Setting	Delivered in a group setting	CBCAP	2009
Dose	The family program consists of the following: • Parent curriculum: series of 10-12 weekly 2.25 hour sessions, including a meal and a 15-minute parent-child activity. • Children's program: series of 10-12 workshops that correspond to the parent curriculum, held simultaneously with the parent workshops. This program has curricula for children aged 2.5-3 years and also for children aged 4-5 years.	CBCAP	2009
Evidence rating	Promising	CBCAP	2009
	Model Programs	SAF	1999
	Exemplary	OJJDP	Not indicated
	2.8 - for parental self-efficacy; use of harsh punishment; and satisfaction with social support systems 2.7 - for child's developmental level	SAMHSA	2006
	Proven	PPN	2004
Used in Australia	Information unavailable		

Syracuse Family Development Research Program		Source	Year
Program description	"The Syracuse Family Development Research Program (FDRP) was a comprehensive early childhood program developed within the context of research. The program provided quality child care daily along with weekly home visits aimed at promoting healthy child development, impacting the long-term outcomes of academic success, and reducing criminal activity. The program was implemented in Syracuse, New York, between 1969 and 1976.	CBCAP	2009
Outcomes	• Child development • Basic child care • Child behaviour		
Population	African-American, single-parent, economically disadvantaged families beginning at birth of the baby and lasting through the preschool years.	CBCAP	2009
Setting	Delivered through centre-based education and home visitation	CBCAP	2009
Dose	"Weekly home visits were focused on training parents on positive parent-child interaction, as well as resource, referral and support for family needs. Toys and books were also shared with families. Home visitors carried a caseload of 15 families. The daily activities at the Children's Centre focused on providing quality child care and promoting experiences and skills for healthy development for each child on an individualised basis. Particular focus on engaging parent interaction with the child care centre was also applied."	CBCAP	2009
Evidence rating	Promising	CBCAP	2009
	Effective	OJJDP	Not indicated
	Promising	PPN	2003
Used in Australia	Information unavailable		

Focus on Families		Source	Year
Program description	"Focus on Families is designed for families with parents who are addicted to drugs. As a result of Focus on Families, parents are expected to have less risk for relapse, to be better skilled to cope with relapse incidents, and to have decreased drug use episodes. Parents objectives are to increase family management skills, anger management skills, refusal and problem solving skills, ability to teach these skills to their children, and the ability to assist their children with academic success. Children will experience less exposure to risk factors and more exposure to protective factors, with the ultimate result being decreased participation in drug use and delinquent behavior."	SAF	1999
Outcomes	• Safety and physical wellbeing • Child behaviour • Child development		
Population	Focus on Families is designed for families with parents who are addicted to drugs. The program is most appropriate for parents enrolled in methadone treatment who have children between 3 and 14 years of age. Parents are encouraged to have at least 90 days of methadone treatment prior to beginning the program.	SAF	1999
Dose	Eligible families participate in a 5-hour "family retreat" where families learn about the curriculum, identify their goals, and participate together in trust-building activities. The first session is followed by 32 curriculum sessions (90 minutes each), conducted twice weekly for 16 weeks. Parent sessions are conducted in the mornings, with practice sessions held in the evenings for parents and children together.	SAF	1999
Evidence rating	Model Programs	SAF	1999
Used in Australia	Information unavailable		

MELD		Source	Year
Program description	"MELD is a community-based parent education program that uses group-based service to deliver quality parent education and to replace the sense of community connectiveness that is missing in families' lives. "	SAF	1999
Outcomes	• Family relationships		
Population	MELD targets parents of preschool children and has been adapted to meet the needs of young, single mothers or single fathers, Hispanic and Southeast Asian parents, deaf and hard of hearing parents, first-time adult parents, and parents of children with special needs. MELD's curriculum and learning processes are usable by parents who are not highly literate, and addresses everyday concerns of low-income parents.	SAF	1999
Dose	MELD's peer discussion groups meet for two years typically twice a month or as often as once a week	SAF	1999
Evidence rating	Model Programs	SAF	1999
Used in Australia	Information unavailable		

Parents Who Care		Source	Year
Program description	"Parents Who Care (PWC) is an educational skill-building program created for families with children between the ages of 12-16. The objective of PWC is to reduce risk factors and strengthen protective factors within family settings that are known to predict later alcohol and other drug use, delinquency, violent behavior, and other behavioral problems in adolescence. The PWC program is grounded theoretically in the social development model which emphasises that young people should experience opportunities for active involvement in family, school, and community, should develop skills for success, and should be given recognition and reinforcement for positive effort and improvement. PWC focuses on strengthening family bonds and establishing clear standards for behavior, helping parents more appropriately manage their teenager's behavior while encouraging their adolescent growth toward independence. In this process, PWC seeks to change specific risk and protective factors in the family and peer domains: parent and sibling drug use, positive parental attitudes towards drug use, poor and inconsistent family management practices, family conflict, low family communication and involvement, family bonding, and association with delinquent and drug using peers."	SAF	1999
Outcomes	• Child behaviour • Family relationships • Child development		
Population	Families with children between the ages of 12-16	SAF	1999
Dose	The program is designed to be led by a facilitator and taught once a week in 5-6 sessions lasting 1-2 hours.	SAF	1999
Evidence rating	Model Programs	SAF	1999
Used in Australia	Information unavailable		

The NICASA Parent Project		Source	Year
Program description	"The NICASA Parent Project was designed specifically to meet the needs of parents in the workplace and community to address issues in effective prevention. The goals of the program are to enrich family relationships and promote healthy environments that build resistance to social and personal dysfunction. Specifically, it focuses on the need to establish supportive networks among parents; improve parent/child relationships; increase ability to balance work and family life; improve corporate climate for workers; and improve parent skills in preventing and identifying substance abuse problems in themselves and their children."	SAF	1999
Outcomes	• Family relationships • Parent-child relationship • Child behaviour • Child development		
Population	The NICASA Parent Project includes programs for parents with children of the following ages: birth to three years, 3-5 years, 5-10 years, and 11-17 years	SAF	1999
Setting	Worksite	SAF	1999
Dose	The program is presented at lunch time at a worksite.	SAF	1999
Evidence rating	Model Programs	SAF	1999
Used in Australia	Information unavailable		

First Step to Success		Source	Year
Program description	"First Step to Success is an early intervention program designed to prevent antisocial behavior in school. The primary goal of the program is to divert antisocial kindergartners from an antisocial behavior pattern during their subsequent school careers and to develop in them the competencies needed to build effective teacher- and peer-related, social-behavioral adjustments. The program targets at-risk kindergartners who show the early signs of an antisocial pattern of behavior (e.g., aggression, oppositional-defiant behavior, severe fits of temper, victimization of others). The intervention is based on the early-starter model of the development of antisocial behavior. Early signs of conduct problems can be detected as early as preschool. Many children bring a pattern of antisocial behavior with them from home when they enter school. This early pattern can indicate the beginning of a stable pattern of maladaptive behavior that predicts more severe problems later on when the youths are then less amenable to treatment. More severe problems include issues such as peer rejection, school dropout, and delinquency. First Step to Success consists of three interconnected modules: 1) proactive, universal screening of all kindergarteners, 2) school intervention involving the teacher, peers, and the target child, and 3) parent/caregiver training and involvement to support the child's school adjustment. The intervention requires about 3 months for full implementation in both school and home settings. A key part of the program is the consultants who act as caseworkers for 2-3 students and are responsible for implementing and coordinating the school and home components of the intervention. Consultants are trained through lectures, videotaped demonstrations, role-playing, skill practice/feedback sessions, materials, and self-evaluation. To build implementation fidelity, training, monitoring, and supervision processes are implemented. The facilitative strategy of the program relies on having the consultant work with teachers and parents to give them the skills to teach students replacement behaviors and reward students when those behaviors are used appropriately and consistently. Strategies for implementation include schedules for praising and awarding points, prepared scripts, daily task lists, and guidelines for application. Students are taught specific skills and behaviors to use in place of inappropriate behaviors they have used in the past. More specifically, during the school day, the consultant or teacher gives the First Step to Success student visual cues (i.e., a green or red card) to indicate whether or not he or she is on task and using appropriate behaviors. Throughout the day, the student accrues points toward his or her behavioral goal. If the student makes the daily goals, he or she gets to choose an enjoyable activity the whole class can do and appreciate. Each evening, parents receive feedback about how their child's day went. Parents are trained and encouraged to reward the student's positive behavior by spending some extra time with their child at an activity, such as playing a game or taking a walk together."	OJJDP	Not indicated
Outcomes	• Child behaviour • Child development		
Population	At-risk kindergartners who show the early signs of an antisocial pattern of behaviour	OJJDP	Not indicated
Evidence rating	Effective	OJJDP	Not indicated
Used in Australia	Information unavailable		

Staying Connected with Your Teen		Source	Year
Program description	"Staying Connected with Your Teen (SCT) is a universal substance abuse and problem behavior preventive intervention for families with early adolescent children that includes parenting, youth, and family components. The program is grounded in the Social Development Model (SDM), which is based on social control theory, social learning theory, and differential association theory. SDM posits that children are socialized through four key processes: 1) perceived opportunities for involvement in activities and interactions with others, 2) the degree of involvement and interaction, 3) skills to participate in such involvement and interaction, and 4) perceived reinforcement from their involvement and interactions. SCT's objectives are to strengthen familial protective factors and reduce risk factors by teaching parents strategies to provide their children with opportunities to contribute to their families, acquire needed skills to take advantage of opportunities, and use reward and recognition strategies to promote family bonding. The original parent and teen group-administered program model was designed to be completed in seven sessions, each 2 to 2½ hours long, with at least one session including the parent and teen together. To increase families' accessibility to SCT, a self-administered format of the program was developed, consisting of a 117-minute video divided into 18 sections, and a 108-page family workbook written to an eighth-grade reading level. The program content is built around seven core lessons, from which the SCT workbook is organized: 1) Roles: Relating to Your Teen; 2) Risks: Identifying and Reducing Them; 3) Protection: Bonding With Your Teen to Strengthen Resilience; 4) Tools: Working With Your Family to Solve Problems; 5) Involvement: Allowing Everyone to Contribute; 6) Policies: Setting Family Policies on Health and Safety Issues; and 7) Supervision: Supervising Without Invading."	OJJDP	Not indicated
Outcomes	• Child behaviour • Family relationships • Parent-child relationship • Child development		
Population	Adolescents and their parents	OJJDP	Not indicated
Evidence rating	Effective	OJJDP	Not indicated
Used in Australia	Information unavailable		

Attachment-Based Family Therapy		Source	Year
Program description	"Attachment-Based Family Therapy (ABFT) is based on the belief that strong relationships within families can buffer against the risk of adolescent depression or suicide and help in the recovery process. ABFT is a psychotherapeutic model, with a foundation in attachment theory. Attachment theory posits that when parents are responsive and protective, children develop a healthy sense of self, trust in others, and better capacity for independence and affect regulation. Ruptures in attachment security can increase the risk for psychopathology. However, as a life-span developmental model, attachment theory posits that attachment ruptures are reparable, and thus children can regain the external and internal resources to promote healthy development. The ABFT model aims to strengthen or rebuild secure parent-child relationships and promote adolescent autonomy. To accomplish this, the therapist helps the family agree to focus on relationship repair as the initial goal of therapy. Then, with the adolescent alone, the therapist helps the adolescent identify perceived attachment ruptures or negative family processes and prepares the adolescent to talk about these problems with his or her parents. In separate sessions with parents, the therapist focuses on reducing parental distress and improving parenting practices. Exploring their own history of attachment rupture helps parents understand their own attachment wounds and builds empathy for the adolescent. When ready, conjoint sessions focus on helping the family successfully discuss these past problems. This process both helps resolve actual problems in the family and allows parents and adolescents to practice new skills related to affect regulation and interpersonal problem solving. As trust begins to re-emerge, therapy focuses on promoting adolescent competency outside the home."	PPN	2011
Outcomes	• Child behaviour • Parent-child relationship • Family relationships • Child development		
Population	Adolescents aged 13-18 and their parents		
Dose	ABFT treatment has five specific tasks, each of which takes from 1-3 sessions to accomplish	PPN	2011
Evidence rating	Proven	PPN	2011
Used in Australia	Yes		

Family Thriving Program		Source	Year
Program description	"The Family Thriving Program (FTP) uses cognitive reframing as a method for correcting parents' biased understanding of the relationship between themselves and their children. It has been proposed that a skewed view of the parent-child relationship may contribute to child abuse and neglect. FTP is an enhancement to home visitation models that incorporates cognitive appraisal methods to assist parents in becoming "competent and independent problem solvers." To do this, parents receiving the enhancement are asked by home visitors to review recent parenting problems. Using a series of questions aimed at identifying the problem's cause, the home visitor arrives at a strategy for addressing the problems raised by the parent, and the home visitor follows up on the results of the strategy in subsequent home visits. FTP has been tested as an enhancement to the Healthy Start home visitation program."	PPN	2010
Outcomes	• Parent-child relationship • Safety and physical wellbeing		
Population	Parents with young children	PPN	2010
Setting	Home	PPN	2010
Evidence rating	Proven	PPN	2010
Used in Australia	Information unavailable		

Family Support and Parenting Education in the Home		Source	Year
Program description	"The Family Support and Parenting Education in the Home Program was developed in 1964 to serve poor children in the city of Baltimore. A woman from the participants' community served as a home visitor for new parents, with the goal of encouraging parental compliance with well-child visits, referring parents to support services when necessary, and discussing child development and parenting skills. The first home visit was made within 7-10 days of the child's birth, and nine subsequent visits were made before the child's second birthday. The program was an augmentation of the Children and Youth (C&Y) program, which operated health clinics for families with children ages 0-18 in inner city Baltimore."	PPN	2010
Outcomes	• Child development • Parent-child relationship		
Population	Families with children aged 0-18 months	PPN	2010
Setting	Home visiting	PPN	2010
Dose	The first home visit was made within 7-10 days of the child's birth, and nine subsequent visits were made before the child's second birthday	PPN	2010
Evidence rating	Proven/Promising	PPN	2010
Used in Australia	Information unavailable		

Make Parenting a Pleasure (MPAP)		Source	Year
Program description	"Make Parenting a Pleasure (MPAP) is a universal group-based parenting education and support program for parents with children 0-6 years of age. The specific content of MPAP was developed in areas parents identified as most important to them including dealing with stress, anger, social isolation, understanding normal child development, gaining positive discipline skills, communication skills, and wanting to develop feelings of competence in parenting. MPAP addresses the factors linked to child abuse, neglect, and family dysfunction. Social isolation, poor parenting skills, low self-esteem, unrealistic expectations, and lack of support are risk factors this program impacts."	SAF	1999
Outcomes	• Child development • Parent-child relationship • Safety and physical wellbeing • Family relationships		
Population	Parents with children 0-6 years of age	SAF	1999
Dose	Programs can be offered as a 13 session series, or as a program of up to one year duration with weekly sessions. Each session is approximately 2 hours in length.	SAF	1999
Evidence rating	Promising Program	SAF	1999
Used in Australia	Information unavailable		

Nurturing Program for Families in Substance Abuse Treatment and Recovery		Source	Year
Program description	"The Nurturing Program for Families in Substance Abuse Treatment and Recovery is a family skills training program designed to strengthen relationships in families affected by parental substance abuse. The goals of the program include: (1) reducing risk factors contributing to substance use/abuse by both parents and children in families affected by parental substance abuse; (2) enhancing relationships between parents and children (i.e. strengthening family protective factors); and (3) strengthening parent's sobriety."	SAF	1999
Outcomes	• Child behaviour • Parent-child relationship • Family relationships		
Population	Families affected by parental substance abuse	SAF	1999
Setting	The program is designed to be used in a variety of settings: residential or outpatient treatment programs; community and family service agencies; and early intervention programs	SAF	1999
Dose	The program consists of 18 sessions, each 90 minutes. The program can be adapted to fewer sessions, and 1 hour each. It may be offered in once or twice weekly sessions.	SAF	1999
Evidence rating	Promising Program	SAF	1999
Used in Australia	Information unavailable		

Strengthening Multi-Ethnic Families and Communities		Source	Year
Program description	"Strengthening Multi-Ethnic Families and Communities Program is a unique integration of various prevention/intervention strategies geared toward reducing violence against self, the family and the community. The program goal is to reduce drug/alcohol use, teen suicide, juvenile delinquency, gang involvement, child abuse and domestic violence. Short term objectives are to increase parent sense of competence, positive family/parent/child interactions, positive parent/child relationships, child self-esteem and self-discipline, child social competency skills and increased parental involvement in community activities."	SAF	1999
Outcomes	• Child behaviour • Safety and physical wellbeing • Family relationships • Parent-child relationship		
Population	The program targets ethnic and culturally diverse parents of children aged 3-18 years who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle.	SAF	1999
Setting	Parent training classes have been held at a variety of locations: churches, schools, community agencies and other locations	SAF	1999
Dose	The program consists of 12 x 3-hour sessions taught in consecutive weeks	SAF	1999
Evidence rating	Promising Program	SAF	1999
Used in Australia	Yes		

Children in Between		Source	Year
Program description	"Children in Between (CIB), formerly known as Children in the Middle, is an educational intervention for divorcing families that aims to reduce the parental conflict, loyalty pressures, and communication problems that can place significant stress on children. CIB consists of one or two 90-120-minute classroom sessions and can be tailored to meet specific needs. The intervention teaches specific parenting skills, particularly good communication skills, to reduce the familial conflict experienced by children. Each parent attending classes typically receives two booklets ("What About the Children" and "Children in Between") that give advice for reducing the stress of divorce/separation on children and promote practice of the skills taught in the course. Each parent also watches the intervention video, which illustrates how children often feel caught in the middle of their parents' conflicts."	SAMHSA	2006
Outcomes	• Family relationships • Parent-child relationship		
Population	Families experiencing divorce	OJJDP	Not indicated
Setting	Other community setting	SAMHSA	2006
Dose	CIB consists of one or two 90-120-minute classroom sessions	SAMHSA	2006
Evidence rating	Promising	OJJDP	Not indicated
	2.2- parental conflict 2.1 - for awareness of effects of divorce on the children 2.4 - for rate of relitigation 2.3 - for communication skills 2.0 - for child-reported stress	SAMHSA	2006
	Other reviewed programs	PPN	Not indicated
Used in Australia	Information unavailable		

Families Unidas		Source	Year
Program description	"Familias Unidas is a family-based intervention for Hispanic families with children ages 12-17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning. Familias Unidas is guided by ecodevelopmental theory, which proposes that adolescent behavior is affected by a multiplicity of risk and protective processes operating at different levels (i.e., within family, within peer network, and beyond), often with compounding effects. The program is also influenced by culturally specific models developed for Hispanic populations in the United States. The intervention is delivered primarily through multiparent groups, which aim to develop effective parenting skills, and family visits, during which parents are encouraged to apply those skills while interacting with their adolescent. The multiparent groups, led by a trained facilitator, meet in weekly 2-hour sessions for the duration of the intervention. Each group has 10-12 parents, with at least 1 parent from each participating family. Sessions include problem posing and participatory exercises. Group discussions aim to increase parents' understanding of their role in protecting their adolescent from harm and to facilitate parental investment. The intervention proceeds in three stages: • Stage 1: The facilitator aims to engage parents in the intervention and create cohesion among the parents in the group. • Stage 2: The facilitator introduces three primary adolescent "worlds" (i.e., family, peers, school), elicits parents' specific concerns within each world (e.g., disobedience within the family, unsupervised association with peers, problems at school), and assures parents that the intervention will be tailored to address these concerns. • Stage 3: The facilitator fosters the parenting skills necessary to decrease adolescent problem behavior and increase adolescent school bonding and academic achievement. In this third stage, group sessions are interspersed with home visits, during which facilitators supervise parent-adolescent discussions to encourage bonding within the family and help parents implement the skills related to each of the three worlds (e.g., discussing behavior management, peer supervision issues, and homework). Each family receives up to eight home visits. Familias Unidas also involves meetings of parents with school personnel, including the school counselor and teachers, to connect parents to their adolescent's school world. Family activities involving the parents, the adolescent, and his or her peers and their parents allow parents to connect to their adolescent's peer network and practice monitoring skills."	SAMHSA	2009
Outcomes	• Child behaviour • Family relationships • Parent-child relationship • Safety and physical wellbeing		
Population	Hispanic families with children aged 12-17	SAMHSA	2009
Setting	Home or School	SAMHSA	2009
Dose	The duration of the intervention ranges from 3 to 5 months depending on the target population	SAMHSA	2009

Families Unidas (continued)		Source	Year
Evidence rating	Promising	OJJDP	Not indicated
	3.9 - for behaviour problems' family functioning; substance use; and risky sexual behaviours 3.8 - for externalising disorders	SAMHSA	2009
Used in Australia	Information unavailable		

Gang Resistance Is Paramount (GRIP)		Source	Year
Program description	"The program's objectives are to educate students about the dangers of gangs, discourage the city's youth from joining gangs, educate the students' parents about the signs of gang involvement, and provide parents with the resources that will help them eliminate gang activities in their homes and neighborhoods. GRIP staff are familiar with gang activity, but they avoided gang involvement. Most of them are community members who live or have lived in Paramount. Their training is updated continually, and the program has had low turnover. GRIP has four elements: 1. A school-based curriculum, consisting of 23 lessons, for second and fifth graders. In eight lessons the second graders are taught about a) peer pressure, b) drugs, c) alcohol, d) self-esteem, e) family, f) crime, g) gangs and territory, and h) gangs and vandalism. They are discouraged from joining a gang through video presentations, workbook exercises, songs, and discussion of alternatives to gangs such as recreational activities. Fifth graders review topics such as gang graffiti, gangs and death, how gang activity affects the family, the consequences of getting gang tattoos, gangs and crime, resisting peer pressure to join a gang, future opportunity preparation, and alternatives to gang membership. Gang membership is discouraged through the promotion of recreational activities, video presentations, current event discussions, and open dialog between students. An in-school follow-up program in the ninth grade caps the program. Topics such as drugs, alcohol, dropping out of high school, teen pregnancy, self-esteem, the consequences of a criminal lifestyle, the importance of higher education, and preparing for career opportunities are discussed. 2. **Parent education** in the form of neighborhood meetings at which parents are taught about the warning signs of gang involvement and how to keep their children out of gangs are held throughout the community. Handouts are given in both English and Spanish and include everything from information on programs and activities at the city's recreation department to information about tattoo removal programs and graffiti hotline numbers. 3. **Antigang counselling of parents** and youths regarding the youths' gang activities. Sessions are set up by request or referral and occur in the parents' home, over the phone, or in office. 4. Involvement in city recreational activities is encouraged. Sports, classes, special events, and programs specifically for young teens are provided, during which gang clothing is not allowed. "	OJJDP	Not indicated
Outcomes	• Child behaviour • Family relationships		
Population	Adolescents and their parents	OJJDP	Not indicated
Evidence rating	Promising	OJJDP	Not indicated
Used in Australia	Information unavailable		

Parenting Partnership		Source	Year
Program description	"Parenting Partnership is a collaborative initiative between corporate worksites and human service providers that concentrates on enhancing parenting skills, knowledge, and attitudes while at the same time facilitating the creation of support networks within the worksite. The program targets employed parents. Recruitment efforts concentrate on broad participation from mothers and fathers, and from employees of varied occupations and rank. It strives to prevent substance abuse and related socioemotional, behavioral, and academic difficulties by reducing the exposure of children and youths to developmental risk conditions and by enhancing protective factors in the family through the delivery of training sessions in partnership with corporations at the worksite. The program also aims to reduce family stress levels and attitudes that affect parents' risk for substance abuse. The delivery strategy was designed to overcome common barriers to participation. Parent training courses are held during the lunch or dinner break so parents do not have to take time away from their family. To avoid stereotypes of being in a substance abuse program, the program is presented as a parenting enhancement program. Supervisors in the workplace encourage their employees to attend the sessions, thus increasing the acceptability of the program among peers. Training materials and coursework cover the development of a "parenting network." Each complete Parenting Partnership course provides 24 x 1-hour sessions, twice a week, for 12 weeks. Separate content materials are available for parents of children aged 0-6, 7-12, and 13-18."	OJJDP	Not indicated
Outcomes	• Family relationships • Child behaviour • Child development • Safety and physical wellbeing		
Population	Employed Parents	OJJDP	Not indicated
Dose	Each complete Parenting Partnership course provides 24 x 1-hour sessions, twice a week, for 12 weeks	OJJDP	Not indicated
Evidence rating	Promising	OJJDP	Not indicated
Used in Australia	Information unavailable		

Peace Works		Source	Year
Program description	"Peace Works is a curriculum that teaches students the dispositions, behaviors, and skills necessary to peaceably resolve conflict. The goals of Peace Works are to • Promote students' prosocial behavior through the use of conflict resolution • Enhance school climate through caring and support • Teach parents constructive problem solving and anger management • Improve parents' positive affiliation with school The model contains grade-specific, classroom-tested curricula for prekindergarten through 12th grade. The modules, which offer from 16 to 48 lessons a year, are as follows: • Peacemaking Skills for Little Kids (prekindergarten through grade 2) • Peace Scholars (grades 3–4) • Creative Conflict Solving for Kids (grade 5) • Creating Peace, Building Community (grades 6–7) • Fighting Fair (grade 8) • Win! Win! (grades 9–12) There also is a peer-mediation training component for grades 4–12. The curriculum content has six essential components: 1) communication building, 2) rules for fighting fair, 3) understanding conflict, 4) the role of perceptions, 5) anger management, and 6) effective communication. The curriculum methodology is to model, teach, coach, encourage, and export. (Exporting involves having the more advanced students coach the less experienced; this is also peer mediation.) The approach centers on establishing peaceful norms of behavior for students early, preferably during the 1st year at each of the three school levels (elementary, middle, and high). The second phase of this approach (during each following year) is to reinforce the peaceful norms with interactive programs that emphasise skill development and application."	OJJDP	Not indicated
Outcomes	• Child behaviour • Family relationships • Parent-child relationship		
Population	Children in prekindergarten through 12th grade	OJJDP	Not indicated
Evidence rating	Promising	OJJDP	Not indicated
Used in Australia	Information unavailable		

Rural Educational Achievement Project (REAP)		Source	Year
Program description	"Prevention research postulates that interventions must be delivered early in life to disrupt the developmental pathways leading to adverse adolescent and adult outcomes, such as substance use and poor mental health status. Following on this theory, the Rural Educational Achievement Project (REAP) is a comprehensive, multilevel approach to prevention that involves a universal prevention program (All Stars, Jr.), a selective program delivered in the summer (Camp GUTS: Gearing Up To Success), and a family program (Duke Family Coping Power). REAP targets fourth grade students enrolled in elementary school. The All Stars, Jr., program is based on a character-education and problem-behavior–prevention curriculum designed for middle school students. The idea is to draw from an individual's lifestyle, aspirations, social background, and other existing ideals that are likely to be incongruent with high-risk behaviors and build or strengthen that perception in the student. The summer Camp GUTS program is a selected 6-week, protocol-driven, school-based program designed to strengthen academic and social competencies and self-esteem. The Duke Family Coping Power program is delivered to parents of high-risk students. The content, derived from Social Cognitive Theory, teaches parents the skills to deal with various aspects of child aggression. The program also includes sessions on stress management."	OJJDP	Not indicated
Outcomes	• Child behaviour • Child development		
Population	REAP targets fourth grade students enrolled in elementary school		
Evidence rating	Promising	OJJDP	Not indicated
Used in Australia	Information unavailable		

Active Parenting Now		Source	Year
Program description	"Active Parenting Now is a video-based education program targeted to parents of 2-12-year-olds who want to improve their parenting skills. It is based on the application of Adlerian parenting theory, which is defined by mutual respect among family members within a democratically run family. The program teaches parents how to raise a child by using encouragement, building the child's self-esteem, and creating a relationship with the child based upon active listening, honest communication, and problem solving. It also teaches parents to use natural and logical consequences to reduce irresponsible and unacceptable behaviors."	SAMHSA	2008
Outcomes	• Parent-child relationship • Child behaviour		
Population	Parents of children aged 2-12 years		
Setting	Home, school and other community settings		
Dose	Active Parenting Now is conducted in one 2-hour classes per week for six weeks		
Evidence rating	3.1 - for parental perceptions; and parental attitudes and beliefs 3.3 - for parent-child relationship problems 2.2 - for positive and negative child behaviours	SAMHSA	2008
Used in Australia	Information unavailable		

Active Parenting of Teens: Families in Action		Source	Year
Program description	"Active Parenting of Teens: Families in Action is a school- and community-based intervention for middle school-aged youth designed to increase protective factors that prevent and reduce alcohol, tobacco, and other drug use; irresponsible sexual behavior; and violence. Family, school, and peer bonding are important objectives. The program includes a parent and teen component. The parent component uses the curriculum from Active Parenting of Teens. This curriculum is based on Adlerian parenting theory, which advocates mutual respect among family members, parental guidance, and use of an authoritative (or democratic) style of parental leadership that facilitates behavioral correction. A teen component was developed to complement the parent component. Active Parenting of Teens: Families in Action uses a family systems approach in which families attend sessions and learn skills. Each of the sessions includes time during which parents and youth meet in separate groups and time during which all family members meet together. Modules address parent-child communication, positive behavior management, interpersonal relationships for adolescents, ways for families to have fun together, enhancement of the adolescent's self-esteem, and factors that promote school success. Youth are taught about the negative social and physical effects of substance use, they learn general life skills and social resistance skills, and they are provided opportunities to practice these skills. Parents are taught skills to help reinforce their teen's skills training. During the portion of each session involving the youth and parents together, they participate in a family enrichment activity and receive a homework assignment to complete before the next session."	SAMHSA	2010
Outcomes	• Child behaviour • Safety and physical wellbeing • Family relationships • Parent-child relationship • Child development		
Population	Middle school-aged youth	SAMHSA	2010
Setting	Typical groups consist of 5-12 families. Setting include home, school and other community settings.	SAMHSA	2010
Dose	The program is offered in six weekly 2-hour sessions	SAMHSA	2010
Evidence rating	2.6 - for positive attachment to family, school and peers; and attitudes towards alcohol use 2.2 - for participation in counselling 2.7 - for self-esteem	SAMHSA	2010
Used in Australia	Information unavailable		

Celebrating Families!		Source	Year
Program description	"The Celebrating Families! program uses a cognitive behavioral theory (CBT) model to achieve three primary goals: • Break the cycle of substance abuse and dependency within families • Decrease substance use and reduce substance use relapse • Facilitate successful family reunification. The CBT model defines substance use as a learned social behavior that is acquired through modeling or imitation of the observed behavior in others with whom one has some type of social relationship. In this model, addiction is considered a disease. The CF! program provides weekly instruction focusing on a healthy lifestyle free from drugs and alcohol, addressing risk and protective factors as well as developmental assets of family members. Following a family dinner, parents and children participate in separate 90-minute instructional group sessions devoted to a particular theme. Parents then reunite with their children for a 30-minute activity to practice what has been presented and learned and to receive feedback on their performance. Themes include (1) healthy living, (2) nutrition, (3) communication, (4) feelings and defenses, (5) anger management, (6) facts about alcohol, tobacco, and other drugs, (7) chemical dependency as a disease, (8) the effects of chemical dependency on the whole family, (9) goal setting, (10) making healthy choices, (11) healthy boundaries, (12) healthy friendships and relationships, and (13) individual uniqueness. Originally designed for the Family Treatment Drug Court (FTDC) system, CF! is currently used by drug courts, dependency courts, faith-based organisations, residential and outpatient treatment services, and social service agencies serving parents and children ages 4-17. Started in the mid-1990s, the FTDC is the most recent and the fastest growing type of drug court in the United States. It provides a setting for all the participants in the child protection system to come together to determine the individual treatment needs of substance-abusing parents whose children are wards of the court. The goal of the FTDC is to rehabilitate the parents as competent caretakers so that their children can be safely returned to their parents' care."	SAMHSA	2008
Outcomes	• Child behaviour • Family relationships • Safety and physical wellbeing • Parent-child relationship		
Population	Families in which one or both parents are in early stages of recovery from substance addiction and/or domestic violence/ and or child abuse	SAMHSA	2008
Setting	Residential, outpatient and other community settings	SAMHSA	2008
Dose	"Recommended intensity: After intake, 2.5-hour weekly gatherings consisting of a Family Meal followed by Opening, Insights for Living, Closing, and Connecting with My Family sections. Recommended duration: 16 weeks."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
	2.3 - for parenting skills 2.4 - for parent tobacco and substance use 2.6 - for parent depressive symptoms 2.1 - for family environment; child behaviours and family reunification	SAMHSA	2008
Used in Australia	Information unavailable		

Clinician-Based Cognitive Psycheducational Intervention for Families		Source	Year
Program description	"The Clinician-Based Cognitive Psychoeducational Intervention is intended for families with parents with significant mood disorder. Based on public health models, the intervention is designed to provide information about mood disorders to parents, equip parents with skills they need to communicate this information to their children, and open dialogue in families about the effects of parental depression."	SAMHSA	2006
Outcomes	• Parent-child relationship • Family relationship		
Population	Families with parents with significant mood disorder	SAMHSA	2006
Setting	Outpatient, home or other community settings	SAMHSA	2006
Dose	The intervention consists of 6-11 sessions that include separate meetings with parents and children, family meetings, and telephone contacts or refresher meetings at 6- to 9-month intervals	SAMHSA	2006
Evidence rating	3.5 - for child-related behaviours and attitudes toward parental illness as reported by parents 3.3 - children's understanding of parental illness 3.7 - for internalising symptomology 3.5 - for family functioning	SAMHSA	2006
Used in Australia	Information unavailable		

Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families who are at Risk for Physical Abuse		Source	Year
Program description	"Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families Who Are at Risk for Physical Abuse is a structured treatment program for children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies. The target population includes families in which child physical abuse by parents has been substantiated, families that have had multiple referrals to a child protection services agency, and parents who have reported significant stress and fear that they may lose control and hurt their child. The program aims to reduce children's Post Traumatic Stress Disorder (PTSD) symptoms, other internalising symptoms, and behavior problems while improving parenting skills and parent-child relationships and reducing the use of corporal punishment by parents. CPC-CBT is grounded in cognitive behavioral theory and incorporates elements (e.g., trauma narrative and processing, positive reinforcement, timeout, behavioral contracting) from empirically supported CBT models for families who have experienced sexual abuse, physical abuse, and/or domestic violence, as well as elements from motivational, family systems, trauma, and developmental theories. CPC-CBT can be delivered in either an individual or a group modality."	SAMHSA	2011
Outcomes	• Safety and physical wellbeing • Child behaviour • Parent-child relationship • Child development • Family relationships		
Population	Families who are at risk for physical abuse	SAMHSA	2011
Setting	Outpatient	SAMHSA	2011
Dose	The individual therapy program consists of 90-minute sessions, and the group therapy program (which was used in the study evaluated by NREPP) consists of 2-hour sessions. Trained clinicians deliver the CPC-CBT components in 16-20 sessions.		
Evidence rating	3.2 - for children's PTSD symptoms; and parenting skills	SAMHSA	2011
Used in Australia	Information unavailable		

Family Foundations		Source	Year
Program description	"Family Foundations, a program for adult couples expecting their first child, is designed to help them establish positive parenting skills and adjust to the physical, social, and emotional challenges of parenthood. Program topics include coping with postpartum depression and stress, creating a caring environment, and developing the child's social and emotional competence. Family Foundations is delivered to groups of couples through four prenatal and four postnatal classes of two hours each. Prenatal classes are started during the fifth or sixth month of pregnancy, and the postnatal classes end when the children are six months old. The classes are designed to foster and enhance the coparenting relationship, and they include conflict resolution strategies, information and communication exercises to help develop realistic and positive expectations about parenthood, and videos presenting couples discussing the family and personal stresses they have experienced as well as the successful strategies they have employed. Key aspects of parenting that are addressed include fostering child emotional security, attending to infant cues, and promoting infant sleep. Family Foundations is delivered in a community setting by childbirth educators who have received three days of training from Family Foundations staff. It is recommended, but not required, that classes be codelivered by a male and a female."	SAMHSA	2011
Outcomes	• Basic child care • Child development • Family relationships • Parent-child relationship • Child behaviour		
Population	Adult couples expecting their first child	SAMHSA	2011
Setting	Other community settings	SAMHSA	2011
Dose	Four prenatal and four postnatal classes of two hours each	SAMHSA	2011
Evidence rating	3.6 - for co-parenting; and parent-child interaction 3.7 - for parental adjustment; and child adjustment	SAMHSA	2011
Used in Australia	Information unavailable		

Family Matters		Source	Year
Program description	"Family Matters is a family-directed program to prevent adolescents 12 to 14 years of age from using tobacco and alcohol. The intervention is designed to influence population-level prevalence and can be implemented with large numbers of geographically dispersed families. The program encourages communication among family members and focuses on general family characteristics (e.g., supervision and communication skills) and substance-specific characteristics (e.g., family rules for tobacco and alcohol use and media/peer influences). The program involves successive mailings of four booklets to families and telephone discussions between the parent and health educators. Two weeks after family members read a booklet and carry out activities intended to reinforce its content, a health educator contacts a parent by telephone. A new booklet is mailed when the health educator determines that the prior booklet has been completed. The program can be implemented by many different types of organisations and people, such as health promotion practitioners in health departments, school health educators and parent-teacher groups, volunteers in community-based programs, and national nonprofit organisations."	SAMHSA	2006
Outcomes	• Child behaviour • Family relationships		
Population	Adolescents aged 12-14 years and their families	SAMHSA	2006
Setting	Home	SAMHSA	2006
Evidence rating	Exemplary	OJJDP	Not indicated
	3.2 - for prevalence of adolescent cigarette use; prevalence of adolescent alcohol use; and onset of adolescent cigarette use	SAMHSA	2006
	Other Reviewed Programs	PPN	Not indicated
Used in Australia	Information unavailable		

Family Support Network (FSN)		Source	Year
Program description	"Family Support Network (FSN) is an outpatient substance abuse treatment program targeting youth ages 10-18 years. FSN includes a family component along with a 12-session, adolescent-focused cognitive behavioral therapy--called Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT12)--and case management. The family component attempts to engage adolescents and their parents in a joint commitment to the treatment and recovery process. It establishes a support system, encourages family communication, and teaches parents behavioral management skills with the ultimate goal of improving the quality of family interrelationships. "	SAMHSA	2008
Outcomes	• Child behaviour • Family relationships		
Population	Youth aged 10-18 years	SAMHSA	2008
Setting	Outpatient and Home	SAMHSA	2008
Dose	The Family Component includes: • Six biweekly, multifamily education meetings addressing teen beliefs, adolescent development, adolescent drug use patterns, drugs and adolescents, the recovery process, and family management issues such as boundaries, parental discipline, and communication. • Four monthly home visits to reinforce the family's commitment to treatment and help the adolescent and his or her family individualise the skills they learned	SAMHSA	2008
Evidence rating	3.7 - for abstinence from substance use; and recovery from substance use 3.5 - for cost effectiveness	SAMHSA	2008
Used in Australia	Information unavailable		

Multisystemic Therapy (MST) for Juvenile Offenders		Source	Year
Program description	"Multisystemic Therapy is a treatment for juvenile offenders that uses a combination of empirically-based treatments (e.g. cognitive behavior therapy, behavioral parent training, functional family therapy) to address multiple variables (i.e. family, school, peer groups) that have been shown to be factors in juvenile behavior. Multisystemic Therapy's overall goals are to improve the youth's ability to make good decisions when choosing his/her peer group, and the family's ability to monitor his/her behavior. To achieve these goals, the Multisystemic Therapist: (1) interviews the youth, his/her family and peers, and school officials to identify the youth's problem behaviors and their causes; (2) identifies the youth's personal strengths, and positive aspects of his or her family, peer group, and school, which can be used to address the problem behavior (e.g. an athletic youth might be encouraged to join a sports team to keep him or her occupied after school, or a family member who lives nearby could help supervise the youth); and (3) sets goals for the youth (e.g. regular school attendance, less contact with delinquent peers) and his/her parents (e.g. enforcement of curfew, more frequent communication with the youth's teachers) to be achieved during treatment."	SPW	Not indicated
Outcomes	• Child behaviour • Family relationships • Safety and physical wellbeing		
Population	Juvenile offenders and their families	SPW	Not indicated
Setting	Home or community locations (i.e., school, recreation centre)	SPW	Not indicated
Dose	The therapists are available to the youth and his/her family 24 hours a day, 7 days a week	SPW	Not indicated
Evidence Rating	No rating	SPW	Not indicated
	2.9 - for posttreatment arrest rates 3.0 - for long-term arrest rates; alcohol and drug use; and perceived family-functioning cohesion 3.1 - for long-term incarceration rates; and peer aggression 3.2 - for self-reported criminal activity	SAMHSA	2007
Used in Australia	Yes		

Parenting Through Change		Source	Year
Program description	"Parenting Through Change (PTC) is a theory-based intervention to prevent internalising and externalising conduct behaviors and associated problems and promote healthy child adjustment. Based on the Parent Management Training--Oregon Model (PMTO), PTC provides recently separated single mothers with 14 weekly group sessions to learn effective parenting practices including skill encouragement, limit-setting, problem-solving, monitoring, and positive involvement. PTC also includes strategies to help parents decrease coercive exchanges with their children and use contingent positive reinforcements (e.g., praise, incentives) to promote prosocial behavior. Topics are presented in an integrated, step-by-step approach and are typically introduced in one or more sessions, then reviewed and revisited throughout the remainder of the program."	SAMHSA	2006
Outcomes	• Child behaviour • Child development • Parent-child relationships		
Population	Separated single mothers	SAMHSA	2006
Setting	Other community settings	SAMHSA	2006
Dose	14 weekly group sessions	SAMHSA	2006
Evidence rating	3.6 - for internalising behaviours; and delinquency 3.4 - for externalising behaviours; and noncompliance with mother's directives 3.8 - for academic functioning	SAMHSA	2006
Used in Australia	Information unavailable		

Partners with Families and Children: Spokane		Source	Year
Program description	"Partners with Families and Children: Spokane (Partners) provides services to families with children under 30 months old who are referred by child protective services, law enforcement, or other public health agencies due to chronic child neglect or risk of child maltreatment. These families generally are low income, marginally integrated into conventional life and family structures, and present multiple needs across life domains. Partners is a multidisciplinary intervention based on wraparound service principles and attachment theory. Its characteristic features are intensive case management using an integrated system of care approach; on-site resources for gender-specific, integrated parental substance abuse and mental health services; parental coaching to improve parent-child interactions and relationships; and a commitment to provide services as long as the family wants and benefits from services. Families who enter Partners are assigned to a Family Team Coordinator, who completes an initial formal assessment and develops a team of professionals and family members to participate in service plan development and delivery. Based on family need, collaborations are routinely developed with schools, Head Start, and local public health and other agencies to ensure service coordination. When a family enters Partners, the Coordinator arranges an initial home visit, begins a planning process for evaluation, and consults with core team members. The Coordinator continues to provide intensive case management services. Family team meetings typically occur at least once a month and include the professional team as well as individuals personally involved with and identified by the family. Family teams place a strong emphasis on the quality of the parent-child relationship and the quality of interactions, using infant psychotherapy principles to guide treatment goals. Meetings focus on informal modeling of appropriate relationship and behavior with the child, progressive encouragement and support of increasingly competent behavior, and parental self-reflection regarding the parent-child relationship."	SAMHSA	2008
Outcomes	• Safety and physical wellbeing • Parent-child relationship • Family relationships • Child behaviour		
Population	Families with children under 30 months old who are referred by child protective services, law enforcement, or other public health agencies due to chronic child neglect or risk of child maltreatment.	SAMHSA	2008
Setting	School	SAMHSA	2008
Evidence rating	2.5 - for interpersonal violence within families; parenting stress; child behaviour problems; caregiver-child attachment 2.4 - for service access	SAMHSA	2008
Used in Australia	Information unavailable		

Advocacy for Women and Kids in Emergencies (AWAKE)		Source	Year
Program description	"In 1986, a group of advocates, social workers, nurses, and doctors began AWAKE, Advocacy for Women and Kids in Emergencies, at Children's Hospital in Boston. The basic goal of the project was to identify and help battered women with abused or neglected children and offer to the women support and advocacy. In this way, women would be better protected, and, as a result, so would their children. The argument was that children's safety was usually - although not always - largely dependent on their mother's. AWAKE seeks to provide comprehensive services to abused children and mothers. Abused women who accept AWAKE's services are paired with an advocate who collaborates with hospital staff and outside agencies to devise a safety plan and, whenever possible, to keep mothers and children together. Services provided include housing guidance, such as shelter referrals, court advocacy, referrals for medical and legal care, and individual counseling and support groups for women. AWAKE also provides consultation and education to hospital staff and the community. AWAKE provides opportunities for abused women, in seeking medical attention for their children, to access services for themselves that they might not have sought otherwise."	CEBC	2010
Outcomes	• Safety and physical wellbeing • Family relationships		
Population	Battered women with abused and neglected children	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Behavior Analysis Services Program (BASP)		Source	Year
Program description	"The Behavior Analysis Services Program (BASP) is a parent training and child intervention program designed to promote the placement stability of dependent children with challenging behaviors. The program provides caregiver training classes for individuals who are becoming licensed foster parents, caregiver training classes for pre- and post-adoptive parents, and parent training seminars for individuals in the community who are not involved in the foster care system. Applied behavior analysis (ABA) services are also provided for children in the foster care system and BASP providers work closely with foster parents to increase parenting skills and decrease child problem behavior. The goal of the BASP program is to increase the placement stability of foster children who engage in problem behavior by training caregivers to competency on behavior analytic procedures, including (but not limited to) non-contingent reinforcement, differential reinforcement, contingency management, and extinction/planned ignoring."	CEBC	2011
Outcomes	• Basic child care • Child behaviour • Family relationships • Safety and physical wellbeing		
Population	Foster, adoptive, and biological caregivers and their children	CEBC	2011
Setting	Behaviour Analysis Services Program (BASP) was designed to be conducted in a group setting. Recommended group size: 10-20 individuals. This program is typically conducted in a(n): Adoptive Home or Foster Home.	CEBC	2011
Dose	"Recommended intensity: Parent training classes are weekly 3-hour sessions. Home visits usually occur at least weekly. Often times, home visits occur more than once per week. Recommended duration: Parenting classes last 6 weeks. The number and duration of the home visits is contingent on the skill level of the caregivers and the topography/severity of the problem behavior of the child. On average, in-home services can last from one month to over a year as needed."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

BehaviorTools		Source	Year
Program description	"The BehaviorTools™ curriculum identifies 12 frequently used forms of coercion, describes the effects of using coercion and provides alternative management strategies that are positive, proactive, and more effective in producing long-term improvements in behavior. The BehaviorTools™ program was developed from the Behavior Analysis Services Program (BASP), funded by the State of Florida from 1996 to 2008. BASP developed a curriculum entitled Tools for Positive Behavior Change, which was designed to teach caregivers basic principles of behavior. The curriculum was written for caseworkers and caregivers of foster children who were abused (sexually, physically and emotionally) and neglected. In 2008, statewide budget cuts forced DCF to terminate funding BASP. However, the curriculum was revised and rewritten by Professional Crisis Management Association, Inc. And is now called BehaviorTools™. The revised curriculum still pertains to the prior populations but has expanded to include caregivers of children and adults with developmental disabilities (including autism spectrum disorder)."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing		
Population	"Foster, adoptive and biological parents; caseworkers; care managers; and direct care staff of residential and group home facilities; and caregivers and teachers of children and adults with disabilities."	CEBC	2011
Setting	"This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Community Agency; Foster Home; Hospital; Outpatient Clinic; Residential Care Facility; or School."	CEBC	2011
Dose	"Recommended intensity: Skills taught in training are used by participants on an as needed basis in their home or work environments. Recommended duration: Skills taught in training are used by participants on an as needed basis in their home or work environments."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Boot Camp for New Dads (BCND)		Source	Year
Program description	"Boot Camp for New Dads is a unique father-to-father community-based workshop that inspires and equips men of different economic levels, ages and cultures to become confidently engaged with their infants, support their mates and personally navigate their transformation into dads."	CEBC	2012
Outcomes	• Parent-child relationship	CEBC	2012
Population	Dads-to-be in the months surrounding their baby's birth	CEBC	2012
Evidence rating	Not able to be rated	CEBC	2012
Used in Australia	Information unavailable		

Caring Dads: Helping Fathers Value their Children		Source	Year
Program description	"The Caring Dads program combines elements of parenting, fathering, and child protection practice to address the needs of maltreating fathers. Program principles emphasise the need to: • enhance men's motivation • promote child-centered fathering • address men's ability to engage in respectful, non-abusive co-parenting with children's mothers • recognise that children's experience of trauma will impact the rate of possible change • work collaboratively with other service providers to ensure that children benefit (and are not unintentionally harmed) as a result of father's participation in intervention. The program uses a combination of motivation enhancement, parent education (including skills training and behavioral practice), and cognitive behavioral therapy to: • improve men's recognition and prioritization of children's needs • improve men's understanding of developmental stages • improve men's respect and support for children's relationships with their mothers • improve men's listening and using praise • improve men's empathy for children's experiences of maltreatment • identify and counter the distortions underlying men's past, and potentially ongoing, abuse of their children and/or children's mothers. The overarching goal is to ensure the safety and wellbeing of children who have been impacted by men's abuse or neglect, including domestic violence. The program aims to achieve this goal, and the following specific goals, through fathering group intervention, as well as through mother contact and coordinated case management: • to develop sufficient trust and motivation to engage men in the process of examining their fathering. • to increase men's awareness and application of child-centered fathering • to eliminate fathers' use of abuse and neglect towards their children and to promote respectful and non-abusive co-parenting with children's mothers • to promote men's appreciation of the impact of their past abuse on their children and family and help men take responsibility for these behaviors • to provide supportive outreach to children's mothers to provide information about the program, safety planning, and referral, as necessary • to work with other professionals to plan for the future safety and wellbeing of children who have been impacted by abuse, neglect, and/or domestic violence."	CEBC	2011
Outcomes	• Parent-child relationship • Safety and physical wellbeing • Child development • Family relationships		

Caring Dads: Helping Fathers Value their Children (continued)		Source	Year
Population	"Fathers (including biological, step, and common-law) who have physically or emotionally abused their children, or neglected them; exposed them to domestic violence; or who are deemed to be at high-risk for these behaviors. The program also involves contact with mothers and coordinated case management to contribute to the safety and wellbeing of children."	CEBC	2011
Setting	"This program is typically conducted in a(n): Community Agency; Departments of Social Service; or Outpatient Clinic."	CEBC	2011
Dose	"Recommended intensity: Two-hour weekly session. Recommended duration: 17 sessions."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Child Protective Services Reintegration Project (CRP)		Source	Year
Program description	"CRP provides home- and community-based services to help children/adolescents with mental health challenges transition back to the community from out-of-home placements, such as residential treatment centers (RTCs), hospitals, foster homes, and shelters. CRP utilises the Wraparound process, which builds on families' inherent strengths to care for youth with complex needs. Each youth/family is assigned to a Care Coordinator, whose role is to empower the youth and family—to set their own goals, decide how to meet them, and access/advocate for necessary support. The goal of the CPS Reintegration Project (CRP) is to reduce the number of children/adolescents involved in the child welfare system due to their mental health needs by exiting children/adolescents from licensed care and reintegrating with caregivers in their home community. These caregivers are biological parents, adoptive parents, relatives, and fictive kin. This program involves the family or other support systems in the individual's treatment: The coordinator takes the parent/caregiver through strength and needs assessments and identifies family resources to support the reintegration. The program encourages other family/fictive kin members to become part of the Child and Family Team and to work with the parent/caregiver and child/adolescent to make the reintegration successful. Other members of the household, or immediate family, can receive services and supports through the program to provide a holistic intervention."	CEBC	2012
Outcomes	• Safety and physical wellbeing • Parent-child relationship		
Population	"Children/adolescents aged 5-17 who reside in therapeutic or residential placement facilitated by child welfare and have an Axis I diagnosis (i.e., a clinical disorder(s), including major mental disorders, learning disorders, and substance use disorders)."	CEBC	2012
Setting	This program is typically conducted in a(n): Adoptive Home or Birth Family Home	CEBC	2012
Dose	"Recommended intensity: Contact depends on the phase of service: The Screening phase lasts for 30 days and is generally 3 face-to-face visits with the parent/caregiver and 1-2 face to face visits with the child/adolescent. The length of time varies from 1 to 3 hours. The Pre-Integration Planning phase is two Child and Family Team Meetings; one contact with the child; and numerous telephone calls and emails to collaborate with team members. The Reintegration phase varies from weekly to twice-a-month contact depending on the length of time a child/adolescent has been residing in the home. There are also weekly phone calls, emails, and meetings with school personnel. The Ongoing phase varies in contact from twice-a-month to once-a-month depending on the level of need and functioning of the family. Recommended duration: The program serves the family until the child/adolescent has stabilized in the community and has dependable supports and services. The total length of service is on average 16 months (1 month screening; 3 months planning for reintegration; 6 months in home with open CPS case; 6 months in-home with CPS case closed)."	CEBC	2012
Evidence rating	Not able to be rated	CEBC	2012
Used in Australia	Information unavailable		

Child Welfare Organizing Project - Parent Leadership Curriculum (CWOP)		Source	Year
Program description	"Leadership Curriculum in East Harlem, the South Bronx, and North and Central Brooklyn. These are New York City communities characterized by high rates of child maltreatment reports and foster care placements. Co-designed and co-led by parents and professionals, the CWOP Parent Leadership Curriculum is intended to orient parents involved with the public child welfare system to their rights and responsibilities, laws and regulations governing local practice, and the contractual obligations of service provider agencies. Another goal of the curriculum is to prepare parents for paraprofessional roles as peer organizers and advocates. The CWOP Parent Leadership Curriculum consists of both classroom sessions and experiential learning and leadership opportunities. Over 120 people have completed the curriculum and more than half of them have secured employment as parent advocates in foster care, preventive, and legal services agencies. Over 70% of the participants who had children in foster care at the point of enrollment had regained custody by completion of the curriculum. Goals of the CWOP Parent Leadership Curriculum are to: • Orient parents to their rights and responsibilities within the child welfare system. • Engage parents in policy analysis and systemic advocacy."	CEBC	2010
	• Safety and physical wellbeing • Family relationships		
Population	Anyone who has had personal experience with the child welfare system (could be as a parent, child, foster parent, etc.).	CEBC	2010
Setting	Child Welfare Organizing Project – Parent Leadership Curriculum (CWOP) was designed to be conducted in a group setting. Recommended group size: 10-15 This program is typically conducted in a(n): Community Agency	CEBC	2010
Dose	Recommended intensity: 10 hours per week. Recommended duration: 6 months.	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Child Witness to Violence Project		Source	Year
Program description	"Child Witness to Violence Project at Boston Medical Center provides trauma-focused clinical intervention to children age 8 and younger who have been exposed to domestic or community violence. Approximately 150 families are seen each year; 85% of cases seen are for exposure to domestic violence; 65% of the children are age 6 or younger. The intervention requires the active participation of at least one parent and is focused on addressing the traumatic experiences of the child within the context the child-parent relationship. The intervention incorporates principles of Child-Parent Psychotherapy and Trauma-Focused Cognitive Behavioral Therapy. Components of the intervention include advocacy and case management, parent guidance, along with dyadic and/or individual psychotherapy. Services are primarily outpatient and office-based."	CEBC	2010
Outcomes	• Safety and physical wellbeing • Child-parent relationship • Child behaviour		
Population	"Children aged 8 and younger, with the majority being under age six, from a racially diverse urban area."	CEBC	2010
Setting	Birth family home and outpatient clinic	CEBC	2010
Dose	"Recommended intensity: Weekly 1-1.5-hour sessions. Recommended duration: At least five months."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Circle of Parents		Source	Year
Program description	"Circle of Parents is a national network of statewide non-profit organisations and parent leaders that are dedicated to using the mutual self-help support group model as a means of preventing child abuse and neglect and strengthening families. Circle of Parents offers anyone in a parenting role the opportunity to participate in weekly group meetings with other parents to exchange ideas, share information, develop and practice new parenting skills, learn about community resources, and give and receive support. Groups are parent-led with the support of a trained group facilitator, are conducted in a confidential and non-judgmental manner, are free of charge, and provide developmentally-appropriate children's programs or child care concurrent with the parent group meetings. Developing leadership on the individual, family, community, and societal levels, as desired by parent participants, is a central theme of the Circle of Parents model."	CEBC	2010
Outcomes	• Safety and physical wellbeing • Family relationships • Child development		
Population	Any parent or individual in a parenting role for children ages 0-18 years. This may include biological parents, adoptive parents, foster parents, grandparents, kinship caregivers, etc. Many programs target specific groups such as fathers, parents of children with disabilities, parents with disabilities, immigrant and refugee families, incarcerated parents, teen parents, parents in substance abuse recovery, and other parenting challenges	CEBC	2010
Setting	This program is typically conducted in a(n): Community Agency; Community Daily Living Settings; Outpatient Clinic; Prison; Religious Organisation; or School Circle of Parents was designed to be conducted in a group setting. Recommended group size: 10-12 participants	CEBC	2010
Dose	"Recommended intensity: Support groups meet once weekly for an average of 1.5 hours. Occasionally, due to factors such as access in rural communities, availability of the program site or the choice of the particular group, the group may meet less often but not less than once a month. Recommended duration: The length of time for participation is open-ended except for situations where the program setting or structure limits the availability of the program. For example, programs that occur in schools may only operate 9 months out of the year and programs that occur in correctional institutions may be time limited by direction of the authorities."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Confident Parenting: Survival Skill Training Program		Source	Year
Program description	"The Confident Parenting: Survival Skill Training Program uses a cognitive-behavioral orientation to train parents in using non-violent child management skills in their relationships with children. Parents are also encouraged to use such skills in relating to spouses and other adults. It was originally developed in the 1970s in child mental health settings and has become the program of choice in many other human service and educational settings since that time. The Confident Parenting: Survival Skill Training Program is the main parenting intervention provided by the staffs of various regional offices of the Los Angeles County Department of Children and Family Services. It is designed as a 10-session program to be used with small groups of parents. This way each parent can receive individualised consultation from the instructor on the home behavioral change projects that are assigned. A one-day seminar version of the program for large numbers of parents has recently been created."	CEBC	2011
Outcomes	• Child behaviour • Parent-child relationship • Safety and physical wellbeing • Family relationships		
Population	Parents of children (2-12 years old) who are experiencing behaviour or emotional problems	CEBC	2011
Setting	This program is typically conducted in a(n):Adoptive Home; Birth Family Home; Community Agency; Foster Home; Hospital; Outpatient Clinic; Residential Care Facility or School. Confident Parenting: Survival Skill Training Program was designed to be conducted in a group setting. Recommended group size: 10 x 2-hour sessions format: 8-12 parents; One-day seminar format: 50-200 parents.	CEBC	2011
Dose	"Recommended intensity: Two-hour basic training sessions per week for entire program; or one-day for abbreviated seminar format. Recommended duration: 10 consecutive weeks, with either monthly booster sessions; or the opportunity to take the entire program for a second time."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

DADS Family Project		Source	Year
Program description	"The DADS Family Project is an innovative program that is designed to adapt to a variety of settings, from schools and churches to prisons and businesses. The purpose of the program is to assist dads to improve their understanding of the essential role of fathering. It is critical that the program be presented in a supportive gathering of fathers. Traditionally, parent education has been offered in mixed groups composed of mothers and fathers. The DADS Family Project is based on the belief that in a supportive learning environment fathers can be inspired, empowered, and enabled, through skill building techniques, to gain mastery and confidence in their role as a parent."	CEBC	2010
Outcomes	• Basic child care • Parent-child relationship		
Population	Not specified	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Early Steps to School Success (ESSS)		Source	Year
Program description	"ESSS provides parent education and support, home visiting and pre-literacy and language development services for families in rural, geographically isolated communities. ESSS is a model designed to be culturally relevant and provide early childhood education services to pregnant women and children from birth to age five, education services to parents, and ongoing staff training to community early childhood educators. It not only recognises the essential role families have in preparing their children for school, but also reinforces parents' roles as advocates in raising awareness for community-wide efforts that support school readiness. It does this through community collaboration and by creating strong connections between parents and the schools their children will attend."	CEBC	2010
Outcomes	• Child development • Family relationships • Basic child care		
Population	Families living in rural, geographically isolated communities.	CEBC	2010
Setting	This program is typically conducted in a(n): Birth Family Home; Community Agency; Foster Home; or School Early Steps to School Success (ESSS) was designed to be conducted with individual families or with groups of children and their parents.		
Dose	Recommended intensity: • Home visits: 2 per month for 60 minutes each • Parent and child education and support groups: 1 per month for 60 minutes • Literacy activities for children aged 3 -5 years: 2 per month for 30 minutes each. Recommended duration: The program works with families from the time they are expecting a child (prenatal) until the child enters kindergarten.	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Families First of Michigan		Source	Year
Program description	"Families First of Michigan offers families intensive and short-term crisis intervention and family education services in their home for four weeks (with the possibility of an extension up to a maximum of six weeks) using the Families First of Michigan model. Families First of Michigan workers are available and accessible to the family 24 hours a day, seven days a week. The workers assist families by establishing individual family goals designed to reduce risk of out of home placement and increase child safety. Families First of Michigan workers assist families in meeting goals by teaching, modeling, and reinforcing appropriate parenting and by providing concrete services and connections to community services."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Family relationships		
Population	Children who are at high risk of removal from their families due to abuse or neglect.	CEBC	2011
Setting	Birth family home	CEBC	2011
Dose	"Recommended intensity: The intensity varies according to the needs of the family. The workers spend a minimum of 10 hours a week with each of the families on their caseload and the average visit is two hours. Recommended duration: The program, as designed, works with families for a period of four weeks. Cases can be extended to a maximum of six weeks. Extensions are based on joint decision-making by the family preservation worker and supervisor, the referring worker and supervisor and the family. The decision-making is focused on goal achievement, risk reduction, and safety."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Father's Time Fatherhood Academy		Source	Year
Program description	"The intent and purpose of the Father's Time Fatherhood Academy is to systematically engage men in the embracement of values that are life-giving and life-sustaining, for the benefit of themselves and their families. It is a multicultural educational class for fathers and fathers-to-be, which teaches the basic fundamentals and essentials of fatherhood referred to as Life Values. Fathers are given the tools and the process to create their own personal visionary plans, which can be directly implemented in their homes and relationships."	CEBC	2011
Outcomes	• Basic child care • Family relationships		
Population	"Fathers from age 14 to 80 in any aspect of fatherhood: married with children, non-residential/custodial, single, addicted, impoverished, incarcerated, teenage, military, step, stand-in, or about to become a father."	CEBC	2011
Setting	"This program is typically conducted in a(n): Community Agency; Community Daily Living Settings; Prison; Religious Organisation; or School."	CEBC	2011
Dose	"Recommended intensity: 2-hour weekly sessions. Recommended duration: 10 weeks (3 months). Total time is 12 weeks when including the orientation class and graduation."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Fundamentals of Foster and Adoptive Parenting		Source	Year
Program description	"Fundamentals of Foster and Adoptive Parenting focuses on training participants to develop the skills, knowledge, values, traits, and motives necessary to prepare them to understand and cope with the experience of receiving an adoptive or foster child into their home. The program's curriculum was developed by stakeholders from the Maine Department of Health and Human Services (DHHS), and the Child Welfare Training Institute (CWTI), a division of the Muskie School of Public Service at the University of Southern Maine, collaborated with experienced foster and/or adoptive parents. Together they defined the knowledge-base, skills, abilities, and underlying personal characteristics needed to be an effective foster and/or adoptive parent."	CEBC	2011
Outcomes	• Basic child care • Parent-child relationships		
Population	The target populations of this program are prospective foster and adoptive parents and kinship providers	CEBC	2011
Setting	This program is typically conducted in a(n): Community Agency; Departments of Social Service or Hospital	CEBC	2011
Dose	"Recommended intensity: Depending on the needs of the prospective parent/kin participants, there are either 3 hours or 6 hours of training a week. With 3 hours of training, there is 1 session a week. With 6 hours of training, it can either be 2 x 3-hour sessions or 1 x 6-hour session. Recommended duration: Duration is 4-8 weeks for a total of 24 hours of training."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Individual Family- Psychoeducational Psychotherapy (IF-PEP)		Source	Year
Program description	"IF-PEP is a manual-based treatment for children aged 8-12 years with mood disorders (depressive and bipolar spectrum disorders). IF-PEP is based on a biopsychosocial framework and utilises cognitive-behavioral and family-systems based interventions. IF-PEP is a 20-24 session, 50-minutes-per-session treatment with 20 scripted and 4 "in-the-bank" sessions that alternate between parents and children attending. One special session each is devoted to working with school professionals and siblings. IF-PEP's goals are to help parents and children learn about, then effectively manage, symptoms of mood disorders via improved communication, problem solving, and emotion regulation. It is the intention of IF-PEP that, by giving the parents and child a better understanding of the disorder, family tension will decrease and consumer skills will improve resulting in reduced symptom severity and improved functioning."	CEBC	2010
Outcomes	• Child behaviour • Family relationships • Child development		
Population	"Children aged 8-12 with major mood disorders (depressive and bipolar spectrum) and their parents."	CEBC	2010
Setting	This program is typically conducted in a(n): Community Agency or Outpatient Clinic	CEBC	2010
Dose	"Recommended intensity: Weekly 45-50-minute sessions, though it can be biweekly sessions. Recommended duration: Varies from 10 -24 weeks (depends if sessions are weekly or biweekly)."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

InsideOut Dad		Source	Year
Program description	"InsideOut Dad™ strives to increase inmates' contact with their children and improve inmates' awareness, knowledge, and attitudes about being an involved, responsible, and committed father. It includes 12 core sessions and 26 optional sessions that allow facilitators to customize the program for the unique needs of the fathers they serve. InsideOut Dad™ has been used in state and federal facilities, pre-release programs, and community organisations, among others."	CEBC	2011
Outcomes	• Parent-child relationships		
Population	"Fathers with children 18 years old and younger. It is designed specifically for the issues/challenges faced by incarcerated fathers (e.g., challenge of successful re-entry)."	CEBC	2011
Setting	Prison	CEBC	2011
Dose	"Recommended intensity: Weekly 1-hour session. Sessions may be extended with one or more optional sessions on the same topic. The program may also be delivered in a shorter duration depending on the audience (e.g., two sessions per week for a total of two hours). Recommended duration: 12 weeks. Program may be delivered in a shorter duration depending on the audience (e.g., six weeks with two sessions per week)."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Kids in Transition to School (KITS)		Source	Year
Program description	"Kids in Transition to School (KITS) is a short-term, intensive intervention designed to enhance psychosocial and academic school readiness in children at high risk for school difficulties. KITS features a two-pronged approach: (a) a 24-session therapeutic playgroup focused on promoting social-emotional skills and early literacy in children, and (b) an 8-session parent workshop focused on promoting parent involvement in early literacy and the use of positive parenting practices. The KITS curriculum is delivered during the summer before and the early fall of kindergarten."	CEBC	2012
Outcomes	• Child development • Child behaviour • Parent-child relationship		
Population	"Foster children and other children at high risk for school difficulties who are entering kindergarten."	CEBC	2012
Setting	Community agency; School	CEBC	2012
Dose	"Recommended intensity: Playgroups meet 2 times a week for 2 hours in the 2 months preceding kindergarten entry. Once school starts, playgroups meet once a week for 2 hours during the first 8 weeks of school (typically September to October). Parent groups meet for 2 hours every other week. Recommended duration: 16 weeks total."	CEBC	2012
Evidence rating	Not able to be rated	CEBC	2012
Used in Australia	Information unavailable		

Los Ninos Bien Educados (LNBE)		Source	Year
Program description	"The Center for the Improvement of Child Caring's (CICC) LNBE program is a parenting skill-building program created specifically for parents of Latino American children. It has become one of the main parenting interventions provided by the staffs of the Latino Family Preservation units in the Los Angeles County Department of Children and Family Services. It is designed as a 12-session program to be used with small groups of parents, and as a one-day seminar for large numbers of parents. Over 1500 professionals, from 20 states, have been trained to deliver it since the late 1980s when it became available for national use through instructor training workshops conducted in cities nationwide."	CEBC	2011
Outcomes	• Child behaviour • Parent-child relationship		
Population	For parents of Latino descent who are raising children in the United States, both Spanish and English speakers	CBEC	2011
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Community Agency; Foster Home; Hospital; Outpatient Clinic; Residential Care Facility; or School. Los Ninos Bien Educados (LNBE) was designed to be conducted in a group setting. Recommended group size: The best size of groups to receive the full, 12-session version of the program is from 10 to 15 parents. The one-day seminar version can be taught to 50 to 150 parents at a time	CEBC	2011
Dose	"Recommended intensity: Three-hour sessions weekly or a 6.5-hour one-time seminar. Recommended duration: 12 weeks of sessions or the one-day seminar."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Love and Logic		Source	Year
Program description	"The Love and Logic Institute, Inc., developed training materials designed to teach educators and parents how to experience less stress while helping young people learn the skills required for success in today's world. This approach is called Love and Logic and is based on the following two assumptions: 1. That children learn the best lessons when they're given a task and allowed to make their own choices (and fail) when the cost of failure is still small 2. That the children's failures must be coupled with love and empathy from their parents and teachers. This model has been used by parents and teachers for 30 years and has been applied to a wide range of situations."	CEBC	2010
Outcomes	• Child development • Parent-child relationship		
Population	Parents, grandparents, teachers, and other caretakers working with children.	CEBC	2010
Setting	This program is typically conducted in a(n): Community Daily Living Settings; Religious Organisation; and School. Love and Logic was designed to be conducted in a group setting.	CEBC	2010
Dose	"Recommended intensity: Parents, grandparents, and/or teachers attend a voluntary one-day seminar, or 3-day, 5-day, or 6-day conference to help them learn the techniques. Recommended duration: 1 day to 6 days depending on length of training they choose to attend."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Minority Youth and Family Initiative for African-Americans (MYFI)		Source	Year
Program description	"MYFI in Polk County, Iowa, aims to reduce the proportion of African-American children in the child welfare system. Public child welfare staff addresses needs and concerns of these families and engages them as team members from the beginning of the case by utilising Pre- and Post-Removal Family Conferencing and Family Team Meetings (facilitated by African-American workers). Parent Partners (alumni of the child welfare system) serve as guides and advocates for families involved. Also includes culturally competent services, resources and support for families, training for staff, and flexible dollars used to meet family needs."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Family relationships		
Population	"African American children and families involved with the child welfare system"	CEBC	2011
Setting	Birth family home, community agency and hospital	CEBC	2011
Dose	"Recommended intensity: 1-2 hours per week with family team meeting, parent partner contacts, and other referrals based on need. Recommended duration: 2-3 months."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Parent and Child Together Project (PACT)		Source	Year
Program description	"The PACT program serves young mothers referred by Social Services. Priority is given to mothers who are 16-24 years old, with children 0-3, who have risk factors associated with neglect. The program is provided in a residential setting of 6 mothers to a unit. The residential portion of the program can last from 12 weeks to 18 months. Follow-up care is provided for 9 months. During the residential portion of the program, mothers are provided training and assessment on basic infant and childcare skills. Other services address partner relationships, household management, and preparation for life in the community. Aftercare services include ongoing childcare assessments, establishing social and community support, and assisting them to explore opportunities for education and employment. PACT also provides support for those mothers who have been separated from their children."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Basic child care • Family relationships • Child development		
Population	Mothers referred by Social Services. Priority is given to mothers who are 16-24 years old with children aged 9-3 who have risk factors associated with neglect	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Parent Partners - Iowa		Source	Year
Program description	"Parent Partners – Iowa uses an approach that not only celebrates individuals that have overcome obstacles through change, recovery, and accountability, but also uses their skills to mentor families who are currently navigating through the Department of Human Services as their children are in foster or kinship care. These Parent Partners demonstrate advocacy and effective communication, while holding families accountable."	CEBC	2010
Outcomes	• Safety and physical wellbeing • Family relationships		
Population	Parents involved with Department of Human Services' Child Protective Services.	CEBC	2010
Setting	This program is typically conducted in a(n): Birth Family Home; or Departments of Social Service. Parent Partners – Iowa was designed to be conducted in a group setting. Recommended group size: 8-12 participants	CEBC	2010
Dose	"Recommended intensity: For the mentoring, or one-on-one piece of the program it is recommended that Parent Partners spend 1-2 hours per parent per week of face-to-face contact. Recommended duration: The length of the program varies as much as the resources, needs, and identified concerns of the parent/family varies. It is recommended to receive at least 6 months of mentoring."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Parent Support Outreach Program (PSOP)		Source	Year
Program description	"PSOP is a voluntary early intervention family support program serving families with young children (under age 10) who are at risk of child maltreatment. Referrals are identified through screened out child maltreatment reports or through community or self-referral based on risk exposure. Services are largely consumer driven with a significant focus on addressing the provision of basic needs. Families are asked to participate in a strengths and needs assessment that is used to help the family and agency determine an appropriate service plan. Services are delivered through county-based child welfare programs or through a contract for service with a community-based provider. The primary goal of the Parent Support Outreach Program is a reduced risk of child maltreatment. This is attained by addressing unmet family needs and employing family strengths. Overall family well-being improvement is also sought and measured by the strengths and needs assessment."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Family relationships		
Population	"Families at risk of child maltreatment as identified by screened out child maltreatment reports, community referrals, or self-referral. Families that are referred by the community or through self-referrals must have at least two risk factors including, but not limited to, poverty, past maltreatment history, domestic violence, chemical dependency, and emotional or behavioral health problems."	CEBC	2011
Setting	Birth family home	CEBC	2011
Dose	"Recommended intensity: Depends on family's goals and service requests. Contact is usually focused on obtaining whatever resources or services desired and not on treating the family. Recommended duration: No specific time limit, but services are usually very specific and time limited (90-180 days average)."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Parenting with Love and Limits (PLL)		Source	Year
Program description	"PLL combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, and attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation. The program also has been used with teenagers with less extreme behaviors. PLL teaches families how to re-establish adult authority through consistent limits while reclaiming a loving relationship. It includes six multifamily sessions, conducted by two facilitators that employ group discussions, videotapes, age-specific breakout sessions, and role-play. Individual families also receive intensive 1-2-hour therapy sessions in an outpatient or home-based setting to practice the skills learned in the group setting. Three or four family therapy sessions are recommended for low to moderate-risk adolescents; up to 20 sessions may be recommended for those with more severe problems such as involvement with the juvenile or criminal justice system. PLL 's integration of group sessions and family therapy is designed to help families apply skills and concepts to real-life situations and prevent relapse."	CEBC	2009
Outcomes	• Child behaviour • Safety and physical wellbeing • Family relationships • Child development		
Population	"Children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, and attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation. The program also has been used with teenagers with less extreme behaviors."	CEBC	2009
Setting	Parenting with Love and Limits (PLL) was designed to be conducted in a group setting. Recommended group size: 6 to 8 adolescents and their families per group	CEBC	2009
Dose	"Recommended intensity: 2-hour weekly group sessions with 1 hour of parents and teens meeting together and 1 hour of the parents and teens meeting separately, and 1-2 hour weekly family sessions, as needed. Recommended duration: 6 weeks for group sessions, and 4-20 sessions for family sessions."		
Evidence rating	Not able to be rated	CEBC	2009
	Exemplary	OJJDP	Not indicated
	2.9 - for conduct disorder 2.3 - for readiness for change and parent-teen communication 2.2 - for youth attitudes and behaviour 2.7 - for self-perception of substance abuse	SAMHSA	2008
	Other reviewed Programs	PPN	Not indicated
Used in Australia	Yes		

Parents as Tender Healers (PATH)		Source	Year
Program description	"PATH is a 10-week curriculum developed to train prospective foster parents. Sessions are intended to help parents decide whether fostering or adoption is appropriate for them. Sessions address: • How resource families differ from birth families. • How and why children in the welfare system develop survival behaviors. • The different roles of birth, legal, and caregiving parents. • Characteristics of successful resource families. • The types of abuse and neglect experienced within the child welfare system, survival behaviors developed, and the emotional issues underlying these behaviors. • The impact of separation and trauma on children, and the importance of emotional attachment. • Understanding issues faced by children in transition, and identifying existing and future family strengths and support. • Tools and techniques to help children develop attachment. • Disciplinary techniques for children who have experienced trauma. The final session consists of a panel discussion with experienced Resource parents and children."	CEBC	2011
Outcomes	• Child behaviour • Safety and physical wellbeing • Family relationships • Child development • Parent-child relationship		
Population	Prospective foster parents	CEBC	2011
Evidence rating	Not able to be rated		
Used in Australia	Information unavailable		

Parents Engagement and Self-Advocacy (PESA)		Source	Year
Program description	"PESA is an adaptation of Columbia University's Parent Empowerment Program (PEP) and the Building a Better Future Program developed by Sandra Jimenez and Naomi Weinstein as a Family-to-Family Initiative of the Annie E. Casey Foundation. PESA helps birth parents, foster parents, and caseworkers work together to address the mental health needs of youth in foster care."	CEBC	2010
Outcomes	• Child behaviour		
Population	"Birth parents, foster parents, and caseworkers of children aged 10-17 who are in foster care and candidates for reunification."	CEBC	2010
Setting	Community agency. Parent Engagement and Self-Advocacy (PESA) was designed to be conducted in a group setting. Recommended group size: 12-15	CEBC	2010
Dose	"Recommended intensity: One session per week of 2-3 hours. Recommended duration: 5-6 weeks."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

Positive Discipline		Source	Year
Program description	"Based on the work of Alfred Adler and Rudolf Dreikurs, Positive Discipline promotes an internal locus of control, self-regulation, understanding others' perspectives, and the desire to contribute in meaningful ways to the community. The model can be categorized as a form of "authoritative" parenting – one which promotes strong parent to child connection, as well as clear boundaries/limits. Positive Discipline is taught in groups using an experiential model. Participants engage with the material through role play and activities that invite them to connect the new material with their current life. The model also gives parents/care-givers the opportunity to practice new skills within the safe environment of the class."	CEBC	2011
Outcomes	• Parent-child relationship • Child behaviour		
Population	"Parents of children who are typically developing (infants through teens) and teachers of children (toddlers through teens) who are typically-developing. Parents, teachers, and service providers of children with special needs (infants through teens), including children with disorders of attachment, children on the autism spectrum and children exposed to trauma."	CEBC	2011
Setting	"This program is typically conducted in a(n): Community Agency; Residential Treatment Center; School. Positive Discipline was designed to be conducted in a group setting. Recommended class size is 15-25, but classes are sometimes up to 40 adults. Large groups of 100-300 are usually one time introductory presentations or workshops. Experiential exercises can be utilised even in large group settings."	CEBC	2011
Dose	"Recommended intensity: Weekly classes of 1.5-2 hours. Recommended duration: 7-10 weeks (14 or more total hours recommended)."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Project 12-ways		Source	Year
Program description	"Project 12-ways is a comprehensive program aimed at preventing child abuse and neglect. Families are referred to the program through the Illinois Department of Child Abuse and Neglect. Participating families receive training in parent-child interaction, structuring daily routines, health maintenance and nutrition, stress reduction, home safety and cleanliness, infant care and development, teaching basic childhood skills, problem solving, and money management. Parents also receive self-esteem and assertiveness training in resolving conflicts in a positive way. Assistance in obtaining employment and access to community services is also provided. Project 12-ways is the precursor to SafeCare, which is also listed under this topic area."	CEBC	2011
Outcomes	• Safety and physical wellbeing • Parent-child relationship • Basic child care • Family relationships • Child development		
Population	Families at risk of child abuse and neglect	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Project Fatherhood		Source	Year
Program description	"Project Fatherhood has fathers meet in a group setting. There the fathers discuss day-to-day issues involved with parenting their children. The members of the group can only relate to each other in a positive supportive manner. A children's group and a significant others' group also meet and do activities at the same time as the fathers' group. The goal of Project Fatherhood is to help fathers parent their children in a manner that helps them develop a trusting supportive relationship."	CEBC	2011
Outcomes	• Parent-child relationship • Family relationships		
Population	Fathers, significant others, and at-risk children	CEBC	2011
Setting	This program is typically conducted in a(n):Community Agency; Religious Organisation; or School	CEBC	2011
Dose	"Recommended intensity: 90-minute weekly sessions. Recommended duration: Open-ended, 6-10 months."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

Shared Family Care (SFC)		Source	Year
Program description	"SFC is an innovative approach to helping families achieve permanency for their children and move toward self-sufficiency. Unlike traditional child welfare services, SFC involves the placement of a parent (usually the mother) and at least one young child in the homes of community members who mentor the families and help them to obtain the skills and resources they need to achieve these goals. The families are given comprehensive services to meet their needs and increase their social and life skills, as well as connect them to community supports for ongoing/future relationships. The overall mission of SFC is to protect children by offering services to parents and children together in a safe and supportive family setting. This setting helps either to preserve families or to facilitate the transition to other permanent arrangements."	CEBC	2011
Outcomes	• Family relationships • Safety and physical wellbeing		
Population	"Families with an infant or young child in the child welfare system who are at risk of having their children removed or who are in the process of reunifying with them. The program targets parents who have custody of at least one infant or very young child and may have just completed a residential alcohol or drug treatment program or are actively participating in an outpatient program, or have a high risk of substance abuse relapse, as well as a potential for homelessness and child removal. Most children have open child welfare cases. However, this is not an eligibility criterion."	CEBC	2011
Setting	Not specified	CEBC	2011
Dose	"Recommended intensity: By design, the family receiving help is placed in the home of a trained mentor family who is available for support 24 hours a day. During the first month of placement, intensive services are provided as follows: • Case manager: 2 home visits each week • Trainer: 2 home visits in the month • Drug/Alcohol counsellor: 1 home visit each week in the first month • Housing specialist: 2 home visits in the month. After the first month and for the duration of the placement: • Case manager: 1 home visit each week • Trainer: 2 home visits each month • Drug/Alcohol counsellor: 2 home visits each month • Housing specialist: 2 or more home visits as needed. In the event of an emergency, services are available as needed. Recommended duration: The recommended placement duration is 6 months in the mentor home. Optional aftercare services are available up to 6 months after placement is over. The average length of each contact/home visit is 1-hour minimum; but depending on the services rendered the visit may last up to five hours."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

SPIN Video Home Training (SPIN VHT)		Source	Year
Program description	"SPIN VHT is a home visiting program that targets the relational skills of abusive/neglectful/at-risk parents. It can operate as a stand-alone program, or be integrated into existing parent education/support programs. The model is informed by attachment theory, theories of primary intersubjectivity, learning theory, and adult learning principles. SPIN VHT was developed in the Netherlands in the early 1980s and disseminated across that country with ten years of government funding. SPIN Institutes, located in approximately ten countries in Europe, Eastern Europe, the Middle East, and North America, including the US, oversee the model's fidelity and development. SPIN VHT practitioners videotape parent-child interactions and offer strengths-based self-modeling feedback using carefully edited video samples of parents' successful interactions with their children. Interactions are analyzed, and feedback plans are designed, using a process that focuses on creating sustained patterns of successful interactions to improve relational skills and meet goals jointly developed by parent and practitioner within the context of broader program goals."	CEBC	2009
Outcomes	• Safety and physical wellbeing • Parent-child relationship		
Population	At-risk children and families, families in conflict, foster parents/children, and adoptive families.	CEBC	2009
Setting	This program is typically conducted in a(n): Adoptive Home; Birth Family Home; Community Agency; Foster Home; Outpatient Clinic; or Residential Care Facility	CEBC	2009
Dose	"Recommended intensity: Minimum is one hour per week. Can be more often if program into which model is integrated requires more frequent contact. Recommended duration: Average, 20-30 weeks (approximately 6 months). Partially determined by program into which the model is implemented."	CEBC	2009
Evidence rating	Not able to be rated	CEBC	2009
Used in Australia	Information unavailable		

Steps to Effective Enjoyable Parenting (STEEP)		Source	Year
Program description	"Developed in 1986 by Drs. Byron Egeland and Martha Farrell Erickson, STEEP works on the premise that a secure attachment between parent and infant establishes ongoing patterns of healthy interactions. Through home visits and group sessions, STEEP facilitators work alongside parents to help them understand their child's development. Parents learn to respond sensitively and predictably to their child's needs and to make decisions that ensure a safe and supportive environment for the whole family. Specific topics and strategies included in training: • Making relationship-based practice real, from recruitment to termination. • Using videotaping and guided viewing to promote understanding, sensitivity, and responsiveness. • Planning and leading parent-infant groups. • Challenging and supporting parents in examining how their own relationship history influences attitudes and parenting behavior. • Using an ecological approach to help reduce risk and maximize parents' support for themselves and their children. • Using reflective supervision or consultation to sustain service providers and ensure effective service."	CEBC	2011
Outcomes	• Parent-child relationship • Child development • Safety and physical wellbeing		
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Yes		

Strengthening Families through Early Care and Education		Source	Year
Program description	"The Strengthening Families initiative is a research-based, cost-effective strategy to prevent child abuse and neglect by strengthening and supporting families. This initiative, which has been implemented in over 30 states, helps early childhood centers work with families to build five protective factors shown by research to correlate with child abuse and neglect prevention: Parental resilience, parental social connections, parental knowledge of parenting and child development, concrete parental support in times of need, and healthy social and emotional child development."	CEBC	2010
Outcomes	• Safety and physical wellbeing • Child development • Family relationships		
Population	All families with young children; families under stress	CEBC	2010
Setting	Not specified	CEBC	2010
Dose	"Recommended intensity: Almost daily contact with parents and young children through their early care and education providers. Recommended duration: The model is based on the long-term engagement that families have with their child's early care and education provider. Surveys should only be administered to parents whose children have been participating in one of the programs for over six months."	CEBC	2010
Evidence rating	Not able to be rated	CEBC	2010
Used in Australia	Information unavailable		

The FATHER (Fostering Actions to Help Earnings and Responsibility) Project		Source	Year
Program description	"The FATHER Project aims to empower fathers to overcome the barriers that prevent them from supporting their children economically and emotionally. It is designed to be a "one-stop shop," connecting low-income fathers with all the services they need in one location. The FATHER Project has developed a model for bringing together parenting education, child support, GED education, employment services, legal services, and early childhood education under one roof. In addition to fathers, mothers and children also actively participate in FATHER Project services. The model has been used with diverse populations, leveraging the expertise of culturally-specific organisations in implementing the holistic approach. The ultimate long-term impact of the program involves service recipients hopefully progressing to become community leaders through intensive engagement in one of three 'Leadership Track' options after key program goals have been accomplished."	CEBC	2011
Outcomes	• Family relationships • Safety and physical wellbeing • Child development • Parent-child relationship		
Population	Low-income fathers, primarily non-custodial	CEBC	2011
Setting	Birth family home or community agency. The FATHER (Fostering Actions To Help Earnings and Responsibility) Project was designed to be conducted in a group setting. Recommended group size: 10-20 group members.	CEBC	2011
Dose	"Recommended intensity: There are multiple forms of contact and program delivery, and the program is customised for each participant. The following are average contact times for different program components: • Parenting Class: 4 sessions per month, 2 hours per session (8 hours per month) • Case Management: Twice per month, 1 hour per meeting • Job Club: Weekly, 2 hour for participants seeking employment, individual meetings based on need • Child Support: 1 hour orientation for all, individual meetings (45 minutes) based on need • GED: depends on need, ranges from 4-15 hours per week • Interactive Skill-Building Parenting Class (early childhood development focus): 4 sessions per month, 2 hours per session • Home Visiting (early childhood, school readiness focus): 2 hours per months, from 6-12 months • Family Law: 1 hour orientation for all, individual meetings, consultations, up to and including full representation (much more time intensive) based on need. Recommended duration: 1 year for the typical participant, with options for continued leadership development and service after that year."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Information unavailable		

The Happiest Baby (THB)		Source	Year
Program description	"The Happiest Baby (THB) explains that the current culture's conceptualization of the first three months of life is flawed. In many ways, newborns are not fully ready for the world at birth, they still need a protected environment filled with rhythmic, monotonous, entrancing stimulation ... a fourth trimester. It teaches five simple methods of activating the "calming reflex" by imitating the uterine sensory milieu - the "5 S's" - Swaddle, Sidestomach position, Shush, Swing, Suck. Laboratory research has demonstrated that elements of this program, including swaddling, sound, and movement, improve the quality of sleep and promote greater arousability, which may protect against Sudden Infant Death Syndrome (SIDS). This program promotes good parent-infant bonding and aims to assist in the prevention of a number of severe and life-threatening consequences of infant crying. These consequences are marital stress, Shaken Baby Syndrome (SBS), Post-Partum Depression (PPD), Sudden Infant Death Syndrome (SIDS), excessive use of Emergency Room/physician time, overly aggressive medical evaluation and treatment for Gastroesophageal Reflux Disease (GERD), and perhaps even in the prevention of obesity."	CEBC	2011
Outcomes	• Parent-child relationship • Child behaviour • Safety and physical wellbeing		
Population	New parents, grandparents, teachers and healthcare professionals	CEBC	2011
Setting	This program is typically conducted in a(n):Adoptive Home; Birth Family Home; Community Agency; Group Home; Hospital; Outpatient Clinic; Residential Care Facility; or School The Happiest Baby (THB) was designed to be conducted in a group setting. Recommended group size: 1-6 couples.	CEBC	2011
Dose	"Recommended intensity: A single 90-minute class prenatally; may offer a follow-up postnatal class (or just postnatally if the population cannot be captured prenatally). The program is designed so that all participants receive two parenting tools (an educational DVD and a CD of white noise). For high-risk patients, there should be 90-minute home visits and/or telephone follow-ups. Recommended duration: One class for most new parents. A home visit and follow-up phone calls at one week, 3-4 weeks, and 6-8 weeks post-partum for high-risk parents."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Yes		

24/7 Dad		Source	Year
Program description	"24/7 Dad™ is a unique set of programs designed to equip fathers with the self-awareness, compassion, and sense of responsibility that every good parent needs. It focuses on building the man first and the father second. It is available in both a basic and a more in-depth version: • 24/7 Dad™ A.M., the basic version, is for first-time dads, or for fathers lacking vital skills, knowledge, and attitudes. • 24/7 Dad™ P.M includes more in-depth information for more experienced fathers, or for dads who have completed the A.M. program. The philosophy behind the programs supports the growth and development of fathers and children as caring and compassionate people who treat themselves, others, and the environment with respect and dignity. This philosophical basis of caring and compassion forms the underlying structure that constitutes the values that are taught in the programs. The goals of the 24/7 Dad™ programs are emphasised in each session. They are to increase: • Awareness among fathers about the elements to being good fathers • Knowledge among fathers about the elements to being good fathers • Capacity or skills to carry out what the fathers learn. These will include better skills in caring for children and building relationships with the mother of their children. Each program includes an evaluation tool (questionnaire) that allows facilitators to measure changes in fathers as a result of participating in the programs."	CEBC	2011
Outcomes	• Basic child care • Parent-child relationship		
Population	Fathers with children age 18 or younger. It is designed for custodial and non-custodial fathers with instructions on how to deliver it most effectively to non-custodial and unemployed and underemployed fathers	CEBC	2011
Setting	This program is typically conducted in a(n):Community Agency; Departments of Social Service; Outpatient Clinic; Religious Organisation; Residential Care Facility; School; or Workplace	CEBC	2011
Dose	"Recommended intensity: Weekly 2-hour sessions; may be delivered in a shorter duration depending on the audience (e.g., 2 sessions per week for a total of 4 hours). Recommended duration: 12 weeks for both A.M. and P.M. programs; may be delivered in a shorter duration depending on the audience (e.g., 6 weeks with 2 sessions per week)."	CEBC	2011
Evidence rating	Not able to be rated	CEBC	2011
Used in Australia	Yes		

Health Care Program for First-Time Adolescent Mothers and their Infants		Source	Year
Program description	"During regularly- scheduled well-baby health check-ups, teen mothers received additional services, including (i) counselling on birth control methods and referral to a birth control clinic, if appropriate, and (ii) one-on-one education in basic parenting and child health (e.g., how to feed and hold a baby, how to take their temperature) and how to manage minor health problems not requiring emergency care (e.g., runny noses, diaper rash, etc.). After any missed appointment, mothers received regular reminder letters and phone calls for up to eight weeks."	SPW	2011
Outcomes	• Basic child care	SPW	2011
Population	Teen mothers	SPW	2011
Setting	Children's Hospital	SPW	2011
Evidence rating	Not rating	SPW	2011
Used in Australia	Information unavailable		

Recovery Coaches		Source	Year
Program description	"The Recovery Coach works with the parent, child welfare caseworker and substance-abuse treatment agencies to (i) remove barriers to treatment, (ii) engage the parent in treatment, (iii) provide outreach to re-engage the parent if necessary, and (iv) provide ongoing support to the parent and family through the duration of the child welfare case. "	SPW	2012
Outcomes	• Safety and physical wellbeing • Family relationships	SPW	2012
Population	Parents who have temporarily lost custody of their children to the state, and are suspected substance abuses	SPW	2012
Evidence rating	Not rating	SPW	2012
Used in Australia	Information unavailable		

Appendix 5. REA data extraction template

Program name: _____ Record IDs: _____

Rater: _____ Program effectiveness rating: _____

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
						Number of sessions: Duration of sessions: Frequency of sessions: Total duration of program:	Parents (n =): Description: Sex: Age: Children (n =): Description: Sex: Age:	Parents (n =) Description: Sex: Age: Children (n =): Description: Sex: Age:	Statistically significant: Maintenance of effect: Non-significant: Descriptive:

Appendix 6. REA program rating checklist template

Evidence of effectiveness criteria		Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
1.	No evidence of risk or harm	☐	☐	☐	☐	☐	
2.	If there have been multiple studies, the overall evidence supports the benefit of the program	☐	☐	☐			
3.	Clear baseline and post measurement of outcomes for both conditions	☐	☐	☐			
4.	At least **two** RCTs have found the program to be significantly more effective than comparison group. Effect was maintained for at least **one** study at **1 year** follow-up.	☐					
5.	At least **one** RCT has found the program to be significantly more effective than comparison group. Effect was maintained at **6 month** follow-up.		☐				
6.	At least one study using some form of contemporary comparison group demonstrated some improvement outcomes for the intervention but not the comparison group			☐			

Evidence of effectiveness criteria		Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
7.	There is insufficient evidence demonstrating the program's effect on outcomes because: a) the designs are not sufficiently rigorous (criteria 1-6) OR b) the results of rigorous studies are not yet available				☐		
8.	Two or more RCTs have found no effect compared to usual care OR the overall weight of the evidence does not support the benefit of the program					☐	
9.	There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect on participants						☐

Appendix 7. Summary of evidence of the effectiveness of each program identified in the REA

FSP evaluations highlighted in orange

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Well Supported					
Stepping Stones Triple P	Child behaviour Child development Parent-child relationship	Children with a disability and behaviour problems, typically aged between 2 and 12 years	To treat specific problems of children with a disability, aiming to improve social behaviour and increase language, as well as to decrease inappropriate behaviours	Australian evidence exists for several modes of delivery to this population with these outcomes: Group Stepping Stones Triple P - five sessions for groups of parents, plus four sessions for individual parents Standard Triple P - ten sessions for individual parents Enhanced Triple P - 16 sessions for individual parents	Not specifically, but general Triple P was Well Supported
Triple P	Child Behaviour Parent-child relationship Family relationships Child development	Children with behavioural concerns, typically aged between 2 and 12 years	Aims vary slightly according to program level In general, the aim is to increase parents' competence and confidence, to reduce disruptive child behaviour problems and help practitioners to deal more effectively with requests for assistance with behaviour management	Australian evidence suggests that the following modes of delivery are **Well Supported**: Standard Triple P - eight to ten sessions for individual parents Self-directed Triple P – ten home-based sessions for individual families Enhanced Triple P – twelve sessions for individual parents or eight group sessions plus four telephone sessions The evidence suggests that the following modalities are **Supported**: Telephone Assisted Triple P – ten telephone-based sessions with individual parents	Yes - Well Supported

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Supported					
Triple P (continued)				Primary Care Triple P (provided by primary care professionals) – 3-4 sessions for individual parents in a primary care setting The evidence suggests that the following modalities are **Emerging**: Group Triple P – four sessions with groups of parents and four telephone sessions with individual parents or eight sessions with groups of families. Also available is Enhanced Group Triple P which includes an additional two group sessions.	
Couple CARE for Parents (CCP)	Basic child care Family relationships	Women in committed relationships in their 20th – 35th week of their first pregnancy. Singleton pregnancy.	To promote positive couple adjustment to parenthood	One session for groups of parents based at a university psychology clinic, plus five home-based sessions for individual parents	No
Gifted and Talented Triple P	Parent-child relationship Child behaviour Family relationships	Gifted children aged up to 10 years, with behavioural concerns	To improve parenting styles, child behavioural and emotional problems and family adjustment	Five sessions for groups of parents and three telephone sessions for individual parents	Not specifically, but general Triple P was Well Supported
Group Lifestyle Triple P	Safety and physical wellbeing Child behaviour	Overweight or obese children	To reduce children's risk of chronic weight problems by increasing parents' skills and confidence in managing children's weight-related behaviour	Nine sessions for groups of parents at a psychology clinic and primary school, plus three telephone sessions	Not specifically, but general Triple P was Well Supported

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Hassle-free Shopping (brief parent group discussion based on Triple P)	Child behaviour Parent-child relationship	Children showing behaviour problems during shopping trips	To prevent behaviour problems during shopping trips and in other settings	One session for groups of parents	No
Supported					
Hendrie & Golley (2011)	Safety and physical wellbeing	Healthy children (4-13 years of age) who are regular-fat dairy consumers	To improve dietary intakes and health outcomes of changing dairy foods consumed by children from regular to reduced fat varieties	Three clinic-based sessions for groups of parents	No
Indigenous Group Triple P	Parent-child relationship Child behaviour Child development	Indigenous families where the primary caregiver had concerns about their child's behaviour or their own parenting skills	To promote positive, caring relationships between parents and their children and to help parents develop effective management strategies for dealing with a variety of common behaviour problems and developmental issues	Six sessions for groups of parents and two home-based sessions for individual parents	Not specifically, but general Triple P was Well Supported
Intensive Lifestyle Education, plus Triple P	Child behaviour Parent-child relationship Safety and physical wellbeing	Overweight 6-9 year old prepubertal children	To promote parental competence to manage their child's behaviour	Group Triple P (four group sessions for parents at a hospital, plus four individual telephone sessions), plus seven hospital-based sessions for groups of parents	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Khan, O'Meara, Stevermuer & Henry (2004)	Safety and physical wellbeing	Children with asthma	To improve the skills of parents to recognise and avoid triggers, to use written asthma action plans and medication at the time of crisis, and to seek help appropriately	One telephone session with individual parents	No
Supported					
Kennedy, Rapee, & Edwards (2009)	Child behaviour	Children with behavioural inhibition and parents with anxiety	To teach parents to reduce their child's anxiety using strategies such as graded exposure, contingency management, parent training and parent anxiety management	Eight sessions for groups of parents, plus one telephone session for individual parents	No
Morawska, Haslam, Milne and Sanders (2011) - brief parent group discussion based on Triple P	Child behaviour Parent-child relationship Family relationships	Parents concerned by their child's disobedience	To increase parents' skills in promoting social, emotional, behaviour competence in children; reduce parents' use of coercive and punitive methods of discipline; improve communication about parenting; reduce parental stress	One session for groups of parents and one telephone call to individual parents	No
NOURISH	Safety and physical wellbeing	First time mothers with healthy term infants	To reduce childhood obesity risk	Twelve sessions with groups of parents at child health centres	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Parent-child interaction therapy (PCIT)	Child behaviour Parent-child relationship	Preschool children with disruptive behaviours	To improve child-parent relationships and provide parents with skills to manage disruptive behaviour	Up to 12 sessions with individual parents in clinics	Yes - Well Supported
Supported					
Parenting Preschools Programme	Child behaviour Child development Parent-child relationship	Preschool children	To improve child prereading skills and parent behaviour management skills	Combination of sessions for groups of children at preschools and schools, as well as group sessions for parents at preschools and schools and individual parent sessions conducted at preschools and via telephone	No
Parents Under Pressure	Parent-child relationship Family relationships Safety and physical wellbeing Child behaviour	Parents on methadone maintenance or involved in criminal justice system	Targets multiple domains of family functioning including the psychological functioning of individuals in the family, parent-child relationships and social contextual factors	Ten home-based sessions for individual families	No
Parent Education and Behavior Management (PEBM)	Child behaviour	Children with autism	To improve the mental health and adjustment of parents with preschool children recently diagnoses with autistic disorder	Ten sessions for groups of families and ten sessions for individual families	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
PRAISE parenting program (also called DIET) as part of Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS) study	Safety and physical wellbeing	Overweight or obese children	To improve dietary intakes and food behaviour of overweight and obese children	Ten community-based sessions with groups of parents, plus three telephone sessions with individual parents	No
Supported					
Rapee, Kennedy, Ingram, Edwards, & Sweeney (2005); Rapee, Kennedy, Ingram, Edwards & Sweeney (2010)	Child behaviour	Children with a high number of withdrawn/inhibited behaviours aged 36-62 months	To prevent the development of anxiety in preschool children	Six sessions for groups of parents	No
Resilient families intervention	Child behaviour Parent-child relationship Family relationships	Year 7 students	To improve parental metal health and family functioning and prevent adolescent substance abuse	Combination of groups sessions for children and one session for groups of children, plus eight sessions for groups of parents	No
Teen Triple P	Child behaviour Parent-child relationship Family relationships Child development	Children aged 12-13 years from a high school serving a low socio-economic area	Addresses issues that might lead to severe adolescent antisocial behaviour. Teen Triple P targets parenting risk factors such as: harsh, coercive discipline styles; parent-teenager conflict and communication difficulties; parental monitoring of teenagers' activities; parental	Australian evidence indicates that this mode of delivery is **Supported**: Group Teen Triple P - Four sessions for groups of parents in a community setting plus four telephone sessions for individual parents Evidence for the following modes is not Supported, only **Promising** at this stage: Self-directed Teen Triple P Standard – ten sessions for individual	Not specifically, but general Triple P was Well Supported

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			depression; and marital conflict	parents Self-directed Teen Triple P Enhanced – ten sessions for individual parents, plus ten telephone sessions	
Tuning in to Kids: Emotionally Intelligent Parenting	Child behaviour Parent-child relationship	Children attending preschools in lower to middle class areas	To assist parents in teaching their preschool children some basic skills in understanding and regulating emotions	Six to eight sessions at community locations with groups of parents	No
Supported					
Universal Triple P	Child behaviour Parent-child relationship	Any parent and child	To reduce or prevent child behaviour problems	This modality was found to be **Supported** in a transition to school project. It involved population-based media campaigns at schools, targeting child behaviour but was not specifically for children with behavioural problems. This was delivered in conjunction with Group Triple P to a subset of the sample. A further large scale population-based study evaluated the implementation of all 5 Levels of Triple P, including Level 1 (Universal) in conjunction with the other Triple P modalities.	Yes - Well Supported
Universal Triple P (continued)				Evidence for this approach is **Promising** at this stage.	
Van Bergen, Salmon, Dadds, & Allen (2009)	Parent-child relationship	Not indicated	To train parents in elaborative, emotion-rich reminiscing to increase children's autobiographical memory and emotion knowledge	Four session for individual mother-child dyads in a university setting	No
Workplace Triple P	Family relationships	Working parents with children ranging in age from 1-16 years	Targets difficult areas for working parents and involves	Four sessions for groups of parents and four individual telephone	Not specifically, but general Triple P was

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
	Parent-child relationship	and having difficulties balancing family and work commitments	helping parents manage stress and improve coping skills, as they both relate to work and family situations as well as specific strategies for dealing with key transition times such as getting ready for work and arrival home from work	sessions	Well Supported
Supported					
1-2-3 Magic	Child behaviour Parent-child relationship	Child aged 2-12 years with behavioural concerns	To target , manage and reduce undesirable behaviour in children aged 2-12 years	Two-three sessions for groups of parents in a community setting	Yes - Supported
Promising					
ABCD Parenting Young Adolescents Program	Child behaviour Parent-child relationship Child development	Custodial or non-custodial parents with regular access to their adolescent aged 10 -14 years	To provide parents with information and skills for developing and maintaining trusting, positive and accepting relationships with their young adolescents which, in turn, encourages them to test their independence within safe boundaries and make the transition to adolescence	Six sessions with groups of parents in community settings	No
AusParenting in Schools Transition to Primary	Child development Child behaviour	Children about to start school	To enhance parents' knowledge and confidence in their ability to help their child	Four sessions for groups of parents at school	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
School Parent Program			make a smooth transition and mange any difficulties that may arise at this time		
Bustos, Jaaniste, Salmon & Champion (2008)	Child development	Parents of infants aged 5 – 7 months due for immunisation	To teach parents to engage in behaviours likely to result in favourable infant pain outcomes	Information sheet and contact in the home	No
Promising					
Cottage Community Care Pilot Project (CCCPP)	Safety and physical wellbeing Child development Family relationships Parent-child relationship	Vulnerable parents	The CCCPP was designed to directly address factors in first-time families that are associated with child maltreatment: lack of parenting skills, little or no knowledge about child development, the isolation many new families experience due to loss or absence of extended family support, single parent status and the inability or reluctance of some new families to access available community supports and resources	Twenty-four sessions in the home for individual parents plus eight months of sessions in a community setting for groups of parents	No
Grillo, Ng, Gassner, Marshman, Dunn, Hudson & Ng (2006)	Safety and physical wellbeing	Children with atopic eczema	To educate parents and paediatric patients about atopic eczema (AE)	Two hospital-based sessions	No
Group Triple P	Family relationships	Families with Japanese parents	Targets coercive family	Five sessions for groups of families, plus three telephone sessions	Not specifically, but

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
(Japanese population)	Child behaviour Parent-child relationship Child development	living in Australia whose children were aged 2-10 years	interactions known to contribute to the development and maintenance of children's disruptive behaviour problems.	for individual families	general Triple P was Well Supported
Promising					
Having a Baby	Basic child care Child development Family relationships	Pregnant women	To increase confidence and competence of women with a new baby in the early weeks and therefore enhance parenting self-efficacy	Eight sessions to groups of parents in hospital	No
Home Interaction Program For Parents and Youngsters (HIPPY)	Family relationships Parent-child relationship	Preschool children who are developmentally vulnerable due to disadvantage or social exclusion	To improve interaction between parents and their children, foster a love of learning in children , promote	Home-based sessions for individual parents plus sessions for groups of parents	No
Home Interaction Program For Parents and Youngsters (HIPPY) (continued)	Child development Child behaviour		cognitive and social development and enhance school readiness, increase parents' confidence and skills as their child's first teacher, increase participation in kindergarten, school and community life		

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Home Learning Program (HLP)	Safety and physical wellbeing Child development	Parents with intellectual disability and a child under 5 years	Targeted to parents with intellectual disability to promote child health and home safety in the preschool years	Ten home-based sessions for individual parents	No
Promising					
The Miller Early Childhood Sustained Home-Visiting (MECSH) Programme	Parent-child relationship Child behaviour Child development Safety and physical wellbeing	At risk mothers in SES disadvantaged areas	To improve transition to parenting, improve maternal health and wellbeing, improve child health and development, develop and promote parents aspirations for themselves and their children, improve family and social relationships and networks	16 home-based sessions for individual parents	No
Mother & Baby Program (M&B)	Family relationships	New mothers	To improve the psychological health outcomes of postnatal women	Nine hospital-based sessions for groups of parents	No
Parenting Adolescents: A Creative Experience	Safety and physical wellbeing	Eighth grade students	To reduce adolescent risk factors implicated in youth	Seven school or community-based sessions with groups of parents	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
(PACE)	Child behaviour		suicide		
Parenting Wisely	Child behaviour	Not indicated	To increase parental sense of competence and reduce child behaviour problems	One to three clinic sessions with individual parents or with groups of parents	Yes - Promising
Promising					
Pathways Triple P	Parent-child relationship Child development Child behaviour	Parents with borderline to clinically significant relationship disturbance and child emotional and behavioural problems	To promote positive parent-child relationships	Nine sessions for groups of parents	Not specifically, but general Triple P was Well Supported
PremieStart Parent Sensitivity Training Program	Safety and physical wellbeing Child development	Parents of premature infants (<30 weeks gestation)	To reduce parent's stressful experiences	Nine sessions for individual parents in NICU and one session for individual parents at home	No
Preparation for Parenthood, with additional postpartum session	Family relationships	First-time parents	To 1) increase the couple's understanding of each other's concerns, especially postpartum concerns; 2) to enable the couples to identify helpful and unhelpful behaviours if either found new parenthood stressful; 3) to provide participants with strategies other couples have	Seven hospital-based sessions for groups of parents, plus mails outs to the home	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			found helpful when parenthood has been stressful' 4) to normalise any feelings of stress, isolation or lack of confidence that may be experienced postpartum		
Promising					
Queen Elizabeth Centre's Day Stay Program	Family relationships Child behaviour	Mothers experiencing difficulties managing their infants or toddlers	To improve infant and toddler care and reduce parental distress	One session for individual parent-child dyads and groups of parent-child dyads at an early parenting centre	No
Quinlivan, Box, Evans (2003)	Child development Safety and physical wellbeing Basic child care Family relationships	Teenage mothers	To reduce the frequency of adverse neonatal outcomes and increase knowledge of contraception, breastfeeding and vaccination schedules in teenage mothers younger than 18 years	Five home-based session for individual parents	No
Reach for Resilience	Child behaviour	Preschool children	To prevent anxiety and other mental health problems in children	Six sessions for groups of parents held at preschools	No
Rapee, Abbott & Lyneham (2006)	Child behaviour	Children with anxiety disorder	To reduce anxiety in children by using parent-delivered bibliotherapy	Home-based program running for a total of 3 months	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Salmon, Dadds, Allen & Hawes (2009)	Parent-child relationship Child behaviour	Children exhibiting oppositional behaviour	To provide parent management training (PMT) and elaborative, emotion-rich reminiscing (ER) to parents of children with oppositional behaviours	Six sessions with individual parent-child dyads	No
Promising					
Shelton, LeGros, Norton, Stanton-Cook, Morgan & Masterman (2007)	Child development Parent-child relationship	Overweight or obese children	To reduce body mass index (BMI), caloric consumption, reduce time engaged with sedentary electronic media, increase time in physical activity and decrease waist circumference in children	Four sessions for groups of parents in a community centre	No
Signposts	Child behaviour	Children with an intellectual disability	To help parents manage difficult behaviour of their child with an intellectual disability	Groups, telephone, individual or self-directed options with six fortnightly sessions. Some better evidence for group option	No
Sofronoff & Farbotko (2002); Sofronoff, Leslie & Brown (2004)	Parent-child relationship Child behaviour	Children with Asperger's syndrome	To improve parental self-efficacy in the management of problem behaviours associated with Asperger's syndrome using Parent Management Training	One session for groups of parents at a university or six sessions for individual parents	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Tuned in Parenting	Parent-child relationship Basic child care	Mothers seeking treatment for their child's sleeping, crying or feeding	To improve parent-infant/child relationships especially where thechild exhibits functional regulatory disturbances	Nine sessions for groups of parents	No
Your Defiant Child	Child behaviour	Children aged 2-12 years with disruptive behaviour, attention-deficit hyperactivity and learning difficulties	To improve child behavioural problems	Self-help book plus option to call primary care provider. Followed up with weekly or fortnightly calls for 12 weeks	No
Emerging					
The African Migrant Parenting Program	Child development Parent-child relationship Child behaviour Family relationships	African migrant and refugee parents living in Melbourne	To enhance both effective parenting and relationship skills, in order to help parents to raise their children confidently and understand their children's needs throughout various developmental stages in the new cultural, social and educational environments	Eight sessions for individual parents in a community setting and three home-based sessions for individual parents	No
The Australian Supported Learning Program – Me and My Community (ASLP)	Family relationships	Mothers with learning difficulties	Designed to strengthen the social relationships and improve the psychological wellbeing of mothers with learning difficulties	8 - 10 community-based groups sessions with parents, plus 12 home-based sessions with individual parents	No
Beatty, Cross & Shaw (2008)	Parent-child relationship	Parents of preadolescent children	To increase parent-child communication regarding alcohol, tobacco and other	Five rounds for individual parents in the home	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			drug (ATOD) use		
The BEST Plus Program	Child behaviour	Families in which one child displays problematic behaviour including abusing alcohol and using drugs, such as cannabis, amphetamines and ecstasy	To reduce adolescent problem behaviours	Four sessions with groups of parents and four sessions with groups of families	No
Emerging					
The BEST Plus Program	Child behaviour	Families in which one child displays problematic behaviour including abusing alcohol and using drugs, such as cannabis, amphetamines and ecstasy	To reduce adolescent problem behaviours	Four sessions with groups of parents and four sessions with groups of families	No
Better Beginnings	Child development Parent-child relationship	Parents with children aged 6-8 weeks	To provide positive language and literacy influences for young children through encouraging parents to read to their new-born baby	One community health clinical session to individual parents and library-based sessions for groups of parents and children.	No
The Boomerangs Aboriginal Circle of Security Parenting Camp Program	Parent-child relationship Child development	Indigenous parents	To teach parents attachment theory, to improve parents' skills in identifying parent/child interactions, to enhance parent sensitivity, to explore parents strengths and under developed capacities in the parent, to build on	Two sessions with individual parent-child dyads at a mental health service. Plus 20 sessions including two camps at a Aboriginal Women's Centre an a local camp site	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			parent's strengths, to reflect on trauma		
Bringing Up Great Kids Program	Parent-child relationship Child development	Parents of Nixon Street Primary School children	To increase parenting skills, examine how parents communicate with their children and generational influences on parenting	Five sessions with groups of parents	No
Emerging					
Building Blocks	Child development Family relationships Child behaviour	Children aged between 2.5-3.5 years with Autistic Disorder, Asperger's Disorder or Pervasive Developmental Delay-NOS	To build capacity to meet the immediate needs of the child and the family and in better understanding autism	Twenty home-based sessions for individual parent-child dyads or forty centre-based sessions for groups of parent-child dyads	No
Child Therapy Plus Parent/Teacher Training	Child behaviour Child development	Children with severe difficulty going to school and emotional problems	To improve school attendance, emotional distress and self-efficacy and overall child functioning	Eight sessions for individual children, plus eight sessions for individual parents and teachers	No
Community Bubs Program	Family relationships Safety and physical wellbeing Child development	Families living in high need public housing estates with infants aged 0-4 months, who had been identified by health or welfare professionals as having significant risk issues and for whom without intensive support, notification to	The model of intensive outreach aimed to facilitate the strengthening of the individual, family and community resources, in order for the at-risk infant to thrive and develop safely in the care of his/her	Twelve months of support for families at the individual level in the home, as well as group and community-based support	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
		child protection was possible.	parents/caregivers		
Elias, Hay, Homel & Freiberg (2006)	Child development	Children who linguistically performed at the two lowest Preschool Language Assessment Instrument (PLAI) levels	To increase children's language and emergent literacy development, and increase parental involvement in their preschoolers' education	Total duration of 6 months in a school setting	No
Emerging					
The Essential Parenting Program	Child behaviour Parent-child relationship	Preschool children	The program teaches parents ways of emotion coaching their children, which included skills in labelling emotions, viewing emotions as a time for intimacy and teaching, empathising and validating their children's emotions and problem solving around emotional events	Six sessions for groups of parents at preschool settings	No
Families and Schools Together Galiwin'ku (FAST Galiwin'ku)	Family relationships Child behaviour Child development Safety and physical wellbeing Parent-child	Young Indigenous parents and their immediate family/biological children	To strengthen family functioning, prevent the target child from experiencing school failure, prevent substance abuse by the child and family, reduce stress that parents and children experience from daily situations	Eight sessions for groups of families in a school setting	Not specifically but general FAST is Well Supported

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
	relationship				
Family Literacy Program	Child development Family relationships	Families living in a low socio-economic area with children considered to be at risk of literacy difficulties and school failure	To increase parental awareness of the literacy practices of their homes and communities and their awareness of young children's literacy development	Six sessions for groups of parents in a preschool settings	No
Emerging					
Food Cent$	Safety and physical wellbeing Basic child care	Mothers with a mental illness	To increase knowledge about healthy dietary intake, food selection and preparation, and grocery expenditure	Not indicated	No
Fun not Fuss with Food	Child Behaviour Parent-child relationship	Children with an eating or mealtime problem or at risk of developing a problem	To improve children's problem eating and mealtime behaviours	One session with groups of parents	No
Gibbs, Waters, Robinson, Young & Hutchinson (2012)	Safety and physical wellbeing	Parents attending a maternal child health centre	To influence parent poison safety awareness and behaviours	One session for groups of parents at a Maternal and Child Health Centre	No
The Gordoncare Parenting Orders Program	Family relationships Parent-child relationship	Families with court orders and a history of repeated returns to settle contact disputes	To provide support services to help families overcome contact problem	Six sessions for individual parents/carers and six sessions for groups of children	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
Emerging					
Great Kids Program	Parent-child relationship Family relationships Child development	Parents looking to improve their parenting	To support parents to review and change their patterns of communicating with their children which promotes more respectful interactions and encourages children's positive self identity. It aims to identify and address the sources of unhelpful and hurtful attitudes held by parents. It also works to establish a new relationship context for children and their parents through facilitating opportunities for positive exchanges	Six sessions with groups of parents	No
Homeless and Parenting Program Initiative (HAPPI)	Basic child care Safety and physical	Families with children aged 0-12 years who are homeless or at risk of homelessness, with an	To increase the wellbeing of families and children who are homeless or at risk of	Unclear	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
	wellbeing Parent-child relationship Child development Child behaviour Family relationships	emphasis on Indigenous families	homelessness		
Emerging					
Hauck, Hall, Dhaliwell, Bennet & Wells (2011)	Family relationships Child behaviour Basic child care	Parents of infants experiencing sleeping and settling issues	To increase maternal confidence and competence in settling and sleep techniques	One 6 hour session for individual parent-child dyads at a parenting centre	No
Hawes & Dadds (2005); Hawes & Dadds (2007)	Child behaviour	Boys aged 4-8 years with conduct problems	To improve child behaviour	Nine clinic-based sessions with parents	No
Hey Dad!	Family relationships Child development Parent-child relationship	Indigenous fathers, uncles and pops	To support Aboriginal fathers in their parenting role in order to establish better outcomes for the next generation of Aboriginal children.	Weekly program, workshops and two-day program for groups of parents	No
Horn of Africa Parent Support Group	Family relationships	Parents of children with disabilities from the Horn of Africa	To increase social support for families, parent's knowledge of disabilities, awareness of disability services and	Two-hour weekly sessions plus a camp for groups of families. Based at a community centre	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			parental confidence to access disability services		
It Takes Two to Talk	Parent-child relationship	Parents of preschool children with non-progressive motor disorders	To improve interactions between children who have motor disorders and their parents	Seven to eight sessions for groups of parents in a community setting, plus three home-based sessions for individual parent-child dyads	No
Emerging					
Karitane Residential Family Care Unit	Child behaviour Family relationships Basic child care	Parents with depression and/or anxiety	To reduce maternal psychological symptomatology and infant behaviour disturbances	Five days in residential family care unit	No
Kids in Focus	Parent-child relationship Family relationships	Parents who are separated or divorced and attending a family relationship centre	To improve parents' perceived parent-child relationship and decrease parental acrimony	One session for groups of parents at a family relationships centre	No
Let's Start: Exploring Together	Child behaviour Parent-child relationship Child development	Indigenous preschool children with behavioural problems	To reduce levels of child behaviour problems	Ten sessions with groups of children and ten sessions with groups of parents and ten sessions with groups of parent-child dyads. Location may include community settings or schools	No
Marshall & Swan (2010)	Parent-child relationship	Parents who were bringing their children to a maths clinic	To assist parents to help with their children's mathematics learning	Six sessions for groups of parents at a university	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
	Child development				
Masada Private Hospital's Mother Baby Unit (MPHMBU)	Basic child care Child behaviour	Mothers with anxiety and/or depression and unsettled infants	Training in infant care and settling strategies. Infants are assisted to develop an age-appropriate feed, play and sleep routine	Hospital-based sessions for individual parent-child dyads and groups of parent-child dyads	No
Emerging					
Mental Health Positive Parenting Program	Child behaviour Child development Parent-child relationship Family relationships	Parents with a mental illness or mental health problem that impacts parenting	To reduce child behavioural problems and dysfunctional parenting strategies	Six sessions for groups of parents plus four home-based sessions for individual parents	No
Mildon (2008)	Child behaviour Parent-child relationship	Parents with an intellectual disability	To deliver an enhanced assessment-based behavioural parent training (BPT) intervention to parents with an intellectual disability to reduce child problem behaviours	Home-based weekly sessions for individual parent-child dyads	No
Mildon, Wade & Matthews (2008)	Child behaviour Parent-child relationship	Parents with an intellectual disability	To combine the delivery of evidence-based parent education technology for parents with an intellectual disability with two strategies	12 home-based sessions with individual families	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			aimed at promoting the contextual fit of the intervention with these families		
Emerging					
Ngaripirliga'ajirri	Child behaviour Child development Parent-child relationship Family relationships	Indigenous school-aged children with behavioural problems	To address youth social problems, child behavioural concerns and encourage assertive non aggressive parenting	Eight sessions with groups of children and eight sessions with groups of parents and eight sessions with groups of parent-child dyads. Location may include community settings or schools	No
Once Upon A Circus	Parent-child relationship Family relationship	Young people between the ages of 3-25 years including newly arrived migrants, refugees, youth at risk and Indigenous communities	To promote play as a fundamental family activity and use circus, storytelling, and literacy to develop key childhood development skills such as confidence, communication and perseverance in order to build strong, resilient communities	Twenty community and school-based sessions	No
P5 – Participatory Program Promoting Pleasurable Parenting	Child behaviour Parent-children relationship	Any parents	To improve parenting self-efficacy and confidence in relation to child behaviour	Eight sessions for groups of parents in community child health centres	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
			management		
Parenting Eating and Activity for Child Health (PEACH) with Parent Skills Training	Safety and physical wellbeing	Prepubertal moderately obese children	To target parents as the agents of change for implementing family lifestyle changes to reduce adiposity in children	Twelve session for groups of parents in a hospital setting, plus four telephone sessions for individual parents	No
Emerging					
Perceptive Parenting Program	Child behaviour Parent-child relationship	Primary school aged children with Oppositional Defiant Disorder	Uses a cognitive approach that targets parental perceptions, or cognitive schema, and their emotional responding to child misbehaviour	Eight sessions for groups of parents	No
Plutzer & Spencer (2008)	Safety and physical wellbeing	Women in 5th to 7th month of pregnancy	To reduce severe early childhood caries	Written information for individual parents and one telephone-based session for individual parents	No
Relatewell	Parent-child relationship Child behaviour Family relationships	Children with behavioural problems	To support parents to use strategies to reduce negative parent-child interactions, to promote strong, functional and well supported families and promote healthy milestone development in children.	Two sessions for groups of parents	No
Sawyer & Glazner (2004)	Child development	Infants with cystic fibrosis	To provide assessment and education to parents of children diagnosed with cystic	Five day residential hospital-based program for groups of families	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
	Family relationships		fibrosis (CF		
Emerging					
Skilled Parenting Program	Child behaviour Parent-child relationship	Primary school-age children with Oppositional Defiant Disorder (ODD) and comorbid disorders (Attention Deficit Hyperactivity Disorder) and affective disorder	To deliver parent management training (PMT) as a treatment for primary school-age children with Oppositional Defiant Disorder (ODD) and comorbid disorders (Attention Deficit Hyperactivity Disorder and affective disorders) in a public- health-oriented community-based setting	Eight sessions for groups of parents in a community mental health clinic	No
Sing & Grow	Parent-child relationship Child behaviour Child development	Families facing general social and economic disadvantage	To promote positive parent-child relationships and children's behavioural, communicative and social development	Eight to ten session with groups of parent-child dyads in community settings	No
Starting points	Not indicated	Children aged 0 – 4 years	To increase parenting confidence	Groups of parents	No
Symon, Marley, Martin & Norman (2005)	Child behaviour	Parents with newborns	To improve sleep performance in newborn	One hospital-based sessions with individual parents	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
	Basic child care		infants		
The Time 2B Healthy Program	Safety and physical wellbeing Child behaviour	Children aged between 2 and 5 years and overweight or at risk of being overweight	To make behavioural changes and promote healthy weight for overweight or at risk of overweight, preschool-aged children	Five home-based sessions for individual parents	No
Emerging					
Together Parenting Program	Child behaviour Parent-child relationship	Parents who want to enhance their relationship with their child(ren) and learn more effective parenting strategies for managing children's emotional and behavioural problems	To teach parents to reinforce prosocial behaviour instead of reinforcing aggressive or coercive behaviour and how to reduce problem behaviour	Ten sessions for groups of parents in a school or community setting, plus two telephone sessions for individual parents. Two additional sessions for groups of parents, carers and teachers in a school or community setting	No
Tooth Smart Programme	Safety and physical wellbeing	Families of young children (aged under five years) waiting for treatment under general anaesthesia for extensive caries	To stabilise existing carious lesions and prevent new caries in children	Four sessions for individual families in a hospital dental clinic	No
Tresillian Family Care Centre Program	Child behaviour Basic child care	Parents of unsettled infants aged < 20 weeks	To reduce unsettled behaviour in young infants through an individualised multidisciplinary residential program.	Five days and four nights at a residential stay unit. Support for individual parent-child dyads.	No
Tweedle Child and Family Health Service	Basic child care Family relationships	Mothers admitted to Tweedle program for postnatal assistance	To make parenting enjoyable, to increase confidence and develop safe, effective child	Groups of parents and individual parents in residential clinic	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
residential program	Child behaviour Parent-child relationship		rearing practices		
Emerging					
Queen Elizabeth Centre's Residential Program	Parent-child relationship Family relationships Child behaviour Basic child care	Parents of children with sleep difficulties	To improve mother's behaviour during parent-child interaction and improve self-reported wellbeing (depression, anxiety and stress)	Five days at a residential stay centre. Support for individual parent-child dyads and groups of parent-child dyads	No
Weiskop, Richdale & Matthews (2005)	Child behaviour Basic child care	Children with Fragile X syndrome	To reduce sleep problems in children with fragile X syndrome (FXS)	Five sessions for individual parents in the home, a university and a clinic	No
What Were We Thinking! (WWWT)	Child behaviour Family relationships Basic child care	First-time parents	To promote confident parental caretaking, optimise functioning in the intimate partner relationship, improve infant manageability and reduce common postnatal mental disorders in women	Thirteen sessions for groups of families at Maternal and Child Health Centres	No

Parenting Program or authors *	Outcomes	Target population **	Program aim	Program details	In clearinghouses analysis?
No Effect					
Bartu, Ludlow & Doherty (2006)	Safety and physical wellbeing Child development	Illicit drug using mothers	To increase breastfeeding and immunisations rates and reduce drug use in illicit drug-using mothers	Eight home-based sessions for individual parents	No
Toddlers without Tears	Child behaviour Family relationships Parent-child relationship Child development	Mothers attending a Maternal and Child Health Centre	To prevent child behaviour problems, improve parenting and maternal mental health	One session for individual parents and two sessions for groups of parents at a Maternal and Child Health Centre	No
Wake, Tobin, Girolametto, Ukoumunne, Gold, Levickis, Sheehan, Goldfeld, & Reilly (2011)	Child development Child behaviour	Toddlers with slow early development of expressive vocabulary	To improve children's language development outcomes at 2 and 3 years and reduce behavioural problems	Six sessions with groups of parent-child dyads in a community centre	No
Wakefield, Banham, McCaul, Martin, Ruffin, Badcock and Roberts (2002)	Safety and physical wellbeing Child development	Children with asthma aged 1 – 11 years who resided with at least one parent who was a smoker	To encourage parents to impose bans on smoking in the home	Two telephone-based sessions for individual parents	No

* Authors' names are provided where there is no indication of program name.

** All programs are aimed at parents. 'Target population' provides a description of the group of children/parents that each program was designed for.

Appendix 8. Programs rated as Well Supported in the REA (data extracted from papers and program rating checklists)

Well Supported programs were rated as follows on the evidence of effectiveness checklist:

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
1.	No evidence of risk or harm	☒	☐	☐	☐	☐	
2.	If there have been multiple studies, the overall evidence supports the benefit of the program	☒	☐	☐			
3.	Clear baseline and post measurement of outcomes for both conditions	☒	☐	☐			
4.	At least **two** RCTs have found the program to be significantly more effective than comparison group. Effect was maintained for at least **one** study at **1 year** follow-up.	☒					
5.	At least **one** RCT has found the program to be significantly more effective than comparison group. Effect was maintained at **6 month** follow-up.		☐				
6.	At least one study using some form of contemporary comparison group demonstrated some improvement outcomes for the intervention but not the comparison group			☐			

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
7.	There is insufficient evidence demonstrating the program's effect on outcomes because: a) the designs are not sufficiently rigorous (criteria 1-6) OR b) the results of rigorous studies are not yet available				☐		
8.	Two or more RCTs have found no effect compared to usual care OR the overall weight of the evidence does not support the benefit of the program					☐	
9.	There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect on participants						☐

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Turner & Sanders (2006)	To improve child behaviour problems, reduce dysfunctional parenting practices and increase use of appropriate discipline and positive parenting strategies as well as increase parental confidence and adjustment	Child behaviour Parent-child relationship	Randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures	Individual parents	Primary care settings	Number of sessions –3-4 Duration of sessions – 30 minutes Frequency of sessions – weekly with a break of 3 to 4 weeks before the fourth session if it was required Total duration of program – not indicated	Parents (n = 16) Description – parents seeking advice about child behaviour problems or developmental issues in low income areas Sex – F = 15 Age – mother's mean age = 33.67 years; father's mean age = 35.27 years Children (n = 16) Description – children between 2 and 6 years of age who have not started primary school Sex – M = 43.8% Age – mean = 37.38 months	Parents (n = 14) Description – parents seeking advice about child behaviour problems or developmental issues in low income areas Sex – not indicated Age – mother's mean age = 34.62 years; father's mean age = 35.09 years Children (n = 14) Description – children between 2 and 6 years of age who have not started primary school Sex – M = 64.3% Age – mean = 43.07 months	Statistically significant – Parents receiving the Primary Care Triple P-Positive Parenting Program intervention reported significantly lower levels of targeted child behaviour problems, dysfunctional parenting and reduced parental anxiety and stress in comparison to wait listed parents at post assessment. Maintenance of effect – Short term effects were largely maintained at 6 month follow-up assessment of the intervention group.

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Sanders, Pidgeon, Gravestock, Connors, Brown & Young (2004)	Targets parents' negative attributions regarding their child's and their own behaviour and parents' anger-control deficits	Safety and physical wellbeing Parent-child relationship Child behaviour	Randomised controlled trial Contemporary alternate treatment Pre-post-follow-up (6 months) measures	Groups of parents	Not indicated	Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – not indicated	Parents (n = 50) Description – parents at risk of child maltreatment Sex – F = 94% Age – mother's mean age = 33.68 years; father's mean age = 36.45 years Children (n = 50) Sex – F = 48% Age – mean = 52.84 months	Parents (n = 48) Description – parents at risk of child maltreatment Sex – F = 92% Age – mother's mean age = 33.29 years; father's mean age = 35.32 years Children (n = 48) Sex – F = 52% Age – mean = 53.71 months	Statistically significant – EBFI showed a significantly greater short term improvement on measures of negative parental attributions for children's misbehaviour, potential for child abuse and unrealistic parental expectations than SBFI. Maintenance of effect – At 6 months follow-up both conditions showed similarly positive outcomes on all measures of child abuse potential, parent practices, parental adjustment and child behaviour and adjustment; however EBFI continued to show greater change in negative parental attributions. Descriptive – At post intervention both conditions were associated with lower levels of observed and parent-reported disruptive child behaviour, lower levels of parent reported dysfunctional parenting, greater parental self-efficacy, less parental distress, relationship conflict and similarly high levels of consumer satisfaction.
				Individual parents	Telephone	Number of sessions – 4 Duration of sessions – 15-30 minutes Frequency of sessions – not indicated Total duration of program – 12 weeks			

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Sanders, Bor, & Morawska (2007)	Parents are typically taught to increase positive interactions with children and to reduce coercive and inconsistent parenting practices	Child behaviour Parent-child relationship	Randomised controlled trial Waitlist Pre-post-1 year and 3 year follow-up 3 intervention groups: 1) Enhanced Behavioural Family Intervention **(EBFI)** 2)Standard Behavioural Family Intervention **(SBFI)** 3) Self-directed behavioural family intervention **(SDBFI)**	**EBFI** Individual parents	**EBFI** Not indicated	**EBFI** Number of sessions –12 Duration of sessions – 60-90 minutes Frequency of sessions – weekly Total duration of program – approx. 14 hours of intervention	**EBFI** Parents (n = not indicated) Children (n = 48) Description – children aged between 36 and 48 months with child behaviour problems and no evidence of developmental disorder or significant health impairment Sex – M = 67.50% Age – mean = 84.94 months	**No waitlist demographics available**	Maintenance of effect – The findings showed a very similar pattern of sustained improvement at both 1 and 3 year post intervention irrespective of which variant of Triple P parents received. All three variants showed maintenance of treatment gains and the changes observed in levels of disruptive behaviour had either maintained or shown further improvement by 3 year follow-up. Descriptive – There was no evidence of relapse or negative side effects of intervention on any child or parent measure. Approximately 2/3 of preschoolers who were clinically elevated on measures of disruptive behaviour at pre-intervention moved from the clinical to the non-clinical range. Across conditions, there was a comparable preventive effect for each intervention for these high risk children.
				SBFI Individual parents	**SBFI** Not indicated	**SBFI** Number of sessions –10 Duration of sessions – 60-90 minutes Frequency of sessions – weekly Total duration of	**SBFI** Parents (n = not indicated) Children (n = 50) Description – children aged between 36 and 48 months with child behaviour problems and no evidence of developmental disorder or significant		

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						program – approx. 10 hours of intervention	health impairment Sex – M = 66.20% Age – mean = 83.73 months		
				SDBFI Individual parents	**SDBFI** Home	**SDBFI** Number of sessions –10 Duration of sessions – N/A Frequency of sessions – N/A Total duration of program – not indicated	**SDBFI** <u>Parents</u> (n = not indicated) <u>Children</u> (n = 41) Description – children aged between 36 and 48 months with child behaviour problems and no evidence of developmental disorder or significant health impairment Sex – M = 69.30% Age – mean = 82.64 months		

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Morawska & Sanders (2006)	To prevent child problems	Child behaviour Parent child relationship	Randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures Two interventions: 1) Telephone assisted self directed behavioural family intervention **(TASD-BFI)** 2) Self directed behavioural family intervention **(SD-BFI)**	**TASD-BFI** Individual Parents	**TASD-BFI** Home	**TASD-BFI** Number of sessions – N/A Duration of sessions – N/A Frequency of sessions – N/A	**TASD-BFI** Parents (n = 43) Description –Families with a toddler between the ages of 18 and 36 months with child behaviour problems. **Demographics are for the whole sample** Sex – not indicated Age – mother's mean age = 33.21 years; father's mean age = 35.05 years Children (n = 43) Sex – M = 50.8% Age – mean = 26.10 months	Parents (n = 41) Description – Families with a toddler between the ages of 18 and 36 months with child behaviour problems. **Demographics are for the whole sample** Sex – not indicated Age – mother's mean age = 33.21 years; father's mean age = 35.05 years Children (n = 41) Description – not indicated Sex – m = 50.8% Age – mean = 26.10 months	Statistically significant – There were significant short-term reductions in reported child behaviour problems and improvements in maternal parenting style, parenting confidence and anger. Gains were more clinically significant in the telephone group. For child behaviour problems the two intervention groups differed significantly from the waitlist group. Families who received minimal therapist assistance made more clinically significant gains compared with families who completed the program with no therapist assistance. Maintenance of effect – The intervention effects were maintained at 6 month follow-up Descriptive – Mothers in both intervention groups become more confident than those in the waitlist group.
				Individual parents	Telephone	Number of sessions – 10 Duration of sessions – max. 30 minutes Frequency of			

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						sessions – weekly Total duration of program – 10 weeks			
				SD-BFI Individual Parents	**SD-BFI** Home	**SD-BFI** Number of sessions –N/A Duration of sessions – N/A Frequency of sessions – N/A Total duration of program – 10 weeks	**SD-BFI** <u>Parents</u> (n = 42) Descrscription – Families with a toddler between the ages of 18 and 36 months with child behaviour problems. **Demographics are for the whole sample** Sex – not indicated Age – mother's mean age = 33.21 years; father's mean age = 35.05 years <u>Children</u> (n = 42) Sex – M = 50.8% Age – mean = 26.10 months	

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Ireland, Sanders, & Markie-Dadds (2003)	Aims to teach parents to identify the causes of child behaviour problems, promote children's development, manage misbehaviour and plan ahead to prevent child behaviour problems in "high risk" parenting situations The additional sessions included in EGTP aimed to improve marital communication, enhance consistent use of the positive parenting strategies and to offer support for each other's	Child behaviour Child development Family relationships Parent-child relationship	Randomised controlled trial Pre-post-follow-up (3 months) measures Two interventions 1) Standard Group Triple P **(SGTP)** 2) Enhanced Group Triple P **(EGTP)**	**SGTP** Groups of parents	**SGTP** University	**SGTP** Number of sessions – 4 Duration of sessions – 2 hours Frequency of sessions – weekly	<u>Parents</u> (n = 19) Description – couples experiencing child behaviour problems and concurrent marital conflict Sex – F = 16 Age – mother's mean age = 34.50 years, father's mean age = 8.13 years <u>Children</u> (n = 19) Sex – M = 11 Age – mean = 3.53 years	**Did not use a true comparison group**	<u>Statistically significant</u> – There were significant improvements from pre to post intervention for both conditions, on measures of disruptive child behaviour, dysfunctional parenting style, conflict over parenting, relationship satisfaction and communication. <u>Maintenance of effect</u> – Effects were maintained at 3 month follow-up. <u>Descriptive</u> – No differences were found between the two conditions, with both the EGTP and SGTP programs resulting in similar outcomes.
				Individual parents	Telephone	Number of sessions – 4 Duration of sessions – 15-30 minutes Frequency of sessions – weekly Total duration of program – 8 weeks			
				EGTP As above	**EGTP** As above	**EGTP** As above	**EGTP** <u>Parents</u> (n = 18)		

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
	parenting efforts			Groups of parents		Number of sessions – 2 Duration of sessions – 90 minutes Frequency of sessions – weekly (overlap of 2 weeks where parents participated in a group session and a telephone consultation) Total duration of program – 8 weeks	Description – couples experiencing child behaviour problems and concurrent marital conflict Sex – F = 16 Age –mother's mean age = 34.94 years, father's mean age = 36.69 years Children (n = 18) Sex – m = 13 Age – mean = 3.78 years		

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Dean, Myors, & Evans (2003)	Aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents	Child behaviour Child development Parent-child relationship	Non-controlled trial Pre-post-follow-up (6 and 12 months) measures	Groups of parents	Not indicated	Number of sessions –8 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 560) Description – parents who had at least one child aged 2-10 years with behavioural problems Sex – F = 446 Age – not indicated	None	Statistically significant – There were significant improvements for mothers and fathers on all of the measures, except the fathers' DASS Anxiety Scale score. Parents reported a significant decrease in disruptive child behaviour after attending the groups. Maintenance of effect – Gains were maintained at 6 and 12 month follow-up. Descriptive – Parent evaluations at the conclusion of the program demonstrated a reduction in disruptive child behaviour, lower levels of dysfunctional parenting, reduction in conflict between parents over child-rearing and gains in parental mental health

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Rogers, Cann, Cameron, Littlefield & Lagioia (2003)	Aims to a) enhance the knowledge, skills, confidence, self- sufficiency and resourcefulness of parents of pre-adolescent children b) promote the development of nurturing, safe engaging, non-violent and low conflict environments for children c) enhance children's social, emotional, language, intellectual and behavioural competencies through positive	Safety and physical wellbeing Child development Child behaviour Parent-child relationship	Non-controlled trial Pre- post measures Two delivery modes: 1) **Group Triple P** 2) **Standard Triple P**	**Group Triple P** Group of families	**Group Triple P** Not indicated	**Group Triple P** Number of sessions – 4 Duration of sessions – 2 hours Frequency of sessions – not indicated	<u>Parents</u> (n = 83) Description – families of children at risk of developing emotional and behavioural problems Sex – F = 100% Age – not indicated <u>Children</u> (n = 83) Description – children exhibiting ADHD characteristics Sex – M = 67% Age – 2-15 years (mean = 5 years)	None	<u>Significant</u> – Significant pre to post decrease in child behaviour intensity and problem in both groups. Significant reduction in proportion of children presenting in the clinical range on the ADHD scale of ECBI. Significant pre to post improvement in parent coping, parenting skills and feelings of competence. <u>Descriptive</u> – Following the intervention there was a reduction in problem behaviour scores of children perceived to have a high frequency of behaviours typical of ADHD. Mothers also reported reduced depression, anxiety and stress, increased feelings of satisfaction and competency in parenting, less negative parenting behaviour and reduction in parental conflict.
				Individual families	Telephone	Number of sessions –4 Duration of sessions – 15-30 minutes Frequency of sessions – not indicated			
				Standard Triple P Individual families	**Standard Triple P** Home	**Standard Triple P** Number of sessions – not indicated			

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
	parenting practices					Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – 10-16 weeks			

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Markie-Dadds & Sanders (2006)	Targets coercive family interactions known to contribute to the development and maintenance of children's disruptive behaviour problems	Family relationships Child behaviour Parent-child relationship Child development	Randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures	Individual families	Home	Number of sessions – 10 Duration of sessions – Not indicated Frequency of sessions – weekly Total duration of program – 10 weeks	Parents (n = 32) Sex – F = 100% Age – mother's mean age = 32.47 years Children (n = 32) Description – aged between 2 and 5 years with behavioural concerns and no evidence of developmental disorders or significant health impairment Sex – M = 62.5% Age – mean = 42.91 months	Parents (n = 31) Sex – F = 100% Age – mother's mean age = 31.45 years Children (n = 31) Description – aged between 2 and 5 years with behavioural concerns and no evidence of developmental disorders or significant health impairment Sex – M = 64.5% Age – mean = 43.26 months	Statistically significant – Mothers in the intervention group reported significantly less child behaviour problems, less use of dysfunctional discipline strategies and greater parenting competence than mothers in the waitlist group. Maintenance of effect – Mothers' reports at 6 month follow-up indicated that gains in child behaviour and parenting practices achieved at post intervention were maintained. Non-significant – On measures of parental adjustment, there was no significant difference in conditions at post-intervention based on mothers' reports of depression, anxiety, stress and conflict with partners over parenting issues.

Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Bor, Sanders, & Dadds (2002)	**Standard Triple P:** reduce child disruptive behaviour **Enhanced Triple P:** reduce child disruptive behaviour and reduce psychosocial risk factors associated with child behaviour problems (i.e., partner conflict and parental stress)	Child Behaviour Parent-child relationships Family relationships	Randomised controlled trial Waitlist Pre-post-follow-up (1year) measures Two intervention groups **1) Standard Triple P** **2) Enhanced Triple P**	**Standard Triple P** Individual families	**Standard Triple P** Combination of clinic and home	**Standard Triple P** Number of sessions – 10 Duration of sessions – 60-90 mins Frequency of sessions – weekly Total duration of program – 15 weeks	**Standard Triple P** Families (n = 29) Unclear how many individual parents Family description – across both intervention groups families had at least one risk factor (maternal depression, relationship conflict, single parent, low family income or occupational prestige) Sex – Female and male (proportion unclear) Age – Females: m = 30.21(SD = 4.69);Males: m = 33.65 (SD = 7.89) Children (n = 29) Description – Mother rated child as having co-occurring disruptive	Family description – as per intervention group Child description - as per intervention group Families (n = 32) Unclear how many individual parents Sex - Female and male (proportion unclear) Age – F: mean = 29.72 (SD = 4.57); M: mean = 33.03 (SD = 5.51) Children (n = 32) Sex – F and M (proportion unclear) Age – mean = 42.81 (SD = 3.81) in months	Statistically significant – At post-intervention both intervention programs were associated with significantly lower levels of mother-reported disruptive child behavior and significant improvement in parenting skills compared to the waitlist group. At post-intervention the Enhanced Triple P condition was associated with significantly less observed child negative behavior compared to the waitlist group. At post-intervention the Standard Triple P condition was associated with higher levels of parenting efficacy and competence, and more significant improvements in parent conflict compared to the waitlist group. Maintenance of effect – gains achieved at post-intervention across all outcome measures were maintained at 1-year follow-up. Non-significant – no differences between the two intervention conditions on any of the measures of child behaviour, parenting skills or confidence, or parent conflict at post-intervention or follow-up.

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							and behaviour and attentional/hyperactive difficulties. Sex – F and M (proportion unclear) Age – mean = 39.86 (SD = 3.34) in months		Descriptive – 80% of the children in either intervention group showed clinically reliable improvement in observed negative behaviour from pre-intervention to follow-up.
				Enhanced Triple P Individual families	**Enhanced Triple P** Combination of clinic and home	**Enhanced Triple P** Number of sessions – 12 sessions Duration of sessions – 60-90 mins Frequency of sessions – weekly Total duration of program – 17 weeks	**Enhanced Triple P** Families (n = 26) Unclear how many individual parents Family description – across both intervention groups families had at least one risk factor (maternal depression, relationship conflict, single parent, low family income or occupational prestige) Sex – F and M (proportion unclear) Age – F: mean =		

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							28.41 (SD = 4.21); M: mean = 31.54 (SD = 6.23) Children (n = 26) Description – Mother rated child as having co-occurring disruptive and behaviour and attentional/hyperactive difficulties. Sex –F and M (proportion unclear) Age – mean = 40.41 (SD = 3.80) in months		

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Cann, Rogers, & Matthews (2003)	**Group, individual and self-directed** **Triple P**: reduce child disruptive behaviour **Enhanced Triple P:** reduce child disruptive behaviour and reduce psychosocial risk factors associated with child behaviour problems (i.e., partner conflict and parental stress)	Child behaviour Parent-child relationships	Non-controlled trial Pre and post measures Interventions: **1) Group Triple P** **2) Individual Triple P** **3) Self-directed Triple P** **4) Enhanced Triple P –** Offered to parents still recording critical levels of child or parent	**Group** Group of parents	**Group** Various community locations and home	**Group:** Number of sessions – 8 Duration of sessions – 4x2-hour group sessions and 3 half-hour phone calls, plus 1 final phone or group session Frequency of sessions – weekly Total duration of program – 8 weeks	**Demographics are for the whole sample** Parents (n = 589) Description – mothers who commenced and completed a program and for whom there are pre and post measures available Sex - F Age – not reported Children (n = not reported)	No comparison group	Statistically significant – Significant improvements in measures of child behaviour problems, parental style, parent sense of competence (satisfaction and efficacy), parent depression, anxiety and stress, and couple conflict (problem and intensity scales) from pre- to post-intervention. All changes were clinically significant.

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
			problems following the group program or who had concurrent problems in personal adjustment (stress or depression) or family dysfunction	**Individual** Individual parents	**Individual** Unclear	**Individual** Unclear	Description – unclear Sex – 61% male Age – less than 1 year to 15 years (mean = 4.5, SD = 2.5)		
				Enhanced	**Enhanced** Unclear.	**Enhanced** Number of sessions – unclear Duration of sessions – unclear Frequency of sessions – unclear Total duration of program – 10-16 weeks			

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Self-directed Written version to work through themselves with minimal assistance)	**Self-directed** Home	**Self-directed** Unclear			

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Cann, Rogers & Worley (2003)	To promote the competence and confidence of parents experiencing early difficulties in their relationship with their children to acquire skills known to promote the development, health, safety and emotional wellbeing of children	Child behaviour Parent-child relationships	Non-controlled trial Pre –post measures	Telephone supported, self-directed version of Triple P	Home	Number of sessions – 10 Duration of sessions – 15-30 minutes Frequency of sessions – weekly Total duration of program – 10 weeks	Parents (n = 73) Description – isolated families for whom pre and post data was available. Sex – not reported Age – not reported Children (n = unclear) Description – significant number of the target children had moderate to severe behavioural difficulties. Sex – 60% boys Age – range = 1-11 years, mean = 5.0, SD = 2.5	None	Statistically significant – Significant improvements in child behaviour (problem and intensity),parenting style, parental depression, anxiety, and stress, inter-parent conflict (problem and intensity) and parent sense of competence (satisfaction and efficacy). Non-significant – No change in parent reported marital satisfaction following intervention.

Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Crisante (2003)	Help practitioners to deal more effectively with requests for assistance with behaviour management by parents whose children attend pre-schools and long-day care centres	Child behaviour Parent-child relationships	Non-controlled trial Pre-post measures	Level 3 of Triple P – up to 4 face-to-face sessions with individual parents, tip sheets, video tape and monitoring activities	Delivered by pre-school practitioner at pre-schools and long-day care centres	Number of sessions – up to 4 face-to-face sessions, with average of 3 attended per parent Duration of sessions – 15-30 mins Frequency of sessions – unclear Total duration of program – 6 weeks	Parents (n = 39) Description – had concerns about the management of their children's behaviour Sex – 77% mothers Age – 86% aged between 20 to 40 years Children (n = 39) Description – 42% of children had behaviour problems in the clinical range (ECBI) Sex – 54% M; 33% F; 13% unspecified Age – mean of 3 years	None	Statistically significant – pre- to post-intervention data on Parenting Experience Survey available for 29 parents: significant improvements in perceptions of parenting experiences, support and relationship satisfaction. Descriptive – Practitioners reported improvements in their own skills in managing difficult child behaviour at pre-school.

Stepping Stones Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Plant & Sanders (2006)	Designed for parents who have a child with a disability to promote children's competence and development, parents management of misbehaviour and generalisation and maintenance of parenting skills	Child development Child behaviour	Randomised controlled trial Waitlist Pre-post-follow-up (12 months) measures Two interventions: 1) Stepping Stone Triple P-Enhanced **(SSTP-E)** 2) Stepping Stones Triple P-Standard **(SSTP-S)**	**SSTP-S** Individual parents	**SSTP-S** Not indicated	**SSTP-S** Number of sessions – 10 Duration of sessions – 60-90 minutes Frequency of sessions – weekly Total duration of program – 10 weeks	**SSTP-S** Parents (n = 26) Children (n = 26) Description – children with a developmental disability and behavioural problems Sex – M = 69.2% Age – mean = 54.62 months	Parents (n = 24) Children (n = 24) Description – children with a developmental disability and behavioural problems Sex – M = 83.3% Age – mean = 54.04 months	Statistically significant – Both interventions produced significant reductions in child problem behaviour, with 67% of children in the SSTP-E and 77% of children n the SSTP-S showing clinically reliable change from pre-intervention to follow-up. Maintenance of effect – Gains attained at post-intervention were maintained at 1 year follow-up. Descriptive – At post-intervention, both programs were associated with lower levels of observed negative child behaviour, reductions in the number of care-giving settings where children displayed problem behaviour and improved parental competence and satisfaction in the parenting role as compared with the waitlist condition.
				SSTP-E Individual parents	**SSTP-E** Not indicated	**SSTP-E** Number of sessions – 16 Duration of sessions – 60-90 minutes Frequency of sessions – weekly Total duration of program – 16 weeks	Parents (n = 24) Children (n = 24) Description – children with a developmental disability and behavioural problems Sex – M = 70.8% Age – mean = 56.63 months		

Stepping Stones Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Whittingham, Sofronoff, Sheffield, & Sanders (2008)	To treat specific problems of children with ASD, aiming to improve social behaviour and increase language, as well as to decrease inappropriate behaviours	Child behaviour Child development	Randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures	Groups of parents	Not indicated	Number of sessions – 5 Duration of sessions – not indicated Frequency of sessions – weeks 1, 3, 4, 7 and 9	Parents (n = 29) Sex – F = 29 Age – not indicated Children (n = 29) Description – children with ASD aged between 2 and 9 years Sex – M = 24 Age – mean = 5.62 years	Parents (n = 30) Sex – F = 26 Age – not indicated Children (n = 30) Description – children with ASD aged between 2 and 9 years Sex – M = 23 Age – mean = 6.20 years	Statistically significant – Significant improvements in parental reports of child behaviour and parenting styles. Significant improvements in parental satisfaction and conflict about parenting as well as a sleeper effect for parental efficacy. Maintenance of effect – The treatment effects for child behaviours, parental over reactivity and parental verbosity were maintained at follow-up 6 months later.
				Individual parents	Not indicated	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – weeks 2, 5, 6 and 8 Total duration of program – 9 weeks			

Appendix 9. Programs rated as Supported in the REA (data extracted from papers and program rating checklists)

Supported programs were rated as follows on the evidence of effectiveness checklist:

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
1.	No evidence of risk or harm	☐	☒	☐	☐	☐	
2.	If there have been multiple studies, the overall evidence supports the benefit of the program	☐	☒	☐			
3.	Clear baseline and post measurement of outcomes for both conditions	☐	☒	☐			
4.	At least **two** RCTs have found the program to be significantly more effective than comparison group. Effect was maintained for at least **one** study at **1 year** follow-up.	☐					
5.	At least **one** RCT has found the program to be significantly more effective than comparison group. Effect was maintained at **6 month** follow-up.		☒				
6.	At least one study using some form of contemporary comparison group demonstrated some improvement outcomes for the intervention but not the comparison group			☐			

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
7.	There is insufficient evidence demonstrating the program's effect on outcomes because: a) the designs are not sufficiently rigorous (criteria 1-6) OR b) the results of rigorous studies are not yet available				☐		
8.	Two or more RCTs have found no effect compared to usual care OR the overall weight of the evidence does not support the benefit of the program					☐	
9.	There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect on participants						☐

Couple CARE for Parents (CCP)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Halford, Petch, & Creedy (2010)	To promote positive couple adjustment to parenthood	Basic child care Family relationships	Randomised controlled trial Contemporary alternate treatment Pre-post-follow-up measures	Groups of parents	University based psychology clinic	Number of sessions –1 Duration of sessions – 6 hours Frequency of sessions – once off	Parents (n = 35) Description – women, 20-35 weeks pregnant with their first child and not expecting a multiple birth, in a committed relationship, residing within 50km of the metropolitan area and both partners could read and write English Sex – F = 100% Age – female mean = 29 years; male mean = 31 years	Parents (n = 36) Description – women, 20-35 weeks pregnant with their first child and not expecting a multiple birth, in a committed relationship, residing within 50km of the metropolitan area and both partners could read and write English Sex – F = 100% Age – female mean = 29 years; male mean = 31 years	Statistically significant – Significant effects of CCP on conflict and invalidation (6 months after the communication workshop). Descriptive – Relative to the control group, CCP produced large declines in negative communication. CCP prevented decline in women's but not men's relationship adjustment and self-regulation. There was no difference between alternate treatment and CCP on parenting stress CCP couples had higher consumer satisfaction than alternate treatment couples. Maintenance of effect – The gains were maintained at follow-up (12 months postpartum).
				Individual parents	Home	Number of sessions – 5 Duration of sessions – 45 minutes to 1.5 hours Frequency of sessions – not indicated Total duration of program – 6 months			

Gifted and Talented Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Morawska & Sanders (2009)	To improve parenting styles, child behavioural and emotional problems and family adjustment	Parent-child relationship Child behaviour Family relationships	Randomised controlled trial Waitlist Pre, post, follow-up (6 months) measures	Groups of parents	Not indicated	Number of sessions – 5 Duration of sessions – 2 hours Frequency of sessions – weekly	<u>Parents</u> (n = 37) **Demographics are for the whole sample** Description – parents reported concerns about their child's behaviour and parenting Sex – F = 90.7% Age – mother's mean age = 39.28 years; father's mean = 41.77 years <u>Children</u> (n = 37) Description – gifted children aged between and 10 years Sex – M = 60% Age – mean = 7.81 years	<u>Parents</u> (n = 38) **Demographics are for the whole sample** Description – parents reported concerns about their child's behaviour and parenting Sex - F = 90.7% Age – mother's mean age = 39.28 years; father's mean age = 41.77 years <u>Children</u> (n = 38) Description – gifted children aged between and 10 years Sex – M = 60% Age – mean = 7.81 years	<u>Statistically significant</u> – Results indicated significant intervention effects for the number and frequency of parent reported child behaviour problems, as well as hyperactivity in the intervention group, relative to a waitlist control. Parents also reported significant improvements in their own parenting style, including less permissiveness, harshness and verbosity when disciplining their child. <u>Maintenance of effect</u> – These effects were maintained over the 6 month follow-up period. <u>Descriptive</u> – No intervention effects were evident for teacher reports, except for a trend in relation to hyperactivity.
				Individual parents	Telephone	Number of sessions – 3 Duration of sessions – 15 minutes Frequency of sessions – weekly			
				Groups of parents	Not indicated	Number of sessions – 1 Duration of sessions – 2 hours Frequency of sessions – once Total duration of program – 9 weeks			

Group Lifestyle Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
West, Sanders, Cleghorn & Davies (2010)	To reduce children's risk of chronic weight problems by increasing parents' skills and confidence in managing children's weight-related behaviour	Safety and physical wellbeing Child behaviour	Cluster randomised controlled trial Waitlist Pre-post-follow-up (12 months) measures	Group of parents	University family and child psychology clinic, a hospital and primary schools	Number of sessions – 9 Duration of sessions – 90 minutes Frequency of sessions – not indicated	<u>Parents</u> (n = 52) Sex – F = 51 Age – mean age = 39.08 years <u>Children</u> (n = 52) Description – overweight children Sex – F = 36 Age – mean = 8.58 years	<u>Parents</u> (n = 49) Sex – F = 47 Age – mean = 40.35 years <u>Children</u> (n = 49) Description – overweight children Sex – F = 32 Age – mean = 8.50 years	<u>Statistically significant</u> – Significant reductions in child BMI z score and weight-related problem behaviour. <u>Maintenance of effect</u> – All short term intervention effects were maintained at 1-year follow-up assessment with additional improvements in child body size. <u>Descriptive</u> – At the end of the intervention, parents reported increased confidence in managing children's weight-related behaviour, and less frequent use of inconsistent or coercive parenting practices.
				Individual parents	Telephone	Number of sessions – 3 Duration of sessions – 20 minutes Frequency of sessions – not indicated Total duration of program – 12 weeks			

Hassle-free shopping (brief parent group discussion based on Triple P)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Joachim, Sanders and Turner (2009)	To prevent behaviour problems during shopping trips and in other settings	Child behaviour Parent-child relationships	Randomised controlled trial Waitlist control Pre-post-follow-up measures	Groups of parents	Not indicated	Number of sessions – 1 Duration of sessions – 2 hours Frequency of sessions – once Total duration of program – 2 hours	Parents (n = 26) Description – parents of children showing behaviour problems during shopping trips Sex – F = 96.3% Age – mean = 33.46 Children (n = 26) Description – children with behaviour problems when shopping Sex – M = 53.8% Age – mean = 3.23 years	Parents (n = 20) Description – parents of children showing behaviour problems during shopping trips Sex – F = 95% Age – mean = 34.2 years Children (n = 20) Description – children with behaviour problems when shopping Sex – M = 65% Age – mean = 3.3 years	Statistically significant – A significant intervention effect on parent reported child behaviour was found with parents in the intervention reporting lower score for behaviour intensity and problem at post compared with pre, with no improvements for the control group. Significantly fewer problematic shopping trips were also reported by intervention parents after the program, while there were no improvements for the controls. Significant intervention effects were also found for dysfunctional parenting style, and the behavioural self-efficacy and setting self-efficacy of parental confidence. Significantly fewer intervention children had clinical levels of behavioural intensity power intervention and significantly fewer intervention parents had clinical scores for total parenting style and self-efficacy. Maintenance of effect – Improvements on child behavioural intensity and behaviour were maintained at 6 months, as was parenting self-efficacy. The significant reduction in problematic shopping trips was also maintained.

Hassle-free shopping (brief parent group discussion based on Triple P)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Non-significant – No significant effect was observed for inter-parental conflict over parenting issues or for parental adjustment. Improvements in parenting style were not maintained at 6 months. Descriptive – Intervention parents reported a high levels of satisfaction with the program.

Hendrie & Golley (2011)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Hendrie & Golley (2011)	To improve dietary intakes and health outcomes of changing dairy foods consumed by children from regular to reduced fat varieties	Safety and physical wellbeing	Cluster randomized trial Contemporary alternate treatment Pre-post-follow-up (24 weeks) measures	Group of parents	CSIRO Food and Nutritional Sciences Clinic	Number of sessions – 3 Duration of sessions – 30 minutes Frequency of sessions – monthly Total duration of program – 12 weeks	Parents (n = 76) Sex - F = 85.4% Children (n = 76) Description – healthy children (4-13 years of age) who are regular-fat dairy consumers Sex – M = 57.9% Age – mean = 8.60 years	Parents (n = 69) Sex - F = 88.9% Children (n = 69) Description – healthy children (4-13 years of age) who are regular-fat dairy consumers Sex – M = 62.3% Age – mean = 9.47 years	Statistically significant – LDL-cholesterol concentration was 0.15mmol/L lower in the intervention group at week 24 than the comparison group. Saturated fat intakes were 3.3 percentage points lower in the intervention group at week 24 than in the comparison group. Non-significant – There were no significant group differences in total energy or adiposity measures. Descriptive – There were no group differences in overall dairy intakes. Pentadecanoic acid concentrations were lower at week 12 but not at week 24. LDL-cholesterol concentrations were not different at week 12. Regular-fat dairy group decreased from 88% to 14% of dairy intake in the intervention group. Calcium, magnesium and carbohydrate intakes were higher in the intervention group than in the comparison group; retinol intakes were lower in the intervention group than in the comparison group; and overall vitamin A intakes were similar between groups.

Indigenous Group Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Turner, Richards & Sanders (2007)	To promote positive, caring relationships between parents and their children and to help parents develop effective management strategies for dealing with a variety of common behaviour problems and developmental issues	Parent-child relationship Child behaviour Child development	Randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures	Groups of parents	Not indicated	Number of sessions – 6 Duration of sessions – 1.5-2 hours for the first session; 2-2.5 hours for subsequent group sessions Frequency of sessions – not indicated	<u>Parents</u> (n = 26) Description – Indigenous families where the primary caregiver had concerns about their child's behaviour or their own parenting skills Sex – F = 88.0% Age – mean = 34.52 years <u>Children</u> (n = 26) Description – children were at risk of, but not yet displaying severe pathology. Children aged between 1 and 13 years Sex – M = 65.4% Age – mean = 6.17 years	<u>Parents</u> (n = 25) Description – Indigenous families where the primary caregiver had concerns about their child's behaviour or their own parenting skills Sex – F = 92.0% Age – mean = 34.52 years <u>Children</u> (n = 25) Description – children were at risk of, but not yet displaying severe pathology. Children aged between 1 and 13 years Sex – M = 64.0% Age – mean = 5.52 years	<u>Statistically significant</u> – Parents attending Group Triple P reported a significant decrease in rates of problem behaviour and less reliance on some dysfunctional parenting practices following the intervention in comparison to waitlist families. The programme also led to greater movement from the clinical range to the non-clinical range for mean child behaviour scores on all measures. <u>Maintenance of effect</u> – Effects were primarily maintained at 6 month follow-up.
				Individual parents	Home	Number of sessions – 2 Duration of sessions – 30-40 minutes Frequency of sessions – not indicated Total duration of program – 8 weeks			

Intensive Lifestyle Education, plus Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Golley, Magarey, Baur, Steinbeck &, Daniels (2007)	Aims to promote parental competence to manage their child's behaviour	Child behaviour Parent-child relationship Safety and physical wellbeing	Randomised controlled trial Waitlist Pre-post-follow-up (12 months) measures Two interventions: 1) Triple P (P) 2) Triple P+ intensive lifestyle education (P+DA)	**Triple P (P)** Groups of parents	**Triple P (P)** Hospital	**Triple P (P)** Number of sessions – 4 Duration of sessions – 2 hours Frequency of sessions – weekly	**Triple P (P)** Parents (n = 37) Children (n = 37) Description – overweight 6-9 year old prepubertal children Sex – M = 13 **Child age demographics are for the whole sample** Age – mean = 8.2 years	Parents (n = 36) Children (n = 36) Description – overweight 6-9 year old prepubertal children Sex – M = 13 **Child age demographics are for the whole sample** Age – mean = 8.2 years	Statistically significant – All three groups had a significant reduction in BMI z score over 12 months. Waist circumference z score fell significantly over 12 months in both intervention groups but not in the control group. Boys in the intervention groups had significant reductions in both BMI and waist circumference z scores, which were not observed for girls or the wait listed controls. Maintenance of effect – Gains were maintained at 12 months Non-significant – There was no statistical significance between groups for BMI z scores. Descriptive – After 12 months, the BMI z score was reduced by ~10% with parenting-skills training plus intensive lifestyle education versus ~5% with parenting-skills training alone or wait-listing for intervention. BMI z score decreased over 12 months in double the number of children in the P+DA group compared with the P intervention or intervention wait list group.
				Individual parents	Telephone	Number of sessions –4 Duration of sessions – 15-20 minutes Frequency of sessions – weekly			
				Individual parents	Telephone	Number of sessions – 3 Duration of sessions – 15-20 minutes Frequency of sessions – monthly			

Intensive Lifestyle Education, plus Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						Total duration of program – not indicated			
				Triple P+ intensive lifestyle education (P+DA) As above	**Triple P+ intensive lifestyle education (P+DA)** As above	**Triple P+ intensive lifestyle education (P+DA)** As above	**Triple P+ intensive lifestyle education (P+DA)** Parents (n = 38) Children (n = 38) Description – overweight 6-9 year old prepubertal children Sex –M = 14 **Child age demographics are for the whole sample** Age – mean = 8.2 years		
				Groups of parents	Hospital	Number of sessions – 7 Duration of sessions – not indicated Frequency of sessions – every 2 weeks at first then monthly Total duration of program – not indicated			

Kennedy, Rapee &Edwards (2009)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Kennedy, Rapee, & Edwards (2009)	Aims to teach parents to reduce their child's anxiety using strategies such as graded exposure, contingency management, parent training and parent anxiety management	Child behaviour	Randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures	Groups of parents	Not indicated	Number of sessions – 8 Duration of sessions – 90 minutes Frequency of sessions – weekly	Parents (n = 35) Children (n = 35) Description – high scores on behavioural inhibition and at least one parent with a diagnosis of an anxiety disorder Sex – F = 58% Age – mean = 48.4 months	Parents (n = 36) Children (n = 36) Description – high scores on behavioural inhibition and at least one parent with a diagnosis of an anxiety disorder Sex – F = 51% Age – mean = 45.8 months	Statistically significant – The intervention group showed a significantly greater reduction in anxiety disorders and less interference from their anxiety than the wait list. Maintenance of effect – Gains were maintained at 6 months follow-up. Descriptive – Children in the intervention condition showed greater reductions in parent and laboratory observed measures of behavioural inhibition.
				Individual parents	Telephone	Number of sessions –1 Duration of sessions – not indicated Frequency of sessions – one telephone follow-up call a month after completion Total duration of program – not indicated			

Khan, O' Meara, Stevermuer & Henry (2004)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Khan, O'Meara, Stevermuer & Henry (2004)	To improve the skills of parents to recognise and avoid triggers to use written asthma action plans and medication at the time of crisis, and to seek help appropriately	Safety and physical wellbeing	Randomised controlled trial Contemporary usual care Pre -follow-up (6 months) measures	Individual parents	Telephone	Number of sessions – 1 Duration of sessions – 5-44 minutes (average = 13 minutes) Frequency of sessions – once off Total duration of program – length of telephone consultation	Parents (n = 136) Sex - not indicated Age – not indicated Children (n = 136) Description – children included were those who were discharged from the Emergency Department with asthma Sex – not indicated Age - not indicated	Parents (n = 130) Sex - not indicated Age – not indicated Children (n = 130) Description – children included were those who were discharged from the Emergency Department with asthma Sex – not indicated Age – not indicated	Statistically significant – At follow-up the intervention group children were significantly more likely than controls to possess a written asthma action plan. Both intervention and control groups showed significant decreases in asthma symptoms. Descriptive – Possession of action plans increased from baseline in the intervention group but tended to decrease in the control group. Use of action plans was greater in the intervention group but decreased from baseline in both groups The intervention did not improve the primary outcome of wheeze in the last 3 months. However it increased the possession and regular use of written asthma action plans in the intervention group.

Morawska, Haslam, Milne & Sanders (2011)- brief parent group discussion based on Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Morawska, Haslam, Milne and Sanders (2011)	To increase parents' skills in promoting social, emotional, behaviour competent in children; reduce parents' use of coercive and punitive methods of discipline; improve communication about parenting; reduce parental stress	Child behaviour Parent-child relationship Family relationships	Randomised controlled trial Waitlist Pre-post-follow-up measures (follow-up for intervention only)	Groups of parents	Not indicated	Number of sessions – 1 Duration of sessions – 2 hours Frequency of sessions – once	<u>Parents</u> (n = 33) Description – parents concerned their child's disobedience Sex – **for entire parent sample** – female = 66 Age – mean = 35.91 years <u>Children</u> (n = 33) Description – target child of enrolled parent Sex – M = 57.6% Age – mean = 3.76 years	<u>Parents</u> (n = 34) Description – parents concerned their child's disobedience Sex – **for entire parent sample** – F = 66 Age – mean = 36.68 years <u>Children</u> (n = 34) Description – target child of enrolled parent Sex – M = 52.9% Age – mean = 3.5 years	<u>Statistically significant</u> – Significant pre to post decrease in parent reported child behaviour problems in the intervention but not the control group. Significant pre to post decrease in the use of dysfunctional parent styles in intervention group compared to the controls. Parents in intervention also felt more confident in relation to managing specific behaviours, compared with controls. There was a significant pre to post improvement in intervention parents' relationship with their partner, compared with controls. Significantly more parents in the intervention reported that their child's behaviour improved from pre to post, compared to controls and significantly more intervention parents' than controls attributed this improvement to their own parenting. Significant pre to post improvement in the proportion of intervention children with clinical levels of behaviour problem and intensity and parents with clinical score for parenting style, compared to controls.
				Individual parents	Telephone	Number of sessions – 1 Duration of sessions – 2 hours Frequency of sessions – once Total duration of program – 2 hours			

Morawska, Haslam, Milne & Sanders (2011)- brief parent group discussion based on Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Maintenance of effect – Intervention group improvements were maintained at 6 months for the following – child behaviour intensity and problem, parenting style and confidence, parenting experience and partner support. Non-significant – There were no changes in parent's perception of attachment as result of the intervention. The intervention had no effect on parents' confidence with managing behaviour in different settings. The intervention had no effect on the parenting experience. Descriptive – Overall, parent satisfaction with the program was high.

NOURISH									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Daniels, Mallan, Battistutta, Nicholson, Perry, & Magarey (2012)	To reduce childhood obesity risk	Safety and physical wellbeing	Randomised controlled trial Contemporary usual care Pre-mid-post-follow-up (6 months) measures	Module 1 commencing when the infants were 4-6 months Groups of parents	Child health centres	Number of sessions - 6 Duration of sessions - 1-1.5 hours Frequency of sessions – fortnightly	<u>Parents</u> (n = 352) Description – first time mothers with healthy term infants Sex – F = 100% Age – age at delivery = 30.2 years <u>Children</u> (n = 352) Sex – F = 181 Age – age at baseline = 4.3 months	<u>Parents</u> (n = 346) Description – first time mothers with healthy term infants Sex – F = 100% Age – age at delivery = 29.9 years <u>Children</u> (n = 346) Sex – F = 173 Age – age at baseline = 4.3 months	<u>Statistically significant</u> – At follow-up the control group had higher BMI-for-age-z score and were more likely to show rapid weight gain from baseline to follow-up. Mothers in the control group were more likely to report using non-responsive feeding practices that fail to respond to infant satiety cues such as encouraging eating by using food as a reward or using games <u>Descriptive</u> – At 14 months of age reduced growth-related indicators of future obesity risk were reported in the intervention group. At 14 months of age, with the exception of length, all the anthropometric variables were consistently lower in the intervention group.
				Module 2 commencing when the infants were 13-15 months Groups of parents	Child health centres	Number of sessions – 6 Duration of sessions – 1-1.5 hours Frequency of sessions – fortnightly Total duration of program - not indicated			

Parent-child interaction therapy (PCIT)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Phillips, Morgan, Cawthorn, Barnett (2008)	Treatment of behaviourally disorded preschool-aged children	Child behaviour Parent-child relationship	Non-controlled trial Pre-post measures	Parents (unclear if individual or group)	Toddler clinic	Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once Total duration of program – not indicated	<u>Parents</u> (n = 43) Description – referred for treatment of disruptive child behaviours Sex – F = 100% Age – mean = 32.6 years, range = 19 – 41 years <u>Children</u> (n = 43) Description – children with disruptive behaviours Sex – M = 67.4% Age – mean = 33.8 months Range = 19 -52 months	None	<u>Statistically significant</u> – Significant improvements pre to post in behaviour intensity and problem, maternal anxiety, depression and stress. Significant pre to post changes in proportion of families with clinical levels on parenting stress, behaviour internalising and externalising, behaviour intensity and problem. <u>Non-significant</u> – No significant changes in proportion of parents with clinical levels of depression, anxiety or stress. <u>Descriptive</u> – High levels of satisfaction with the program were reported by parents.
				Parent-child dyads (unclear if individual or group)	Toddler clinic	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – individually tailored			

Parent-child interaction therapy (PCIT)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Individual families	Home	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – individually tailored			

Parent-child interaction therapy (PCIT)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Nixon, Sweeney, Erickson, Touyz (2004)	To improve child-parent relationships and provide parents with skills to manage disruptive behaviour	Child behaviour Parent-child relationship	Randomised controlled trial Pre-post-follow-up measures (no follow-up for waitlist). Four conditions 1.Standard program 2.Abbreviated program 3. waitlist 4.social validity (SV)	**Standard program** Individual parents	**Standard program** Not indicated	**Standard program** Number of sessions – 12 Duration of sessions – 1-2 hours Frequency of sessions – weekly Total duration of program – 15.5 hours	**Standard program** Parents (n = 17) Description – parents of behaviourally disturbed preschoolers Age – mother's mean age = 34.73 years; father's mean age = 37 years Children (n = 22) Description – children with behavioural problems Sex – M = 18 Age – mean = 47.36 months	**Waitlist** Parents (n = 17) Description – parents of behaviourally disturbed preschoolers Children Description – children with behavioural problems	Statistically significant – Reported elsewhere. Maintenance of effect – Pre-treatment to 1 year follow-up significant effects maintained for both treatment groups. Significantly more praise from mothers in abbreviated program than in standard program at 1 year. Non-significant – No significant decrease in child deviant behaviour in observations for standard program. No significant difference from pre to follow-up in mother critical statements, children's compliance and deviant behaviour. No clinically significant differences between groups at follow-up, although more improvements were seen for the standard program families

Parent-child interaction therapy (PCIT)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Abbreviated program Individual parents	**Abbreviated program** Face to face location not indicated Videos of some sessions to watch at home Telephone	**Abbreviated program** Number of sessions – 5 face to face and 5 phone calls Duration of sessions – 1-2 hours for face to face and 30 minutes for phone calls Frequency of sessions – not indicated Total duration of program – 9.5 hours	**Abbreviated program** Parents (n = 20) Description – parents of behaviourally disturbed preschoolers Age – mother's mean age = 33.85; father's mean age = 36 years Children (n = 27) Description – children with behavioural problems Sex – M = 18 Age – mean = 48.3 months	**Social validity** Parents (n = 21) Description – parent of children with no behavioural problems Age – mother's mean age = 35.52; father's mean age = 38.05 Children Sex – M = 15 Age – mean = 44.71 months	

Parent Education and Behavior Management (PEBM)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Tonge, Brereton, Kiomall, Mackinnon, King & Rinehart (2006)	To improve the mental health and adjustment of parents with preschool children recently diagnoses with autistic disorder	Child behaviour	Randomised controlled trial Contemporary control Pre-post-follow-up (6 months) measures	Groups of families	Not indicated	Number of sessions –10 Duration of sessions – 90 minutes Frequency of sessions – fortnightly	Parents (n = 35) Description – parents of children with autism Sex – not indicated Age – not indicated Children Age -2.5-5 years old	Parents control (n = 35); alternate treatment (n = 35) Description – parents of children with autism Sex – not indicted Age – not indicated Children Age – 2.5-5 years old	Statistically significant – Both treatments resulted in significant and progressive improvement in overall mental health at follow-up and mental health significantly improved over time in the 54% of principal caregivers who had the highest levels of mental health problems. Maintenance of effect – Gains were maintained at 6 months follow-up Descriptive – The parent education and behaviour management intervention was effective in alleviating a greater percentage of anxiety, insomnia, and somatic symptoms and family dysfunction than parent education and counseling at 6 months follow-up.
				Individual families	Not indicated	Number of sessions – 10 Duration of sessions – 60 minutes Frequency of sessions – fortnightly Total duration of program – 20 weeks			

Parenting Preschools Programme

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Elliot, Merrigan, Ballinger (2002)	To improve child pre-reading skills and parent behaviour management skills (see design for conditions)	Child behaviour Child development Parent-child relationship	Cluster randomised controlled trial Pre-post-follow-up measures Four conditions: 1.Sound Foundations pre-reading program 2.Parenting Preschoolers Programme 3.both interventions 4.no intervention	**Sound Foundations Pre-reading program only** Groups of children	**Sound Foundations Pre-reading program only** Preschools and schools	**Sound Foundations Pre-reading program only** Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	**Sound Foundations Pre-reading program only** Parents (n = 164) Description – parent of preschool children Children (n = 164) **Demographics for entire sample** Description – preschool children Sex – M = 54.2% Age – mean = 57 months	Parents (n = 122) Description – parent of preschool children Children (n = 122) **Demographics for entire sample** Description – preschool children Sex – M = 54.2% Age – mean = 57 months	Statistically significant – Significantly lower post scores on parent reported anxious-fearful factor for combined group only. Teacher reports from pre to post indicated that children in the pre-reading group had significantly higher hostile-aggressiveness and hyperactive-distractible scores compared to the controls. Maintenance of effect – At 1 year follow-up there was a significant difference between groups on anxious-fearful subscale, with combined group having lowest and parenting group have highest scores. The difference between these two groups was significant at 1 year but not by 2 years. At 2 years, the combined group had significantly lower hyperactive-distractible scores than the control group. Teacher reports of group differences were not maintained. Non-significant – No significant differences on parent reports of behaviour at pre test. No significant differences between groups over time on parent reports of child behaviour. No effect was found for either the pre-reading or parenting groups on academic performance.
				Parenting preschoolers program only Groups of parents	**Parenting preschoolers program only** Preschools	**Parenting preschoolers program only** Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – not indicated	**Parenting preschoolers program only** Parents (n = 19) Description – parent of preschool children Children (n = 19) **Demographics for entire sample**		

Parenting Preschools Programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						Total duration of program – not indicated	Description – preschool children Sex – M = 54.2% Age – mean = 57 months		
				Individual parents	Preschools and telephone	Number of sessions – 3 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated			
				Both reading and parenting program	**Both reading and parenting program** Not indicated	**Both reading and parenting program** Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not	**Both reading and parenting program** <u>Parents</u> (n = 25) Description – parent of preschool children <u>Children</u> (n = 24) **Demographics for entire sample** Description – preschool children		

Parenting Preschools Programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						indicated Total duration of program – not indicated	Sex – M = 54.2% Age – mean = 57 months		

Parents Under Pressure

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Dawe, & Harnett (2007)	Targets multiple domains of family functioning including the psychological functioning of individuals in the family, parent-child relationships and social contextual factors	Parent-child relationships Family relationships Safety and physical wellbeing Child behaviour	Randomised controlled trial Contemporary usual care and alternate treatment Pre-post, follow- up measures	Individual family	Home	Number of sessions – 10 Duration of sessions – 1-2 hours Frequency of sessions – weekly Total duration of program – 10-12 weeks	Parents (n = 22) Description – on methadone maintenance and have at least one child aged between 2 and 8 years Sex – M = 86% Age – mean = 30 years	Parents - alternate treatment (n = 23); usual care (n = 19) Description – on methadone maintenance and have at least one child aged between 2 and 8 years Sex – M = 86% Age – mean = 30 years	Statistically significant – Those receiving the PUP program showed significant reductions in parenting stress, child abuse potential, methadone dose, and child behaviour problems. For the standard group there was a significant worsening on the measure of child abuse potential. For the alternative treatment group there was a significant reduction in abuse potential over time. Maintenance of effect – Post-treatment changes were maintained in the PUP group at 6 months follow-up. Non-significant – For the intervention group there was no significant increase in child prosocial scores. Descriptive – For both control groups, there were no changes for parenting stress, child abuse potential, methadone dose, child behaviour on total problem score and prosocial score. There were no changes in parental substance use scores across time for any group.

Parents Under Pressure									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Frye & Dawe (2008)	As above	As above	Non-controlled trial Pre-post and follow-up measures	As above	Women's place of residence (i.e., in custody or within the community)	As above	Parents (n = 12) Description – women involved in the criminal justice system that were living or intended to live with a child over 18 months. All women reported a history of sexual and physical abuse, domestic violence, histories of drug or alcohol dependence with poor educational attainment and reliance on government benefits at the time of the current offence. Sex – F = 100% Age – mean = 30.2 years Children (n = 12) Age – mean = 5.6 years	None	Statistically significant – Program participation was associated with significant lifestyle improvements in particular maternal emotional wellbeing, parent-child functioning, levels of stress experienced in the parenting role, as well as significant improvements in child behaviour outcomes. Maintenance of effect – The gains appeared to be maintained in the short term (i.e., 3 month follow-up).

PRAISE parenting program (also called DIET) as part of Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS) study									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Burrows, Warren Baur, Collins (2008), Burrows, Warren & Collins (2010) Cliff, Okely, Morgan, Steele, Jones, Colyvas, & Baur (2010) Okely, Collins, Morgan, Jones, Warren, Cliff, Burrows, Colyvas, Steele, & Baur (2010) Collins, okely, Morgan, Jones,	To improve dietary intakes and food behaviour of overweight and obese children	Safety and physical well-being	Randomised comparative trial Pre-post-follow-up measures Three conditions: 1.**PRAISE** parent-centred nutrition program. (Also called DIET) 2.**SHARK** child-centred physical activity skill development program, with some parental involvement (also called PA – physical activity) 3.**Combination** of both programs (also called PA+DIET)	**PRAISE** Groups of parents	**PRAISE** Community	**PRAISE** Number of sessions – 10 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – school term	**PRAISE** <u>Children</u> (n = 45) Description – overweight or obese children Sex – F = 28 Age – mean = 8.1	**Did not have a true control group**	<u>Statistically significant</u> – All groups achieved a significant reduction in energy intake between pre and 6 and 12 months. Signification decrease in mean daily grams of fat at first follow-up. Significant decrease in carbohydrate, including sugar, consumption for all groups. Significant decreases overtime for all groups with regards to pressure to eat and concern about eating. Significant reduction for parent restriction in the PRAISE group but not SHARK at 6 months. Significant improvements on athletic competent at 6 and 12 months for all groups. Significant reduction in screen time for all groups at 6 months. All groups reduced their BMI z scores at 6 months <u>Maintenance of effect</u> – Reductions in energy intake maintained for all groups. Maintained improvement on pressure to eat up until 24 months for all groups. Reduction in parent restriction in the PRAISE but not SHARK group was maintained at 12 and 24 months. Significant reduction in BMI z score at 24 months, with the
				Individual parents	Telephone	Number of sessions – 3 Duration of sessions – not indicated Frequency of sessions – monthly Total duration of program – 3 months			

PRAISE parenting program (also called DIET) as part of Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS) study									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Burrows, Cliff, Colyvas, Warren, Steele & Baur (2011)				**SHARK** Groups of children	**SHARK** Community setting	**SHARK** Number of sessions – 10 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 6 months	**SHARK** <u>Children</u> (n = 58) Description – overweight or obese children Sex – F = 35 Age – mean = 8.1		greatest reduction for the PRAISE compared to the SHARK group. Reductions in BMI z scores for all groups were maintained at 12 months. <u>Non-significant</u> – No significant difference in reduction of energy intake between groups overtime. No changes in vegetable consumption. Non significant improvements at 12 months on athletic competence for the combined group and the SHARK group. No significant differences between groups at follow-up for physical activity. No significant differences between groups on screen time. No significant group by time interaction for waste circumference. No differences between groups at 6 or 12 months on metabolic outcomes <u>Descriptive</u> – Greater improvements in movement skill proficiency at 6 months for the SHARK and combined groups compared to the PRAISE group
				Individual parent-child dyads	Home	Number of sessions – 27 Duration of sessions – 30 minutes Frequency of sessions – 3 times a week Total duration of program – 9 weeks			

PRAISE parenting program (also called DIET) as part of Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS) study									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Groups of parents	Not indicated	Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once Total duration of program – not indicated			
				Individual parents	Telephone	Number of sessions – 3 Duration of sessions – not indicated Frequency of sessions – monthly Total duration of program – 3 months			

PRAISE parenting program (also called DIET) as part of Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS) study									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Combined	**Combined**	**Combined**	**Combined** Children (n = 57) Description – overweight or obese children Sex – F = 30 Age – mean = 7.8		

Rapee, Kennedy, Ingram, Edwards, & Sweeney (2005); Rapee, Kennedy, Ingram, Edwards, & Sweeney (2010)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Rapee, Kennedy, Ingram, Edwards, & Sweeney (2005) Rapee, Kennedy, Ingram, Edwards & Sweeney (2010)	To prevent the development of anxiety in preschool children	Child behaviour	Randomised controlled trial Contemporary no treatment control Pre- follow-up (1 year and 3 years) measures	Groups of parents	Not indicated	Number of sessions –6 Duration of sessions – 90 minutes Frequency of sessions – weekly for the first four, with the fifth session being 2 weeks later and the sixth session being 1 month after that. Total duration of program – 10 weeks	Parents Age – mothers mean age = 35.0 years; fathers mean age = 37.9 years Children (n = 73) Description – children with a high number of withdrawn/inhibited behaviours aged 36-62 months Sex – F = 60% Age –mean = 47.3 months	Parents Age – mothers mean age = 35.0 years; fathers mean age = 37.5 years Children (n = 73) Description – children with a high number of withdrawn/inhibited behaviours aged 36-62 months Sex – F = 49% Age – mean = 46.1 months	Statistically significant – Children whose parents were allocated to the education condition showed a significantly greater decrease in anxiety diagnoses at 12 months relative to those whose parents received no intervention. By the time the children reached middle childhood, at risk children whose parents had received a brief intervention when the children were at preschool age were significantly less likely to display anxiety disorders or report symptoms of anxiety than similar children whose parents had not received the intervention. Maintenance of effect – Gains were reported at 1 year and 3 year follow-ups Non-significant – There were no significant effects demonstrated on measures of inhibition/withdrawal

Resilient Families Intervention

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Shortt, Hutchinson, Chapman & Toumbourou (2007) Yuen and Toumbourou (2011)	To improve parental metal health and family functioning and prevent adolescent substance abuse	Child behaviour Parent-child relationship Family relationships	Cluster randomised controlled trial Contemporary usual care Pre-post-follow-up measures	Groups of children	Not indicated	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	**Demographics are for the entire sample** Parents (n = 1166) Description – parents of year 7 students Sex – F = 88% Age – less than 37 = 12% Children (n = 2315) Description – students in year 7 Sex – F = 57% Age – mean = 12.3 years	**Demographics are for the entire sample** Parents (n = 1166) Description – parents of year 7 students Sex – F = 88% Age – less than 37 = 12% Children (n = 2315) Description – students in year 7 Sex – F = 57% Age – mean = 12.3 years	Statistically significant – Student's exposure to the intervention predicted significant increases in high family attachment and high school rewards at post. Students exposed to the intervention were significantly less likely to report school absences but more likely to report anxiety. Parent attendance at the brief intervention significantly reduced low academic grades and being bullied at post but resulted in significantly more adolescent aggression toward parents. Students whose parents attended PACE were more than twice as likely as their peers to report improvements in problem solving at post. Parents in the intervention group that attended either the brief parent education or the PACE program showed significant improvements in mental health from pre to post, compared to intervention parents who did not attend parent education and compared to parents in control schools. Maintenance of effect – Significant gains in mental health for intervention group parents that attended parent education were maintained at 4 years follow-up.
				Group of parents (brief intervention)	Not indicated	Number of sessions – 1 Duration of sessions – 2 hours Frequency of sessions – once Total duration of program – 2 hours			

Resilient Families Intervention									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Groups of parents (PACE program)	Not indicated	Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – not indicated Total duration of program – 16 hours			<u>Non-significant</u> – No significant differences on mental health between parents in intervention and controls. No significant changes in family conflict. When analyses were adjusted for outlying cases of high parental anxiety and depression, reduction overtime in family cohesion was found to not be significant. Similarly improvements in parental mental health were no longer significant. <u>Descriptive</u> – Family cohesion reduced and family conflict was stable overtime for intervention parents who attended parent education.

Teen Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Stallman &Ralph (2007)	Designed to provide parents with strategies to enable them to continue promoting their teenager's development whilst managing the emotions and increased needs for freedom of adolescents	Child development Child behaviour Parent-child relationship	Randomised controlled trial Waitlist Pre-post-follow-up (3 months) measures Two interventions 1) Self-directed Teen Triple P **(standard)** 2) Self-directed Teen Triple P with minimal therapist support **(enhanced)**	**Standard** Individual parents	**Standard** Home	**Standard** Number of sessions –10 Duration of sessions – N/A Frequency of sessions – weekly Total duration of program – 10 weeks	**Standard** Parents (n = 18) Description – parents of early adolescence (aged 12-14 years) who reported experiencing difficulties with their adolescent's behaviour Sex – F = 94% **(for the whole sample)** Age –mother's mean age = 41.92 years, father's mean = 43.46 years Children (n = 18) Sex –M = 61.1% Age – mean = 12.22 years	Parents (n = 16) Description – parents of early adolescence (aged 12-14 years) who reported experiencing difficulties with their adolescent's behaviour Sex – F = 94% **(for the whole sample)** Age – mother's mean age = 40.79 years, father's mean = 44.43 years Children (n = 16) Sex – M = 56.3% Age – mean = 12.19 years	Statistically significant – At post intervention parents in the enhanced condition reported significantly fewer adolescent behavioural problems and less use of over-reactive parenting strategies than parents in either the standard or waitlist conditions. The intervention effects were clinically significant with parents in the enhanced condition reporting greater clinically meaningful change, moving into non-clinical range post intervention. The standard group was significantly different from the waitlist condition on impact. Maintenance of effect – Improvements were maintained at 3 month follow-up. Non-significant – The standard group was not significantly different from either group on burden of problem behaviour and parental over-reactivity.
				Enhanced As above	**Enhanced** As above	**Enhanced** As above	**Enhanced** Parents (n = 17) Description – parents of early adolescence (aged 12-14 years) who reported experiencing difficulties with their adolescent's		

Teen Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							behaviour Sex – F = 94% **(for the whole sample)** Age – mother's mean age = 43.21 years, father's mean age = 46.17 years <u>Children</u> (n = 17) Sex – M = 64.7% Age – mean = 12.41 years		
				Individual parents	Telephone	Number of sessions – 10 Duration of sessions – 5-20 minutes Frequency of sessions – weekly Total duration of program – 10 weeks			

Teen Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Ralph & Sanders (2004)	Addresses issues that might lead to severe adolescent antisocial behaviour. Teen Triple P targets parenting risk factors such as: harsh, coercive discipline styles; parent-teenager conflict and communication difficulties; parental monitoring of teenagers' activities; parental depression; and marital conflict	Child behaviour Child development Parent-child relationship Family relationships	Cluster randomised controlled trial Waitlist Pre-post-follow-up (6 months) measures	Groups of parents	Not indicated	Number of sessions – 4 Duration of sessions – 2 hours Frequency of sessions – weekly	<u>Parents</u> (n = 78) Description – parents with 12-13 year-old children living in low socioeconomic areas with high juvenile crime rates Sex – 62 <u>Children</u> (n = not indicated) Age – 12-13 years	<u>Parents</u> (n = not indicated) Description – parents with 12-13 year-old children living in low socioeconomic areas with high juvenile crime rates <u>Children</u> (n = not indicated) Age – 12-13 years	<u>Statistically significant</u> – There were significant reductions in a variety of risk factors, including parent-teenager conflict, parenting styles, parental conflict over parenting strategies and parental beliefs on measures of self-efficacy, self-sufficiency and self management. Significant improvements at post treatment for parental depression, anxiety and stress. Parents who had participated in the group program reported significantly less difficult behaviour and greater confidence than the matched comparison group. <u>Maintenance of effect</u> – Some evidence of improvements still being maintained after six months.
				Individual parents	Telephone	Number of sessions – 4 Duration of sessions – up to 30 minutes Frequency of sessions – weekly Total duration of program – 8 weeks			

Teen Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Ralph & Sanders (2003)	Aims to prepare parents for their child's transition to the teenage years by focusing on the all-too common difficulties for children (and parents) of making a successful transition to high school	Child behaviour Parent-child relationship Family relationships Child development	Non-controlled trial Pre-post measures	Groups of families	School library	Number of sessions –8 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 8 weeks	Parents (n = 37) Description – parents with 12-13 year-old children from a high school serving a low socio-economic area Sex – F = 27	None	Statistically significant – Participating parents reported significant reductions in conflict with their teenager and on measures of laxness, over-reactivity and disagreements with their partner over parenting issues. Parents reported significant improvements on measures of self-regulation, including self-efficacy, self-sufficiency and self-management and reductions on measures of depression, anxiety and stress.

Tuning in to Kids: Emotionally Intelligent Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Havinghurst, Harley and Prior (2004)	To assist parenting in teaching their preschool children some basic skills in understanding and regulating emotions	Child behaviour Parent-child relationships	Non-controlled trial Pre- post-follow-up measures	Groups of parents	Community centre or kindergarten	Number of sessions – 6 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 6 weeks	Parents (n = 50) Description – parents of children attending preschools in lower to middle class areas Sex – F = 92% Children (n = 50) Description – all children, but parents of children with social/behavioural problems encouraged Sex – F = 51% Age – 4-5 years	None	Statistically significant – Significant pre to post improvements in all aspects of parenting children's emotions. Most child behaviour changes were for children with pre behaviour problems – significant improvements for this group on distress reactions, punitive reactions, minimisation reactions, expressive encouragement, emotion-focused responses, and problem-focused responses. Significant pre to post improvements on parent inductive reasoning, warmth and punishment/power assertion. Significant improvement in pre to post parenting efficacy. Maintenance of effect – Significant gains continued for emotion-focused responses, problem-focused responses and expressive encouragement. Improvements in parent inductive reasoning, warmth and punishment/power assertion maintained at 3 month follow-up.

Tuning in to Kids: Emotionally Intelligent Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Havighurst, Wilson, Harley, Prior (2009)	To improve parents' emotion responsiveness and coaching skills, as well as increase parents' own emotional competence	Child Behaviour Parent-child relationship	Cluster randomised controlled trial Waitlist Pre-post measures	Groups of parents	Community centre	Number of sessions – 6 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 12 hours	Parents (n = 107) Description – parents with children attending preschools in CALD lower to middle SES regions. **Demographics are for the whole sample** Sex – F = 209 Age – mean = 36.52 Children (n = 107) Description – All invited but those with emotional or behaviour problems encouraged Sex – M = 115 Age – range = 4-5.11 years	Parents (n = 111) Description – parents with children attending preschools in CALD lower to middle SES regions. **Demographics are for the whole sample** Sex – F = 209 Age – mean = 36.52 Children (n = 111) Description – all invited but those with emotional or behaviour problems encouraged Sex – M = 115 Age – range = 4-5.11 years	Statistically significant – Significant increase in emotional coaching and decrease in emotion dismissing in intervention but not control group. Significant pre to post improvement in intervention children's behavioural intensity. Non-significant – No significant differences between groups on parent wellbeing or difficulties with emotion regulation scale of parents' emotional competence. Descriptive – Decrease in percentage of children with clinical levels of behaviour intensity in intervention group, while control group proportions remained similar at pre and post.

Tuning in to Kids: Emotionally Intelligent Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Havinghurst, Wilson, Harley, Prior, Kehoe (2010)	To improve emotion socialization practices in parents of preschool children	Child behaviour Parent-child relationship	Cluster randomised control trial Waitlist control pre-post-follow-up measures	Groups of parents	Community settings	Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – weekly for 6 sessions, then bimonthly Total duration of program – 5.5 months	Parents (n = 106) Description – parents of children from preschools in lower to middle class regions **Demographics are for the entire sample** Sex – F = 207 Age – mean = 36.57 Children (n = 106) Sex – M = 113 Age – range = 4-5.11 years	Parents (n = 110) Description – parents of children from preschools in lower to middle class regions **Demographics are for the entire sample** Sex – F = 207 Age – mean = 36.57 Children (n = 110) Sex – M = 113 Age – range = 4-5.11 years	Statistically significant – Intervention parents reported being significantly less dismissive, more emotion coaching and more empathic at post than at pre, with no change for controls. Significant reduction in intervention children's parent-reported behaviour problems, but not for controls. Maintenance of effect – Significant improvement in intervention parent's emotion awareness and regulation by 6-month follow-up , but no change in controls. Significant improvement in parent's dismissive, more emotion coaching and more empathy maintained at 6 months, with no change for controls. Children of intervention parents showed significantly better emotion knowledge at follow-up than the control children. Teacher reports of child behaviour show significantly lower intensity for intervention group at follow-up. Non-significant – Slight, but non-significant pre to post worsening in intervention parent's emotion awareness and regulation.

Tuning in to Kids: Emotionally Intelligent Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Descriptive – Intervention parents were observed using more emotion labels and engaged in more emotion exploration at follow-up than controls.

Tuning in to Kids: Emotionally Intelligent Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Wilson, Havinghurst and Harley (2012)	To improve emotion socialisation practice in parents of preschool children	Child behaviour Parent-child relationship	Cluster randomised controlled trial Waitlist Pre-post measures (post was 7 months later rather than immediately post)	Groups of parents	Not indicated	Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – weekly for 6 sessions, then bimonthly Total duration of program – 5.5 months	Parents (n = 62) **Demographics for whole sample** Description – parents of preschool children in one municipality Sex – F = 118 Age – mean = 36.3 years Children (n = 62) Description – children attending preschool Sex – M = 52% Age – mean = 4.19 years; range = 4-5.11 years	Parents (n = 66) **Demographics for whole sample** Description – parents of preschool children in one municipality Sex – F = 118 Age – mean = 36.3 years Children (n = 66) Description – children attending preschool Sex – M = 52% Age – mean = 4.19 years; range = 4-5.11 years	Statistically significant – Significant pre to post improvements for parents in the intervention but not control group on emotion dismissing beliefs and practices, emotion coaching practices and positive involvement. Intervention parents reported significantly greater reduction in number of behaviour problems. Non-significant – Not significant change in emotion coaching beliefs for inconsistent discipline. There were no significant intervention effects in measures of child behaviour. Trend toward time by group effect for parent reported behaviour intensity

Universal Triple P

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
McTaggart and Sanders (2003)	To reduce child behaviour problems in the classroom and at home and reduce the risk factors for the development of child behaviour problems	Child behaviour Parent-child relationship	Cluster randomised controlled trial Waitlist Pre-post-follow-up measures	Individual parents	School, home	Continuous media campaign throughout school year (brochures, tip sheets, letters, fortnightly school and Tripe P newsletters and a poster at the school)	<u>Parents</u> (n = not indicated) <u>Children</u> (n = 490) Age – grade 1	<u>Parents</u> (n = not indicated) <u>Children</u> (n = 495) Age – grade 1	<u>Statistically significant</u> – Teachers at intervention schools reported significantly greater improvement in children's behaviour than did teachers at control schools. There were significantly greater numbers of children whose behaviour improved sufficiently to achieve clinically reliable change in the intervention schools than the control schools. <u>Maintenance of effect</u> – The improved school behaviour in the intervention schools was maintained at 6 months. **Note:** Results are for both the Group Triple P and those who only received the media campaign.
				Groups of parents (parents self-selected to receive the group program after receiving the media campaign)	School	Number of sessions – 4 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 4 weeks followed by four 15-30 minute phone calls from facilitators			

Universal Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Sanders, Ralph, Sofronof, Gardiner, Thompson, Dwyer & Bidwell (2008)	To reduce the rate of child mental health problems, parental adjustment difficulties and dysfunctional parenting	Child behaviour parent-child relationship Family relationships	Non-randomised controlled trial Contemporary usual care control group Pre-post measures **Note:** The intervention employed five levels of the Triple P multilevel system. This included universal, workplace, telephone group, primary care, standard and enhanced Triple P delivered by a range of service providers.	Unclear	Unclear	Number of sessions – unclear Duration of sessions – unclear Frequency of sessions – unclear Total duration of program - unclear	Parents (n = 1500) Sex – F = 79.1 % Age – under 31 years = 19.7%; 31-40 = 61.2%; 41-50 = 17%; >51 = 2% Children (n = unclear) Sex – not indicated Age – range = 4-7 years	Parents (n = 1500) Sex – F = 72.5% Age – under 31 years = 11.7%; 31-40 = 63.5%; 41-50 = 22.3%; >51 = 2.5% Children (n = unclear) Sex – not indicated Age – unclear	Statistically significant – At post-intervention there were significantly greater reductions in the Triple P Positive Parenting Program (TPS) communities in the number of children with clinically elevated and borderline behavioral and emotional problems compared to the control communities. The implementation of the TPS was associated with significantly greater reductions in emotional problems and psychosocial difficulties in both children and their parents than in the control condition. Improvements over time in the proportion of children who were clinically elevated on Strengths and Difficulties Questionnaire (SDQ) Total Difficulties were significantly greater for the TPS condition than the control condition. Between Time 1 and Time 2, the proportion of children with Behavioral and Emotional Problems

Universal Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									decreased significantly in the TPS condition and also decreased significantly in the control condition. However, no significant difference was observed between the conditions in the level of change over time. The pre- to post-intervention improvement in depression scores was significantly greater for the TPS condition than the control condition. From Time 1 to Time 2, the proportion of parents in the TPS condition with a score of 'high' on stress did not change. The pre- to post-intervention improvement in the proportion of parents likely to engage in appropriate strategies for child misbehavior was significantly greater for the control condition than the control condition. Non-significant – No significant changes were observedover time for the TPS or control condition

Universal Triple P									
Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
									on hyperactivity. No significant changes were observed over time in the proportion of parents who were high scorers on confidence or support. No significant change was observed over time for either the TPS or control condition on either parenting behavior variables – positive parenting and parenting for fearful/anxious behaviour. <u>Descriptive</u> – The intervention effects were for overall psychosocial problems and emotional difficulties, but not for conduct problems, hyperactivity and peer relationship difficulties. Parental reports of depression reduced by 26% while the control group showed no change. There was a 32% reduction in coercive parenting in the Triple P communities. Although there was a reduction in coercive

Universal Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									parenting in both the TPS and control conditions, there was a 14% greater reduction in the Triple P communities. No change over time was observed in either condition on the Strengths and difficulties (SDQ) Prosocial Scale.

Van Bergen, Salmon, Dadds & Allen (2009)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Van Bergen, Salmon, Dadds, and Allen (2009)	To train parents in elaborative, emotion-rich reminiscing to increase children's autobiographical memory and emotion knowledge	Parent-child relationship	Randomised controlled trail Contemporary alternate treatment Pre-post-follow-up measures	Individual mother-child dyads	University	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – weekly (there was a two-week gap between the third and fourth sessions) Total duration of program – 5 weeks	Parents (n = not indicated) Children (n = 23) Sex – male n = 13 Age – mean = 3.75 years; range = 3.5-5 years	Parents (n = not indicated) Children (n = 21) Sex – F (n = 11) Age – mean = 3.84 years; range = 3.5-5 years	Statistically significant – Intervention group mothers made significantly more high-elaborative utterances and emotion references than did control mothers. Intervention group children made significantly more high-elaborative utterances and emotion references than did control children. Children of intervention mothers showed significantly higher emotion cause knowledge after 6 months than control group. Maintenance of effect – The increase in high-elaborative utterances and emotion references in intervention group mothers was maintained at six months. The increase in high-elaborative utterances and emotion references in intervention group

Van Bergen, Salmon, Dadds & Allen (2009)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									children was maintained at six months. Descriptive – There were no differences between reminiscing and control children's independent recall with an experimenter either immediately following the intervention or 6 months later. The intervention boosted mothers' and their children's references to emotion attributions, behaviours and causes during shared reminiscing, together with their total emotion references.

Workplace Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Sanders, Stallman, McHale (2011)	Targets difficult areas for working parents and involves helping parents manage stress and improve coping skills, as they both relate to work and family situations as well as specific strategies for dealing with key transition times such as getting ready for work and arrival home from work	Family relationships Parent-child relationship	Randomised controlled trial Waitlist Pre-post-follow-up (12 months) measures	Groups of parents	Not indicated	Number of sessions – 4 Duration of sessions – 2 hours Frequency of sessions – weekly	Parents (n = 62) **Demographics are for the whole sample** Description – working parents with children ranging in age from 1-16 years and having difficulties balancing family and work commitments Sex – F = 72.4% Age – not indicated Children (n = 62) Sex – M = 50.4% Age –mean = 6.6 years	Parents (n = 59) **Demographics are for the whole sample** Description – working parents with children ranging in age from 1-16 years and having difficulties balancing family and work commitments Sex – F = 72.4% Age – not indicated Children (n = 59) Sex – M = 50.4% Age – mean = 6.6 years	Statistically significant – Results showed that parents who had received the intervention reported significantly lower levels on measures of personal distress and dysfunctional parenting; and higher levels of work commitment, work satisfaction and self efficacy. Maintenance of effect – Long-term effects (12 months) observed for several indicators of parent and child behaviour intervention effects.
				Individual parents	Telephone	Number of sessions – 4 Duration of sessions – 15-30 minutes Frequency of sessions – weekly Total duration of program – 8 weeks			

Appendix 10. Programs rated as Promising in the REA (data extracted from papers and program rating checklists)

Promising programs were rated as follows on the evidence of effectiveness checklist:

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
1.	No evidence of risk or harm	☐	☐	☒	☐	☐	
2.	If there have been multiple studies, the overall evidence supports the benefit of the program	☐	☐	☒			
3.	Clear baseline and post measurement of outcomes for both conditions	☐	☐	☒			
4.	At least **two** RCTs have found the program to be significantly more effective than comparison group. Effect was maintained for at least **one** study at **1 year** follow-up.	☐					
5.	At least **one** RCT has found the program to be significantly more effective than comparison group. Effect was maintained at **6 month** follow-up.		☐				
6.	At least one study using some form of contemporary comparison group demonstrated some improvement outcomes for the intervention but not the comparison group			☒			

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
7.	There is insufficient evidence demonstrating the program's effect on outcomes because: a) the designs are not sufficiently rigorous (criteria 1-6) OR b) the results of rigorous studies are not yet available				☐		
8.	Two or more RCTs have found no effect compared to usual care OR the overall weight of the evidence does not support the benefit of the program					☐	
9.	There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect on participants						☐

1-2-3 Magic

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Bailey, Phelan and Brooks (2012)	To target , manage and reduce undesirable behaviour in children aged 2-12 years	Child behaviour, parent-child relationship	Randomised controlled trial Contemporary waitlist control Pre-post measures	Unclear	Unclear	Number of sessions – 2 Duration of sessions – 3 hours Frequency of sessions – held over 2 days Total duration of program – 2 days	Parents (n = 5) **Demographics are for entire group** Sex - F = 100% Age – mean = 38.6 years Children (n = 9) Description – behaviour is currently of concern to parents but has not a had previous formal diagnosis of a behavioural disorder Sex – F n = 5 Age – M = 7.5 years, range = 6-12 years	Parents (n = 4) **Demographics are for entire group** Sex - F = 100% Age – mean = 38.6 years Children (n = 4) Description – behaviour is currently of concern to parents but has not a had previous formal diagnosis of a behavioural disorder Sex – F: n = 5 Age – M = 7.5 years, range = 6-12 years	Statistically significant – Within-group comparisons suggest that the improvements observed in the behaviour of target children in the intervention group were significant (on both the Intensity and Problem scale) and that the improvement in scores on the Efficacy Scale made by parents in the intervention group reached significant levels. Non-significant – Parents reported both a greater level of satisfaction and globally a more positive attitude toward the parenting role at follow-up however the change was not of a significant magnitude. Descriptive – Primary caregivers reported that target children engaged less intensively and in fewer disruptive behaviors following intervention. Behavioural scores on Intensity and Problem scales improved from clinical to non-clinical range.

1-2-3 Magic

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Flahery, (2008), Flaherty and Cooper (2010),	To educate carers to better manage unwanted behaviour, encourage wanted behaviour and strengthen the relationship between parent and child	Child behaviour, parent-child relationship	Randomised controlled trial Contemporary waitlist control Pre-post measures	Groups of parents	Community health centre	Number of sessions – 3 Duration of sessions – 2 hours Frequency of sessions – unclear Total duration of program – 6 weeks	Parents (n = 19) Description – parents/carers of children who had experienced moderate to severe child abuse Sex – not indicated Age – mean = 43 years **Children's demographics are for entire group** Children (n = 99) Description – children had been subject of moderate to severe child abuse Sex – not indicated Age – range = 2-16 years	Parents (n = 16) Description – parents/carers of children who had experienced moderate to severe child abuse Sex – not indicated Age – mean = 36 years **Children's demographics are for entire group** Children (n = 99) Description – children had been subject of moderate to severe child abuse Sex – not indicated Age – range = 2-16 years	Statistically significant – A significant increase in self-reported parenting satisfaction for the intervention group. A significant difference was found for the amount of problem behaviours and intensity of problem behaviours. Descriptive – The level of parenting satisfaction more than doubled in the intervention group from 20% prior to 42% post intervention. Parent/carer severity ratings, as a group, changed pre to post intervention from moderate to normal for depression, remained normal for anxiety, and reduced from moderate to normal for stress. The intervention group showed a reduction in depression, anxiety, stress and unwanted child behaviour.

ABCD Parenting Young Adolescents Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Burke, Brennan, & Cann (2012)	To provide parents with information and skills for developing and maintaining trusting, positive and accepting relationships with their young adolescents which, in turn, encourages them to test their independence within safe boundaries and make the transition to adolescence	Child behaviour Parent-child relationship Child development	Randomised controlled trial Waitlist Pre-post measures	Group of parents	Community settings (e.g., schools, community health centers)	Number of sessions – 6 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 6 weeks	Parents (n = 90) **Demographics are for the entire sample** Description – custodial or non-custodial parents with regular access to their adolescent aged 10-14 years. Sex –F = 90% Age – not indicated Children (n = 90) Sex – M = 54% Age – mean = 11.9 years	Parents (n = 90) **Demographics are for the entire sample** Description – custodial or non-custodial parents with regular access to their adolescent aged 10-14 years. Sex –F = 90% Age – not indicated Children (n = 90) Sex – M = 54% Age – mean = 11.9 years	Statistically significant – Parents in the intervention reported significantly higher adolescent prosocial behaviours, lower conduct problems and total difficulties. Intervention parents also reported lower stress associated with adolescent moodiness, parent-life restriction, adult-relations, social isolation, incompetence/guilt, lower stress in the parenting domain and lower overall stress relative to the control condition following the intervention period. Descriptive – Participants reported high satisfaction with all elements of the ABCD program.

AusParenting in Schools Transition to Primary School Parent Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Giallo, Treyvaud, Matthews & Kienhuis (2010)	To enhance parents' knowledge and confidence in their ability to help this child make a smooth transition and mange any difficulties that may arise at this time	Child development Child behaviour	Cluster Randomised controlled trial Contemporary usual care Pre-post measures	Groups of parents	School	Number of sessions – 4 Duration of sessions – 1.5 -2 hours Frequency of sessions – not indicated Total duration of program – 4 months	Parents (n = 286) Description – parents of children about to start school Sex – F = 85% Age – mean (SD) = 35.29 (6.08)	Parents (n = 290) Description – parents of children about to start school Sex – F = 83.8% Age – mean (SD) = 36.18 (5.11)	Statistically significant – Significantly greater pre to post transition to school self efficacy in intervention but not control parents. Significant pre to post effect for parental involvement in children's learning at home and school for intervention but not control parents. Non-significant – No significant differences between groups in pre to post Worry scores. No significant differences between groups in pre to post overall parenting self efficacy. No significant differences between intervention and control group parents or teacher ratings of child happiness to go to school, academic or social adjustment or school readiness. Descriptive – Parents ratings of satisfaction with all aspects of the program were high.

Bustos, Jaaniste, Salmon & Champion (2008)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Bustos, Jaaniste, Salmon &Champion (2008)	To teach parents to engage in behaviours likely to result in favourable infant pain outcomes	Child development	Randomised controlled trial Contemporary usual care control group Pre-post measures	Unclear	Home	Parents received an information sheet prior to their child's immunisation . They were contacted 1-2 days prior to their appointment and encouraged to review the information.	Parents (n = 25) **Parent demographics are for both groups** Sex - infants were accompanied to immunisations by (mother = 40%, father = 6%, both parents = 14%) Age – not indicated Children (n = 25) Sex – F (n = 13) Age – range = 5-7 months	Parents (n = 25) **Parent demographics are for both groups** Sex - infants were accompanied to immunisations by (mother = 40%, father = 6%, both parents = 14%) Age – not indicated Children (n = 25) Sex – F n = 13 Age – range = 5-7 months	Statistically significant – Parents in the intervention condition made significantly more coping-promoting statements in the 30 seconds prior to immunisation than parents in the control conditions. Infants in the control condition cried significantly longer than infants in the intervention condition. Child temperament had a significant effect on infant facial pain response where infants with a more difficult temperament displayed greater facial pain response. Infants rated by their parents as having a more difficult temperament cried for longer than infants who had been rated as having a more easy temperament. For infants with more difficult temperaments, the difference in cry duration and parental coping-promoting behaviour was significant. Non-significant – Infants in the control group had slightly higher scores on the measure of facial pain response however the difference was not significant.

Bustos, Jaaniste, Salmon & Champion (2008)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Infants who were rated as having a more difficult temperament tended to benefit more from the intervention than infants with an easier temperament, although this difference was non-significant. For infants with easy temperament, there was no significant difference between conditions in cry duration or parental coping-promoting. Descriptive – Infants in the control group cried for longer than those in the intervention group. Coping-promoting and distress promoting statements did not differ in terms of affective quality.

Cottage Community Care Pilot Project (CCCPP)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Kelleher, & Johnson (2004)	The CCCPP was designed to directly address factors in first-time families that are associated with child maltreatment: lack of parenting skills, little or no knowledge about child development, the isolation many new families experience due to loss or absence of extended family support, single parent status and the inability or reluctance of some new families to access available community supports and resources	Safety and physical wellbeing Child development Family relationships Parent-child relationship	Non-randomised controlled trial Contemporary comparison group Pre-post measures	Individual parents	Home	Number of sessions – 24 (maximum 108 visits) Duration of sessions – 2 hours Frequency of sessions – weekly or fortnightly	<u>Parents</u> (n = 25) Description – vulnerable parents as determined by a screening instrument Sex – F = 100% Age – not indicated <u>Children</u> Age – <6 weeks of age	<u>Parents</u> (n = 24) Description – vulnerable parents as determined by a screening instrument Sex – F = 100% Age – not indicated <u>Children</u> Age – <6 weeks of age	<u>Statistically significant</u> – Statistically significant differences between intervention and control groups were found in aspects of family functioning: the existence and adequacy of social supports and the degree of age appropriate and flexible expectations of infants. <u>Non-significant</u> – Compared to the control group the intervention group demonstrated a greater improvement in the mean difference between entry and exit mother-child relationship scores. However this differences was not significant. <u>Descriptive</u> – After 1 year, while families in both groups changed, intervention group families showed marked improvement as demonstrated by a greater degree of change in all items.
				Groups of parents	Community settings	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program – 8 months (maximum 18 months)			

Grillo, Ng, Gassner, Marshman, Dunn, Hudson, & Ng (2006)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Grillo, Ng, Gassner, Marshman, Dunn, Hudson & Ng (2006)	To educate parents and paediatric patients about atopic eczema (AE)	Safety and physical wellbeing	Randomised controlled trial Contemporary waitlist control Pre-post-follow-up measures	Not clear	Hospital	Number of sessions – 2 Duration of sessions – 1 Frequency of sessions – once Total duration of program – 2 hours	Parents (n = not indicated) Children (n = 29) **Demographics are for entire group** Description – children with atopic eczema Sex – M = 35, F = 26 Age – mean = 4.3 years, range = 0-16 years	Parents (n = not indicated) Children (n = 32) **Demographics are for entire group** Description – children with atopic eczema Sex – M = 35, F = 26 Age – mean = 4.3 years, range = 0-16 years	Statistically significant – Intervention group had a significant improvement in the scoring atopic dermatitis measure when compared to control at week 4 and week 12. Quality of life measures significantly improved with decreased severity of eczema in the group of children aged 5-16 years. Infant dermatology quality of life scores showed an significant improvement at week 12. Non-significant – Quality of life measures did not significantly improve with decreased severity of eczema except in the group of children aged 5-16 years. Dermatitis family impact scores for both groups showed a marginal but non-significant improvement at 4 and 12 weeks. Infant dermatology quality of life scores showed an improvement at week 4 however this was non-significant. The dermatitis family impact (DFI) score showed no difference between the groups.

Group Triple P (Japanese population)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Matsumoto, Sofronoff, & Sanders (2007)	Targets coercive family interactions known to contribute to the development and maintenance of children's disruptive behaviour problems	Family relationships Child behaviour Parent-child relationship Child development	Randomised controlled trial Waitlist Pre-post-follow-up (3 months) measures	Groups of families	Not indicated	Number of sessions –5 Duration of sessions – 2 hours Frequency of sessions – not indicated	Parents (n = 25) Description – families with Japanese parents living in Australia whose children were aged 2-10 years Age – not indicated Children (n = 25) Sex – M = 16	Parents (n = 25) Description – families with Japanese parents living in Australia whose children were aged 2-10 years Age – not indicated Children (n = 25) Sex – M = 11	Statistically significant – At post-intervention, parents in the intervention group reported significantly lower levels of child problem behaviours, higher levels of parental competence and lower levels of parental disagreements than parents in the wait-list condition. Maintenance of effect – Changes gained at post intervention were maintained at 3 month follow-up Non-significant – Significant effects were not found in levels of parental depression, anxiety or stress.
				Individual families	Home-telephone	Number of sessions – 3 Duration of sessions – 20-30 minutes Frequency of sessions – not indicated Total duration of program – not indicated			

Having a Baby									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Svensson, Barclay and Cooke (2009)	To increase confidence and competence of women with a new baby in the early weeks and therefore enhance parenting self-efficacy	Basic child care Child development Family relationships	Randomised controlled trial Alternate, comparable contemporary treatment Pre-post-follow-up	Groups of parents	Hospital	Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 91) Description – pregnant women Sex – F = 100% Age – mean = 30.08 years, range = 21-41 years Children (n = not indicated)	Parents (n = 79) Description – pregnant women Sex – F = 100% Age – mean = 30.47 years, range = 19-39 years Children (n = not indicated)	Statistically significant – Significant group but time interaction for parenting self-efficacy, with greater improvement in the intervention group. Significant group by time interaction for parenting knowledge with the intervention group reporting greater parenting knowledge gains. Maintenance of effect – Improvements in perceived parenting knowledge were maintained at 8 weeks for the intervention group, whereas they declined in the intervention group. Non-significant – Worry about the baby decreased overtime for both groups and there was no significant difference between groups.

Home Interaction Program For Parents and Youngsters (HIPPY)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Liddell, Barnett, Diallo Roost and McEachran (2011)	To improve interaction between parents and their children, foster a love of learning in children , promote cognitive and social development and enhance school readiness, increase parents' confidence and skills as their child's first teacher, increase participation in kindergarten, school and community life	Family relationships, parent-child relationship, child development, child behaviour	Non-randomised controlled trial Contemporary matched control group Pre-mid-post measures	Individual parents	Home	Number of sessions – unclear Duration of sessions – 0.5-1 hour Frequency of sessions – fortnightly Total duration of program – 2 years	<u>Parents</u> (n = 197) Description – parents from disadvantaged communities Sex – F = 98% Age – mean = 33 years, range = 20-56 years <u>Children</u> (n = 197) Description – preschool children who are developmentally vulnerable due to disadvantage or social exclusion Sex – M = 53% Age – mean = 49 months, range = 30-75 months	<u>Parents</u> (n = 4983) Description – matched sample of dyads drawn from the Longitudinal Study of Australian Children (LSAC) Sex – F = 97% Age – mean = 35 years, range = 19-73 years <u>Children</u> (n = 4983) Sex – M = 51% Age – mean = 57 months, range = 51-67 months	<u>Statistically significant</u> – HIPPY parents felt more confident, supported and respected in their role of raising their child. A significant increase in HIPPY parents' confidence in their role as their child's first teacher between the start and end of the program was observed. HIPPY parents were 80% more likely to consider themselves a 'good' parent, and twice as likely to feel they were supported by family and friends in their role of raising their child, compared with non-HIPPY parents. HIPPY parents were 60% more likely to say that when they needed information about local services they knew where to find it, and twice as likely to report that they were able to access services when they needed them, compared with non-HIPPY parents. HIPPY parents rated their sense of 'neighbourhood belonging' more highly than did their LSAC counterparts. The parenting style of HIPPY parents was significantly less angry or hostile. HIPPY parents did significantly more in-home and out-of-home activities with their child. The gap observed in HIPPY children's early numeracy and early literacy skills at the beginning of the program, compared with the Australian norm, had closed by the end of the
				Groups of parents	Unclear	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – alternating fortnightly with home sessions Total duration of program – 2 years			

Home Interaction Program For Parents and Youngsters (HIPPY)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									program. HIPPY children had fewer problems with their peers. For parents who completed more of the program rather than less of the program, their child displayed higher levels of pro-social behaviour. HIPPY had significant positive impacts on the child's school readiness in terms of both the parent's contact with the school as reported by the child's first teacher and the child having fewer problems with peers as reported by the parent. HIPPY parents reported greater satisfaction with life at the end of the program than at the beginning. The difference was statistically significant but small. By the end of the program the HIPPY group's mean score on the neighbourhood belonging scale was significantly higher than that of the LSAC group. Non-significant – No significant difference between the HIPPY and LSAC groups on the child's language and vocabulary skills as measured by the Peabody Picture Vocabulary Picture Test (PPVT). Descriptive – HIPPY parents reported that their child liked being read to for longer periods of time in any one sitting, compared with non-HIPPY parents. Teachers reported that HIPPY parents were more involved in

Home Interaction Program For Parents and Youngsters (HIPPY)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									their child's learning and development and had greater contact with the school than non-HIPPY parents. HIPPY parents were 81% more likely than LSAC parents to report that they thought their child's maths ability was better than that of the child's classmates. HIPPY parents were nearly 66% less likely than LSAC parents to have concerns about the way their child made speech sounds and 85% less likely to have concerns about their child's ability to understand what they said. HIPPY children had fewer problems with peers as reported by their parents. An 18% improvement in the number of children in the total HIPPY group having low levels of socio-emotional difficulties, as reported by their parents. A larger proportion of HIPPY parents rated their children's health as either excellent or very good—82% of HIPPY parents compared to 65% of LSAC parents. Teachers reported that on average HIPPY parents had more contact with their child's school and were three times more likely to be involved in their child's learning and development. Lower scores for the HIPPY children (on early numeracy and literacy assessment scores) had been observed at the start of the HIPPY

Home Interaction Program For Parents and Youngsters (HIPPY)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									program, by the end of the program the gap had been closed. Improvement in the HIPPY group's hostile parenting scores: at the end of the program, HIPPY parents scored on average slightly better than their LSAC counterparts. At the end of the program, HIPPY parents were scoring considerably better than their LSAC counterparts on the out-of-home activity scale. HIPPY parents were 3.5 times more likely than their LSAC counterparts to report that their child liked being read to for a longer period of time in a single sitting. HIPPY parents were 61% more likely to agree that they knew where to find information about local services, with only a 12% possibility of this result occurring by chance. At the end of the program, HIPPY parents were two and three times more likely to report higher levels of support from 'other family' members and 'friends', respectively, than their LSAC counterparts. HIPPY parents were 82% more likely to give themselves a better rating as a parent than LSAC parents. HIPPY parents were 46% more likely than the LSAC parents to report that they were less happy in their relationship with their partner at the start of the program, but there was no difference between

Home Interaction Program For Parents and Youngsters (HIPPY)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									the groups at the end of the program. HIPPY Indigenous parent reports: increased confidence to teach their child, increased confidence to talk to their child's teacher, improved parenting skills: patience and responding to difficult behaviour, better relationship between parents and child and improved quality time spent with the child, social connectedness from meeting other parents, the child becoming familiar and confident with schoolwork, more insight about school's requirements and expectations , better awareness of their child's skills, abilities and academic needs, pride for both the parent and the child in the child's learning and achievement.

Home Learning Program (HLP; also referred to as Healthy and Safe)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Llewwllyn, McConnell, Honey, Mayes, & Russo (2003)	Targeted to parents with intellectual disability to promote child health and home safety in the preschool years	Safety and physical wellbeing Child development	Randomised controlled trial Four groups received the program, staggered waitlist Pre-post-follow-up (3 months) measures	Individual parents	Home	Number of sessions –10 Duration of sessions – 60-90 minutes Frequency of sessions – weekly Total duration of program – 10-12 week period	**Demographics are for the whole sample** Parents Total (n = 45) Description – parents with intellectual disability and a child under 5 years Sex – mothers = 40 Age – mean = 32 years Children Age – mean = 2.2 years	**Demographics are for the whole sample** Parents Total (n = 45) Description – parents with intellectual disability and a child under 5 years Sex – mothers = 40 Age – mean = 32 years Children Age – mean = 2.2 years	Statistically significant – HLP resulted in significant improvement in parents' ability to learn and also to remember and/or apply the knowledge and skills learned over a 3 month period. Parents significantly improved their understanding of health and symptoms of an illness, knowing when to call or visit the doctor, what information to provide and what questions to ask, along with knowledge of how to use medicines safely. Maintenance of effect – Gains were maintained over a 3month period Descriptive – After taking part in the HLP, parents learnt to recognize dangers to young children in the family home, to identify appropriate precautions in their own home

The Miller Early Childhood Sustained Home-Visiting (MECSH) programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Kemp, Harris, McMahon, Matthey, Vimpani, Anderson, Schmied, Aslam & Zapart (2011)	To improve transition to parenting, improve maternal health and wellbeing, improve child health and development, develop and promote parents aspirations for themselves and their children, improve family and social relationships and networks	Parent-child relationship Child behaviour Child development Safety and physical wellbeing	Randomised controlled trail Contemporary usual care control group Pre-post measures	Individual parents	Home	Number of sessions – mean = 16.3, range = 0-52 Duration of sessions – 60-90 minutes Frequency of sessions – monthly Total duration of program – 24 months	Parents (n = 111) Description – at-risk mothers living in a socioeconomically disadvantaged area in Sydney, booking into the local public hospital for confinement Sex – F = 100% Age – mean = 27.6 years, range = 15-45 years Children (n = not indicated) Age – range = 0-2 years	Parents (n = 97) Sex – F = 100% Age – mean = 27.7 years, range = 17-42 years Children (n = not indicated) Age – range = 0-2 years	Statistically significant – Children in the intervention group were breastfed for significantly longer than children in the comparison group. This difference was attributable to overseas-born mothers in the intervention group feeding for significantly longer than overseas-born mothers in the comparison group. Mothers of infants and toddlers in the intervention group provided a home environment that was statistically significantly more supportive of their child's development through more verbal and emotional responsivity, however, the effect size was small. Non-significant - No significant difference in parent–child interaction between the intervention and comparison groups. No significant overall group differences in child mental, psychomotor or behavioural development. There were no significant group or subgroup differences in maternal health, social support or family outcomes. Descriptive – Intervention mothers were more emotionally and verbally

The Miller Early Childhood Sustained Home-Visiting (MECSH) programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									responsive during the first 2 years of their child's life than comparison group mothers. Australian born mothers in both the intervention and comparison groups breastfed for an average of 10.3 (SD 11.1) and 5.5 (SD 5.0) weeks, respectively. Both groups commenced children on solids at an average age of 5 months. No difference between the intervention and comparison group participants' experience of being a mother. Mothers who were psychosocially distressed antenatally, first-time mothers and mothers born overseas who received intervention were more likely to report a more positive experience of being a mother than those same subgroups of mothers in the comparison group. Intervention group children were breastfed longer, particularly those of overseas-born mothers and the subgroup of children of mothers who had been psychosocially distressed antenatally had clinically better mental development scores than their counterparts from the comparison group. Mothers assessed antenatally as having psychosocial distress showed benefit across a number of areas,

The Miller Early Childhood Sustained Home-Visiting (MECSH) programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									including child development, their experience of being a mother, and small effects in a number of domains of the quality of the environment from a child development perspective; emotional and verbal responsivity, organisation of the environment and provision of appropriate play materials. While the mental development of children of mothers who were not distressed antenatally in both the intervention and comparison groups was comparable with the general population, children's development was particularly poor in the distressed subgroup in the absence of the MECSH intervention. Overseas-born mothers showed benefit in the duration of breastfeeding, their experience of being a mother, and small effects for emotional and verbal responsivity, although benefits were greater for Australian-born mothers in the provision of appropriate learning materials. Benefit accrued particularly for first-time mothers in their experience of being a mother, and in the two HOME subscales of provision of appropriate learning materials and emotional and verbal responsivity.

The Miller Early Childhood Sustained Home-Visiting (MECSH) programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									The outcomes for higher risk (two or more) compared with lower risk (one risk only) mothers showed small benefits in responsivity, organisation of the environment and provision of appropriate play materials.

Mother & Baby Program (M&B)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Norman, Sherburn, Osborne & Galea (2010)	To improve the psychological health outcomes of postnatal women	Family relationships	Randomised controlled trial Contemporary alternate treatment Pre, post and follow-up (4 weeks) measures	Group of parents	Hospital	Number of sessions – 8 Duration of sessions – 1 hour Frequency of sessions – weekly	Parents (n = 62) Description – new mothers Sex – F = 100% Age – mean = 29.3 years Children (n = 62) Age – mean = 7.3 weeks	Parents (n = 73) Description – new mothers Sex – F = 100% Age – mean = 30.1 years Children (n = 73) Age – mean = 8 weeks	Statistically significant – There was significant improvement in wellbeing scores and depressive symptoms of the M&B group compared with the control group over the study period. Maintenance of effect – Significant positive effect on wellbeing scores and depressive symptoms at 8 weeks was maintained 4 weeks after completion of the program. Descriptive – The number of women identified as "at risk" for postnatal depression for pre-intervention was reduced by 50% by the end of the intervention.
				Groups of parents	Hospital	Number of sessions – 1 Duration of sessions – 30 minutes Frequency of sessions – once off Total duration of program – 8 weeks			

Parenting Adolescents: A Creative Experience (PACE)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Toumbourou and Gregg (2002)	To reduce adolescent risk factors implicated in youth suicide	Safety and physical wellbeing Child behaviour	Cluster non-randomised controlled trial Contemporary matched usual care comparison schools Pre-post measures	Groups of parents	Schools or community settings	Number of sessions – 7 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 305) Description – parents of 8th grade students Sex – not indicated Age – < 40 = 44 Children (n = not indicated) Description – 8th grade students Sex – not indicated Age – not indicated	Parents (n = 272) Description – parents of 8th grade students Sex – not indicated Age – < 40 = 33 Children (n = not indicated) Description – 8th grade students Sex – not indicated Age – not indicated	Statistically significant – After adjusting for baseline substance use, the odds of post substance use were significantly reduced for the intervention students but remained stable for the control students. Multiple substance use reduced significantly from pre to post for intervention students, whereas it increased in the control group. The odds of delinquency at post were significantly reduced for the intervention students but increased in the controls – this applies to both those reporting delinquency at pre and those not reporting delinquency at pre. After adjusting for baseline conflict, the odds of post intervention conflict were halved for the intervention group but remained stable for the controls. There was a significant pre to post increase in maternal care in the intervention group but not the control group. Non-significant – Non-significant post trend for lower substance use among intervention students. Of those reporting substance use at pre, there were no significant differences between groups at post. There were no significant pre or post adolescent depressive symptom scores. There was a non-significant reduction in pre to post rates of intervention student

Parenting Adolescents: A Creative Experience (PACE)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									self harm. Descriptive – The intervention showed no effect on substance use cessation. The odds of transition to substance use were halved in the intervention group. Rates of suicidal behaviour were stable in both groups over time. Ratings of paternal care were low and stable for both groups, at both time points.

Pathways Triple P									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Wiggins, Sofronoff & Sanders (2009)	Designed to promote positive parent-child relationships	Parent-child relationships Child development Child behaviour	Randomised controlled trial Waitlist Pre-post-follow-up (3 months) measures	Groups of parents	not indicated	Number of sessions – 9 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 9 weeks	Parents (n = 30) Description – borderline to clinically significant relationship disturbance and child emotional and behavioural problems Sex – F = 29 Age – mother's mean age = 38.3 years Children (n = 30) Sex – M = 23 Age – mean = 6.4 years	Parents (n = 30) Description – borderline to clinically significant relationship disturbance and child emotional and behavioural problems Sex – F = 27 Age – mother's mean age = 35.9 years Children (n = 30) Sex – M = 23 Age –mean = 6 years	Statistically significant – Significant intervention effects for improving parent-child relationships in terms of parent-child attachment, parenting confidence, involvement, blame and intentional attributions for child disruptive behaviour, and dysfunctional discipline practices and for reducing externalising behaviour problems. Maintenance of effect – Gains maintained at 3-month follow-up.

Parenting Wisely

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Cefai, Smith, Pushak (2010)	To increase parental sense of competence and reduce child behaviour problems	Child behaviour	Randomised controlled trial pre-post-follow-up measures Three conditions: 1. **individual intervention** 2. **group intervention** 3. **waitlist control**	**Individual intervention** Individual parents	**Individual intervention** Clinic or treatment centre with CD-ROM	**Individual intervention** Number of sessions – between 1 and 3 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – average of 3.2 hours	**Individual intervention** Parents (n = 40) **Demographics are for entire sample** Description – not indicated Sex – F = 924 Age – mean = 40.7 years, range = 24-55 years Children (n = 40) Description – not indicated Sex – F = 57, M = 59 Age – mean = 11.9 years; range = 9-15 years	Parents (n = 46) Description – not indicated Sex – F = 924 Age – mean = 40.7 years, range = 24-55 years Children (n = 46) Description – not indicated Sex – F = 57; M = 59 Age – mean = 11.9 years, range = 9-15 years	Statistically significant – Significant pre- to post- improvements on parenting satisfaction and efficacy for both treatment groups but not the control group. The increase was greater in the individual format group. Significant pre to post improvements on child behaviour intensity and problem for both treatment groups but not for the control group. Parents in the individual format found the program to be significantly more enjoyable and satisfying than those in the group. Maintenance of effect – Significant improvements in parenting satisfaction and efficacy were only maintained at 3 months for the individual format participants. Significant improvements in behaviour intensity and problem were maintained at 3 months for both groups.
				Group intervention Groups of parents	**Group intervention** Setting not indicated, with facilitator	**Group intervention** Number of sessions – 2 Duration of sessions – 2-3 hours Frequency of	**Group intervention** Parents (n = 39) **Demographics are for entire sample** Description – not indicated		

Parenting Wisely									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						sessions – not indicated Total duration of program – average of 4.5 hours	Sex – F = 924 Age – mean = 40.7 years, range = 24-55 years Children (n = 39) Description – not indicated Sex – F = 57, M = 59 Age – mean = 11.9 years., range = 9-15 years		

PremieStart Parent Sensitivity Training Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Milgrom, Newham, Anderson, Doyle, Gemmill, Lee, Hunt, Bear, & Inder (2010)	To reduce parent's stressful experiences	Safety and physical wellbeing Child development	Randomised controlled trial Contemporary standard care Pre-post measures	Individual parent	Neonatal Intensive Care Unit (NICU)	Number of sessions – 9 Duration of sessions – not indicated Frequency of sessions – twice a week for 2 weeks then weekly until discharge	<u>Parents</u> (n = 22) Description – women who delivered at <30 weeks gestation at the NICU Sex – F = 100% Age – mean = 32.2 years <u>Children</u> (n = 26) Sex – F = 58% Age - infants were at 30-32 weeks postmenstrual age	<u>Parents</u> (n = 23) Description – women who delivered at <30 weeks gestation at the NICU Sex – F = 100% Age – mean = 31.4 years <u>Children</u> (n = 26) Sex – F = 46% Age – infants were at 30-32 weeks postmenstrual age	<u>Statistically significant</u> – Maturation and connectivity of white matter were significantly enhanced in the intervention group. <u>Non-significant</u> – There were no significant effects on either brain volumes or on short-term medical outcomes.
				Individual parent	Home	Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once off Total duration of program – not indicated			

Preparation for Parenthood, with additional postpartum session									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Matthey, Kavanagh, Howie, Barnett, & Charles (2004)	The aims of the additional session were to 1) increase the couple's understanding of each other's concerns, especially postpartum concerns; 2) to enable the couples to identify helpful and unhelpful behaviours if either found new parenthood stressful; 3) to provide participants with strategies other couples have found helpful when parenthood has been stressful	Family relationships	Randomised controlled trial Contemporary usual care and alternate treatment Pre-post-follow-up (6 months) measures	Groups of parents	Hospital	Number of sessions –7 Duration of sessions – not indicated Frequency of sessions – weekly	Parents (n = 89) Description – couples expecting their first baby who were attending the evening 'Preparation for Parenthood' program Sex – not indicated Age – not indicated	Parents usual care (n = 101); alternate treatment (n = 78) Description – couples expecting their first baby who were attending the evening 'Preparation for Parenthood' program Sex – not indicated Age – not indicated	Statistically significant – At 6 weeks postpartum women with low self-esteem who had received the intervention were significantly better adjusted on measures of mood and sense of competence than low self esteem women in either of the two control conditions. Maintenance of effect – There were no main or interaction effects by 6 months postpartum. Non-significant – There were no significant main or interaction effects for men at either time point, other than men with low self-esteem reporting poorer adjustment.
				Individual parents	Home	Post session mail-outs Number of sessions – 2 (antenatally and postpartum) Total duration of program – 7 weeks			

Preparation for Parenthood, with additional postpartum session									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
	4) to normalise any feelings of stress, isolation or lack of confidence that may be experienced postpartum								

Queen Elizabeth Centre's Day Stay Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Hayes, Matthews, Copley and Welsh (2008)	To improve infant and toddler care and reduce parental distress	Family relationships, child behaviour	Randomised controlled trial Contemporary waitlist control group Pre-post-follow-up measures	Individual parent-child dyads and groups of parent-child dyads	Early parenting centre	Number of sessions – one Duration of session – 6 hours Frequency of session – once Total duration of program – 6 hours	Parents (n = 65) Sex – F = 100% Age – not indicated Children (n = 65) Sex – not indicated Age – not indicated	Parents (n = 53) Sex – F = 100% Age – not indicated Children (n = 53) Sex – not indicated Age – not indicated	Statistically significant – For the intervention group there were was significant improvement in depression, anxiety, stress and parental confidence - parental satisfaction and efficacy. For the intervention group there were was significant decreases in problematic child behaviour. Maintenance of effect – The improvements in depression, anxiety, stress and parental confidence in intervention mothers were maintained at 6 weeks. The decreases in problematic child behaviour were maintained at 6 weeks.

Quinlivan, Box & Evans (2003)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Quinlivan, Box and Evans (2003)	To reduce the frequency of adverse neonatal outcomes and increase knowledge of contraception, breastfeeding and vaccination schedules in teenage mothers younger than 18 years	Child development Safety and physical wellbeing Basic child care Family relationships	Randomised controlled trial Contemporary usual care control group Pre-post measures	Individual parents	Home	Number of sessions – 5 Duration of sessions – 1-4 hours Frequency of sessions – at 1 week, 2 weeks, 1 month, 2 months, 4 months, and 6 months after birth Total duration of program – 6 months	Parents (n = 65) Description – teenage mothers <18 years Sex – F = 100% Age – mean = 16.4 years Children (n = 65) Sex – M = 57% Age – range = 0-6 months	Parents (n = 71) Description – teenage mothers <18 years Sex – F = 100% Age – mean = 16.6 years Children (n = 71) Sex – M = 45% Age – range = 0-6 months	Statistically significant – At postnatal assessment, significantly more teenage mothers in the intervention group (n = 53) than in the control group (n = 40) were reliably using contraception. Non-significant – There were no significant differences in breastfeeding scores at antenatal or postnatal assessments. Although the median duration of breastfeeding in the intervention group was 12 weeks compared with 8 weeks in the control group, this difference was not significant. Descriptive – The intervention reduced adverse neonatal events and improved contraception outcomes, but did not affect breastfeeding or infant vaccination knowledge or compliance.

Rapee, Abbott & Lyneham (2006)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Rapee, Abbott and Lyneham (2006)	To reduce anxiety in children by using parent-delivered bibliotherapy	Child behaviour	Randomised controlled trial Contemporary control groups (waitlist or group cognitive-behavioral therapy using Cool Kids program) Pre-post-follow-up measures	Not clear	Home	Number of sessions – not clear Duration of sessions – not clear Frequency of sessions – not clear Total duration of program – 3 months	Parents (n = not indicated) Children (n = 90) Description – meeting DSM-IV criteria for an anxiety disorder Sex – M = 56.4% Age – range = 6-12 years	Parents (n = not indicated) **Control Group 1** Children (n = 76) Description – meeting DSM-IV criteria for an anxiety disorder. Group cognitive-behavioral therapy using the Cool Kids program. Sex – F = 53.3% Age – range = 6-12 years **Control Group 2 (Waitlist)** Children (n = 87) Description - meeting DSM-IV criteria for an anxiety disorder. Sex – M = 70.1% Age – range = 6-12 years	Statistically significant – Bibliotherapy is significantly better than no treatment. Standard cognitive-behavioral group therapy group treatment with a therapist resulted in a greater change than bibliotherapy according to both clinician and parent reports. Children in all three groups reported significant and marked reduction in symptoms over time, however differences between groups were not significant. Descriptive – Children whose parents received bibliotherapy with no therapist contact improved somewhat more than children on waitlist after 12 weeks and these results were maintained at 3 months. Relative to waitlist, around 15% more children were free of an anxiety disorder at 12 and 24 weeks. Bibliotherapy resulted in a greater dropout from participation than did traditional group therapy. Treatment dropouts for all groups had slightly more severe symptomatology than completers.

Reach for Resilience									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Dadds and Roth (2008)	To prevent anxiety and other mental health problems in children	Child behaviour	Non-randomised cluster controlled trial Pre-post-follow-up measures	Groups of parents	Preschool	Number of sessions – 6 Duration of sessions – not indicated Frequency of sessions – fortnightly Total duration of program – 3 months	Parents (n = 355) Description – parents of preschool children Sex – not indicated Age – not indicated Children (n = 355) Description – preschool children Sex – not indicated Age – preschool age	Parents (n = 379) Description – parents of preschool children Sex – not indicated Age – not indicated Children (n = 379) Description – preschool children Sex – not indicated Age – not indicated	Statistically significant – Significant group by time interaction for teacher ratings of child behaviour in the areas of Anxious-Withdrawn, Angry-Aggressive and Social Competence. The comparison group were significantly more Anxious-Withdrawn and Angry-Aggressive than the intervention group. Significant pre to post decrease in reticence in intervention but not control group. Maintenance of effect – Comparison group remained significantly more Angry-Aggressive than intervention group at follow-up. Non-significant – No group by time interactions for any of the parent measures.

Salmon, Dadds, Allen & Hawes (2009)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Salmon, Dadds, Allen and Hawes (2009)	To provide parent management training (PMT) and elaborative, emotion-rich reminiscing (ER) to parents of children with oppositional behaviours	Parent-child relationship, child behaviour	Randomised controlled trial Contemporary alternate care control (parent management training with a non-language adjunct, child-directed play) Pre-post measures	Individual parent-child dyad	Not clear	Number of sessions – 6 Duration of sessions – not indicated Frequency of sessions – weekly for 5 sessions then final session followed 2 weeks after 5th session Total duration of program – 7 weeks	Parents (n = 14) Sex – F = 100% Age – 36.29 years Children (n = 14) Description – children exhibiting oppositional behaviour Sex – M n = 12 Age - range 3-8 years, mean = 5 years	Parents (n = 12) Sex – F = 100% Age – 36.58 years Children (n = 12) Description – children exhibiting oppositional behaviour Sex – M (n = 10) Age – range 3-8 years, mean = 4.5 years	Non-significant – There were no significant effects for low elaborative utterances. No significant effect on children's elaborative and emotion utterances during a researcher-child conversation. Descriptive – Pre-treatment, 70.6% of the control group and 88.2% of the ER group were diagnosed with oppositional defiant disorder. At post-treatment, these reduced to 46.7% and 33.3%, respectively. The number of elaborative and emotion utterances made by parents in the ER condition increased over time to a greater extent than did the number made by those in the control condition.

Shelton, LeGros, Norton, Stanton-Cook, Morgan & Masterman (2007)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Shelton, LeGros, Norton, Stanton-Cook, Morgan and Masterman (2007)	To reduce body mass index (BMI), caloric consumption, reduce time engaged with sedentary electronic media, increase time in physical activity and decrease waist circumference in children with a BMI ≥ 85th percentile. Also to reduce parenting problems and improve parenting style and satisfaction.	Child development, parent-child relationship	Randomised controlled trial Contemporary waitlist control Pre-post measures	Groups of parents	Community centre	Number of sessions – 4 Duration of sessions – 2 hour Frequency of sessions – weekly Total duration of program – 4 weeks	Parents (n = not indicated) Sex - not indicated Age – not indicated Children (n = 28) Description – children had a BMI ≥ 85th percentile after adjusting for age and gender Sex – F (n = 14) Age – mean = 7.89 years, range 3-10 years	Parents (n = not indicated) Sex - not indicated Age – not indicated Children (n = 15) Description – children had a BMI ≥ 85th percentile after adjusting for age and gender Sex – F (n = 9) Age – mean = 7.33 years, range 3-10 years	Statistically significant – A significant reduction in child body mass index (BMI) and energy intake was found post-treatment. Descriptive – Approximately 50% of the intervention group showed a clinically significant reduction in BMI. No differences were found for child sedentary electronic media time, physical activity and waist circumference. A greater reduction in caloric intake for intervention children compared with control group children. No differences between groups on scores of measures of parenting problems, style and satisfaction. No changes in BMI scores of parents or primary care givers across time for either treatment or control group.

Signposts

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Hudson, Matthews, Gavidia-Payne, Cameron, Mildon, Radler & Nankervis (2003)	To help parents manage difficult behaviour of their child with an intellectual disability	Child behaviour	Non randomised controlled trial Wait list Pre-post-follow-up measures (however no follow-up data for control group) 3 modes of Delivery **1) Group** **2) Telephone** **3) Self-directed**	**Group** Group of families	**Group** School	**Group** Number of sessions –6 Duration of sessions – 2 hours Frequency of sessions – fortnightly Total duration of program - 12 weeks	Parents: (n = 46) Sex – F = 100% Children Description – children with intellectual disability	Parents: (n = 27) Sex – F = 100% Age – not indicated Children Description – children with intellectual disability	Statistically significant – For disruptive behaviour and antisocial behaviour subscales there was a statistically significant difference between the pre-test and follow-up scores of the children. However no difference between groups. Descriptive – For measures other than the PHS Child Behaviour Subscale, the experimental groups had a more favorable outcome than the control group. The mothers who have had exposure to the Signposts materials were more confident in their ability as a parent, are less stressed and have fewer hassles with regard to their needs as parents. Furthermore the behaviour of their children is less disruptive and less antisocial. There were minimal differences among the three modes of delivery on the measures used, although families who used the self-directed mode were less likely to complete the materials.
				Telephone Individual families	**Telephone** Home	**Telephone** Number of sessions – not indicated Duration of sessions – approximately 20 minutes Frequency of sessions – fortnightly Total duration of program – 12 weeks	**Telephone** Parents: (n = 13) Sex – F = 100% Age – not indicated Children Description – children with intellectual disability		

Signposts									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							Self-directed Parents: (n = 29) Sex – F = 100% Age – not indicated Children Description – children with intellectual disability		
				Self-directed Individual families	**Self-directed** Home	**Self-directed** N/A Total duration of program – 12 weeks			

Signposts									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Hudson, Cameron, & Matthews (2008)	As above	As above	Non-controlled trial Pre-post-follow-up (3 months) measures Four modes of delivery: **1) Group** **2) Individual** **3)Telephone** **4) Self-directed**	**Group** Group of families	Community setting	As above	Parents (n = 2119) Sex – mothers (n = 1551) Children Description – children with intellectual disabilities or developmental delay Sex – M = 73% Age – 2-18 years (mean = 7.1 years)	None	Statistically significant – Significant improvements on all measures were reported for the group delivery mode. For individual and telephone modes significant improvements on measures of depression, stress, efficacy, satisfaction, child behaviour, parent needs, as well as disruptive and obedient behaviors were reported. Descriptive – Participants reported that they were less depressed, less anxious and less stressed, were more confident and satisfied with managing their child, and were less hassled by their child's behaviour. They also reported their child exhibited fewer difficult behaviors. Effect sizes ranged from small to large, depending on mode of delivery of the program.
				Individual Individual families	Home	not indicated			
				Telephone Individual families	Home	As above			
				Self-directed Individual families	Home	As above			

Sofronoff & Farbotko (2002); Leslie & Brown (2004)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Sofronoff and Farbotko (2002)	To improve parental self-efficacy in the management of problem behaviours associated with Asperger's syndrome using Parent Management Training	Parent-child relationship, child behaviour	Non-randomised controlled trial Contemporary usual care control group Pre-post-follow-up measures Two conditions **1. Group** **2. Individual**	**Group Intervention** Group of parents	**Group Intervention** University	**Group Intervention** Number of sessions – 1 Duration of session – 1 day Frequency of session – once Total duration of program – 1 day	**Group Intervention** Parents (n = 32) Sex – F = 53% Age – not indicated Children (n = not indicated) Description – children meet DSM-IV criteria for Asperger's syndrome Sex – not indicated Age – mean = 8.3 years, range = 6-12 years	Parents (n = 20) Sex – F = 50% Age – not indicated Children (n = not indicated)	Statistically significant – Significant decrease in the number of problem behaviours reported by parents for both the 1 day workshop format and the individual sessions. Mothers showed a significant improvement in self-efficacy. Maintenance of effect – A slight drop in efficacy in the workshop parents was observed at 3 months follow-up. Mothers significant improvement in self-efficacy was maintained at 3 months. Non-significant – No significant difference in self-efficacy between the workshop format and the individual sessions. Fathers showed no change in self-efficacy. Descriptive – Intervention parents reported fewer problem behaviours post intervention compared with control group parents. A reported increase in parental self-efficacy in the management of behaviours for both the workshop and individual formats. A decrease in self-efficacy reported by the control group.

Sofronoff & Farbotko (2002); Leslie & Brown (2004)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Individual Intervention Individual parents	**Individual Intervention** Unclear	**Individual Intervention** Number of sessions – 6 Duration of sessions – 1 hour Frequency of sessions – not indicated Total duration of program – not indicated	**Individual Intervention** <u>Parents</u> (n = 36) Sex – F = 50% Age – not indicated <u>Children</u> (n = not indicated) Description – children meet DSM-IV criteria for Asperger's syndrome Sex – not indicated Age – mean = 8.3 years, range = 6-12 years		

Sofronoff & Farbotko (2002); Leslie & Brown (2004)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Sofronoff, Leslie and Brown (2004)	To increase parental competence in management of problem behaviours associated with Asperger's syndrome using Parent Management Training	Child behaviour	Randomised controlled trial Contemporary waitlist control group Pre-post-follow-up measures Two conditions **1. Group** **2. Individual**	**Group Intervention** Group of parents	**Group Intervention** University	**Group Intervention** Number of sessions – 1 Duration of session – 1 day Frequency of session – once Total duration of program – 1 day	**Group Intervention** Parents (n = 18) Sex – not indicated Age – not indicated Children (n = 51) Description – children meet DSM-IV criteria for Asperger's syndrome Sex – not indicated Age – mean = 9.3 years, range = 6-12	Parents (n = 15) Sex – not indicated Age – not indicated Children (n = not indicated) Age – mean = 9.3 years, range = 6-12 years	Statistically significant – Significant improvement on parent rated number of problem behaviours, intensity of problem behaviours and ratings of social skills. Significant difference for parent ratings of intensity of problem behaviours between workshop group and individual sessions group (individual session parents reported greater improvement). Non-significant – No significant improvement for the control group for any of the outcome variables. No significant difference for parent ratings of intensity of problem behaviours between workshop group and waitlist control group.

Sofronoff & Farbotko (2002); Leslie & Brown (2004)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Individual Intervention Individual parents	**Individual Intervention** University clinic	**Individual Intervention** Number of sessions – 6 Duration of sessions – 1 hour Frequency of sessions – weekly Total duration of program – 6 weeks	**Individual Intervention** Parents (n = 18) Sex – not indicated Age – not indicated Children (n = 51) Description – children meet DSM-IV criteria for Asperger's syndrome Sex – not indicated Age – mean = 9.3 years, range = 6-12		

Tuned in Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Priddis and Wells (2010)	To improve parent-infant/child relationships especially where the child exhibits functional regulatory disturbances	Parent-child relationship Basic child care	Non-randomised controlled trial Contemporary waitlist control Pre-post measures	Groups of parents	Unclear	Number of sessions – 9 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 9 weeks	Parents (n = 17) Description – mothers who were currently seeking treatment for their child's sleeping, crying or feeding. Sex – F = 100% Age – mean = 31.9 years Children (n = 17) Sex – F = 10 Age – mean = 3.4 months	Parents (n = 14) Description – mothers who were currently seeking treatment for their child's sleeping, crying or feeding. Sex - F = 100% Age – mean = 31.4 years Children (n = not indicated) Sex – not indicated Age – mean = 2.7 months	Descriptive – In comparison to maternal behaviour in their pre-intervention film, post-intervention mothers typically allowed their child to lead play, used more feeling words in dialogue with their child, and were more responsive to their child's needy feelings on reunion. Infants in turn expressed a wider range of emotion in the post-test film than in their pre-test film. No such changes were observed in any film of control group dyads. Qualitative observations of maternal-infant interactions noted that change was evident in all except two mothers post-intervention. Intervention mothers made substantial shifts of emphasis – they became more aware of the dynamic nature of their relationship with their children and more thoughtful about their infants' mental state. Intervention mothers showed growing insights about how to support their children in their eating, feeding, sleeping behaviours. 'Parenting has clear rules to follow theme' - pre-test: control and TIP groups similar. Post-test: no change for controls, TIP 48% shift to unconditional acceptance of child.

Tuned in Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Post-test: 66% TIP shift to less emphasis on rules and view parenting as less hard work. Little change in control group. 'Parent-child relationship is collaborative' theme - Pre- and post-test 50% control group relaxed. TIP group move 24% to 78% relaxed. 'Focus on child cues' theme - pre-test: groups are similar. Post-test TIP group 72% move to awareness of emotional needs, 35% move to less focus on action. No change in control group.

Your Defiant Child									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Swift, Roeger, Walmsley, Howard, Furber & Allison (2009)	To improve child behavioural problems	Child behaviour	Randomised controlled trial Waitlist Pre-post measures	Individual parent	Home	Self-help book	Parents (n = 16) **Demographics are for the whole sample** Sex – F = 100% Age – not indicated Children (n = 16) Description – children aged 2-12 years who were referred for disruptive behaviour, attention-deficit hyperactivity and learning difficulties Sex – M = 86% Age – mean = 7 years	Parents (n = 13) **Demographics are for the whole sample** Sex – F = 100% Age – not indicated Children (n = 13) Description – children aged 2-12 years who were referred for disruptive behaviour, attention-deficit hyperactivity and learning difficulties Sex – M = 86% Age –mean = 7 years	Statistically significant – The main behavioural measure showed significantly better outcomes for the training program from pre to post treatment compared to controls. Descriptive – For the parent training group, the mean score for the ECBI Intensity scale was reduced from above the clinical cut-off before treatment to below the cut-off after treatment.
				Individual parent	Telephone (Free call number to access the primary care provider on a weekly basis and if they didn't ring themselves they were followed up fortnightly)	Number of sessions –N/A Duration of sessions – N/A Frequency of sessions – weekly or fortnightly Total duration of program – 12 weeks			

Appendix 11. Programs rated as Emerging in the REA (data extracted from papers and program rating checklists)

Emerging programs were rated as follows on the evidence of effectiveness checklist:

	Evidence of effectiveness criteria	Well Supported	Supported	Promising	Emerging	No Effect	Concerning Practice
1.	No evidence of risk or harm	☐	☐	☐	☒	☐	
2.	If there have been multiple studies, the overall evidence supports the benefit of the program	☐	☐	☐			
3.	Clear baseline and post measurement of outcomes for both conditions	☐	☐	☐			
4.	At least **two** RCTs have found the program to be significantly more effective than comparison group. Effect was maintained for at least **one** study at **1 year** follow-up.	☐					
5.	At least **one** RCT has found the program to be significantly more effective than comparison group. Effect was maintained at **6 month** follow-up.		☐				
6.	At least one study using some form of contemporary comparison group demonstrated some improvement outcomes for the intervention but not the comparison group			☐			

7.	There is insufficient evidence demonstrating the program's effect on outcomes because: a) the designs are not sufficiently rigorous (criteria 1-6) OR b) the results of rigorous studies are not yet available				☒		
8.	Two or more RCTs have found no effect compared to usual care OR the overall weight of the evidence does not support the benefit of the program					☐	
9.	There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect on participants						☐

The African Migrant Parenting Program

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Renzaho & Vignjevic (2011)	To enhance both effective parenting and relationship skills, in order to help parents to raise their children confidently and understand their children's needs throughout various developmental stages in the new cultural, social and educational environments	Child development Parent-child relationships Child behaviour Family relationships	Non-controlled trial Pre-post measures	Groups of parents	Community	Number of sessions –8 Duration of sessions – 2 hours Frequency of sessions – not indicated	Parents (n =39) Description – African migrant and refugee parents living in Melbourne Sex – 21 mothers Age – 19-55 years	None	Statistically significant – More positive parenting practices were obtained at post assessment on the dimensions of parental expectations, parental empathy towards children needs, awareness and knowledge of alternatives to corporal punishment and parent-child family roles. Exposure to the intervention significantly predicted change in parental expectations of their children, as well as changes in attitudes towards the use of corporal punishment. Descriptive – No change was observed in parent scores post-test on the restriction of children's power and independence dimension.
				Individual parents	Home	Number of sessions – 3 Duration of sessions – 45 minutes Frequency of sessions – not indicated Total duration of program – not indicated			

The Australian Supported Learning Program- Me and My Community (ASLP)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
McConnell, Dalziel, Llewellyn, Laidlaw, Hindmarsh (2008)	Designed to strengthen the social relationships and improve the psychological wellbeing of mothers with learning difficulties	Family relationships	Non-controlled trial pre-post measures	Groups of parents	Sites in the community	Number of sessions – 8-10 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 8-10 weeks	Parents (n = 32) Description – mothers with learning difficulties Sex – F = 100% Age – mean = 34.1 years Range (SD) = 16.9-48 years (8.13)	None	Statistically significant – Large pre to post effects were found for parent depression, anxiety and stress. Smaller effects were observed for social support, mastery and constraints. Descriptive – 84% of mothers partially or fully achieved their priority goal. For any one goal, at least 16% reported they came somewhat close to achieving their goal.
				Individual parents	Home	Number of sessions – 12 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program 12 weeks			

Beatty, Cross & Shaw (2008)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Beatty, Cross & Shaw (2008)	To increase parent-child communication regarding alcohol, tobacco and other drug (ATOD) use	Parent-child relationship	Randomised controlled trail Contemporary usual care control group Pre-post measures	Individual parent	Home	Number of education sheets distributed – 5 Frequency of education sheet distribution – every 3 weeks Total duration of program – 15 weeks	Parents (n = 848) **Demographics are for entire group** Sex – F = 75% Age – range = 30-40 years (63% of respondents) Children Age – range = 10-11 years	Parents (n = 353) Sex – F = 75% Age – range = 30-40 years (63% of respondents) Children Age – range = 10-11 years	Significant Tobacco – significantly more favourable outcomes for four of the five tobacco-related parent-child communication variables (ever talked to child about smoking tobacco, recency, levels of engagement, specific essential topics covered). Alcohol – significantly more favourable outcomes for all five alcohol related parent-child communication variables (ever talked, recency, duration, level of engagement, number of topics)

The BEST Plus Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Bamberg, Findley & Toumbourou (2006)	To reduce adolescent problem behaviours	Child behaviour	Non-controlled trial Pre-post measures	Group of parents	Not indicated	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – weekly	<u>Families</u> (n = 1) Description – parents of three children, with one child displaying problematic behaviour including abusing alcohol and using drugs, such as cannabis, amphetamines and ecstasy. <u>Parents</u> (n = 2) Sex = F = 1 Age = not indicated <u>Target child</u> (n = 1) Sex = F Age = 23 years	None	<u>Descriptive</u> – At the end of the intervention the parents described feeling more in control and confident with the way they were dealing with the problem behaviour. Positive changes at home were reported. The sibling felt a lot happier at home. The relationship between the mother and father had improved.
				Groups of families	Not indicated	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program – 8 weeks			

Better Beginnings

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Barratt-Pugh and Allen (2011)	To provide positive language and literacy influences for young children through encouraging parents to read to their newborn baby	Child development Parent-child relationship	Non-controlled trial Pre-post-follow-up measures	Individual parents	Community health clinic	Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once Total duration of program – not indicated	<u>Parents</u> (n = 300) Description – parents of babies aged 6-8 weeks old Sex – F = 100% Age – not indicated <u>Children</u> (n = not indicated) Description – newborn babies Sex – not indicated Age – not indicated	None	<u>Descriptive</u> – There was a pre to post increase in the percentage of mothers reporting that they read to their child. Two thirds of the mothers that read the gift book, liked the book and almost a third recommended the reading list. Two thirds found the tip sheet useful; however some found it difficult to read. Mothers reading techniques post program reflected those in the tip sheets. Parents reported a pre to post increase in the number of books in homes. Parents reported a pre to post increase in frequency of mothers and fathers reading to their children. Parents reported a pre-post increase in child's interest in books. Mothers reported a pre to post increase in confidence with reading to their child and there was an increase in those reporting the value of reading. Mothers reported a pre to post change in opinions about libraries and an increase in library membership and attendance. Less than a quarter reported attending the sessions at libraries but those that did found them useful.
				Groups of parents and children	Libraries	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated			

The Boomerangs Aboriginal Circle of Security Parenting Camp Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Lee, Griffiths, Glossop and Eapen (2010)	To teach parents attachment theory, to improve parents' skills in identifying parent/child interactions, to enhance parent sensitivity, to explore parents strengths and under developed capacities in the parent, to build on parent's strengths, to reflect on trauma	Parent-child relationship, child development	Non-controlled trial Pre-post-follow-up measures	Individual parent-child dyads	Mental health service	Number of sessions – 2 Duration of sessions – not indicated Frequency of session – not indicated Total duration of program – not indicated	Parents (n = 3) Sex – F = 3 Age – 26, 27 and 32 years Children (n=3) Sex – M = 3 Age – 2, 4 and 5 years	None	Descriptive – All three mothers reflected that they had become more aware of their own actions and their children's needs and that they had gained confidence in their parenting capacity.

The Boomerangs Aboriginal Circle of Security Parenting Camp Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Groups of parents	Aboriginal Women's Centre and at a local camp site	Number of sessions - 20 sessions including two camps Duration of sessions – not indicated, camps were three days and two nights Frequency of sessions – not indicated, camps held six weeks apart			

Bringing Up Great Kids Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Cole (2012)	To increase parenting skills, examine how parents communicate with their children and generational influences on parenting	Parent-child relationship, child development	Non-controlled trial Pre-post measures	Groups of parents	Unclear	Number of sessions – 5 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 5 weeks	Parents (n = 7) Sex – F (n = 6) Age – not indicated Children (n = 15) Sex – F = 8 Age – M, mean = 7.5 years, range = 6 months to 14 years , F = 8.7 years, range = 6 months to 17 years	None	Descriptive – Post evaluation showed improved mindfulness parenting, self confidence, knowledge of support networks and understanding of child's behaviours.

Building Blocks

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Parmenter, Evans, Roberts, Williams, Carter, Silove, Clark, & Warren (2009)	Aimed around building capacity to meet the immediate needs of the child and the family and in better understanding autism.	Child development Family relationships Child behaviour	Randomised controlled trial Waitlist Pre-post measures Two models: 1) Home-based model (HB) 2) Centre-based model (CB)	**Home based model (HB)** Individual parent-child dyads	Home	Number of sessions – 20 Duration of sessions – 2 hours Frequency of sessions – fortnightly Total duration of program – 40 weeks	Parents (n = not indicated) Sex – not indicated Age – not indicated Children (n =not indicated) Description – children aged between 2.5-3.5 years at the start of the program, a diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS according to DSM-IV (1994) made by a referring clinician Sex – not indicated Age – not indicated	Parents (n = not indicated) Sex – not indicated Age – not indicated Children (n = not indicated) Description – children aged between 2.5-3.5 years at the start of the program, a diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS according to DSM-IV (1994) made by a referring clinician Sex – not indicated Age – not indicated	Non-significant – HB parental stress scores increased on average from a low baseline score, CB parental stress scores decreased from a high baseline score, differences were not significant when analysis adjusting for baseline score was used Descriptive – All three groups of children in the study made gains in some domains of behaviour, communication or social interaction as assessed by outcome measures. Children in CB programs improved more for behaviour, language development, communication and social interaction than HB. Parent knowledge improved more in the CB program. CB outcomes suggest greater empowerment and satisfaction with disability support, possibly related to increased capacity to access support more effectively.
				Centre based model (CB) Groups of parent-child dyads	Centres	Number of sessions – 40 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 40 weeks			

Child Therapy Plus Parent/Teacher Training

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Heyne, King, Tongue, Rollings, Young, Pritchard, & Ollendick (2002)	To improve school attendance, emotional distress and self-efficacy and overall child functioning	Child behaviour Child development	Randomised controlled trial Pre-post-follow-up (4.5 months) measures Three interventions: 1) Child therapy **(CH)** 2) Parent/Teacher Training **(PTT)** 3) Child Therapy + Parent/Teacher Training **(CH+PTT)**	**CH** Individual Child	**CH** Not indicated	**CH** Number of sessions – 8 Duration of sessions – 50 minutes Frequency of sessions – not indicated	**CH** Parents (n =21) Children (n =21 **Demographics are for the whole sample** Description – severe difficulty going to school and emotional problems Sex – M = 54.1% Age – mean = 11.5 years	**Did not have a true control group**	Statistically significant – Statistically and clinically significant pre-treatment-post-treatment change occurred for each group for all measures of child functioning. Maintenance of effect – improvements were maintained for all groups at follow-up.

Child Therapy Plus Parent/Teacher Training									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				PTT Individual parents and teachers	**PTT** Not indicated	**PTT** Number of sessions – 8 Duration of sessions – 50 minutes Frequency of sessions – not indicated	**PTT** Parents (n=20) Children (n=20) **Demographics are for the whole sample** Description – severe difficulty going to school and emotional problems Sex – M = 54.1% Age – mean = 11.5 years		
				CH+PTT Individual Child	**CH+PTT** Not indicated	**CH+PTT** Number of sessions – 8 Duration of sessions – 50 minutes Frequency of sessions – not indicated	**CH+PTT** Parents (n=20) Children (n =20) **Demographics are for the whole sample** Description – severe difficulty going to school and emotional problems Sex – M = 54.1% Age – mean = 11.5 years		

Child Therapy Plus Parent/Teacher Training									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Individual parents and teachers	Not indicated	Number of sessions – 8 Duration of sessions – 50 minutes Frequency of sessions – not indicated Total duration of program – 4 weeks			

Community Bubs Program

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Flynn & Hewitt (2007)	The model of intensive outreach aimed to facilitate the strengthening of the individual, family and community resources, in order for the at-risk infant to thrive and develop safely in the care of his/her parents/caregivers	Family relationships Safety and physical wellbeing Child development	Non-controlled Pre-post-follow-up (6 months) measures	Individual families	Home	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated	<u>Families</u> (n = 17) Description – families living in high need public housing estates in the Bayside area of Melbourne and who had an infant aged 0-4 months, who had been identified by health or welfare professionals as having significant risk issues and for whom without intensive support, notification to child protection was possible. <u>Parents</u> Description – not indicated <u>Children</u> Description – not indicated	None	<u>Maintenance of effect</u> – Six months post exit: nine families participated in an interview: All identified infant were living at home and 8 infants were reported to be within the range of 'normal' development. All families had continued contact with a Maternal and Child Health Service and most had a regular medical doctor. Financial stability was maintained in all families, but accommodation and family stability was less certain. Five families had relocated within the preceding twelve months with two families having relocated in the preceding three months. During the period of the pilot project, in two families, the parents separated from each other. <u>Descriptive</u> – 87% of participant families developed and maintained appropriate community connections. 100% of the infants have remained living safely at home. 80% of families showed reduced risk factors, and have been assessed by the
				Group of families	Not indicated	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated			

Community Bubs Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Community support	Community	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – 12 months			Parent Support Worker as being at lower risk. 87% of infants were assessed by the worker to have established a positive attachment with their parent/s. 87% of families showed evidence of stability in maintaining housing, finances and key relationships. 87% of participants stated that they have found participation in the program either 'very helpful' or 'helpful'. 80% of participants stated that they have either 'mostly' or 'totally' met their goals.

Elias, Hay, Homel & Freiberg (2006)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Elias, Hay, Homel and Freiberg (2006)	To increase children's language and emergent literacy development, and increase parental involvement in their preschoolders' education	Child-development	Non-controlled trial	Unclear	School	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – 6 months	Parents (n = 62) Description – parents in a low socio-demographic disadvantaged area Sex – not indicated Age – not indicated Children (n = 68) Description – children who linguistically performed at the two lowest Preschool Language Assessment Instrument (PLAI) levels Sex – M = 53% Age - Unclear	None	Descriptive – The amount of time spent in parent-child reading doubled. Prior to the intervention, 2385 minutes of reading was occurring each week, an average of 38 minutes parent-child reading each week. After the intervention, 5545 minutes of reading was occurring each week, an average of 89 parent-child reading each week. Year One teachers in the following year reported positively on the children's literacy readiness, compared to previous intakes.

The Essential Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Havighurst, Harley & Prior (2004)	The program teaches parents ways of emotion coaching their children, which included skills in labeling emotions, viewing emotions as a time for intimacy and teaching, empathizing and validating their children's emotions and problem solving around emotional events	Child behaviour Parent-child relationship	Non-controlled trial Pre-post-follow-up (3 months) measures	Group of parents	Preschool centres	Number of sessions – 6 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 6 weeks	Parents (n = 47) Description – parents with a 4-5 year-old child Sex – F = 92% Age – not indicated Children (n = 47) Sex – F = 51% Age – 4-5 years	None	Statistically significant – The results from analyses of the parenting of children's emotions scale showed that there were significant improvements on all aspects of parenting around children's emotions. There were significant changes on the more general aspects of parenting. Children showed less emotional negativity and had significant reductions in difficult behaviours, especially those who had behaviour problems prior to their parents' participation in the program. Maintenance of effect – While most change occurred over the time that parents participated in the group, gains continued to occur during the follow-up period especially for emotion-focused responses, problem-focused responses, and expressive encouragement. Gains in general parenting skills remained stable from post to follow-up time points. Descriptive – The most notable changes were parent reports of improvements in their parenting around children's emotions and in

The Essential Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									reductions in children's difficult behaviour and improved emotional functioning.

Families and Schools Together Galiwin'ku (FAST Galiwin'ku)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Guenther (2011)	To strengthen family functioning, prevent the target child from experiencing school failure, prevent substance abuse by the child and family, reduce stress that parents and children experience from daily situations	Family relationships, child behaviour, child development, safety and physical wellbeing, parent-child relationship	Non-controlled trial Post measures	Groups of families	School	Number of sessions – 8 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program – 8 weeks	Parents (n = unclear, 9 families) Description – Sex – not indicated Age – not indicated Children (n = unclear) Sex – not indicated Age – not indicated	None	Non-significant – A slight increase in mean school attendance (from 48% to 53%) however the change was not significantly different. Descriptive – An average of 54.9 % of responses indicated positive change across all FAST domains (social relationships, parental involvement in education, family environment, parental self-efficacy, child behaviour), 44.6% of responses indicated no change. Only one response suggested a negative change (0.5%). A total of 61.1 % of all responses in the 'family environment' domain suggested a change for the better since the FAST program. Most of the comments from families suggested that children were more helpful doing jobs around the house. A total of 60% of all responses in the 'social relationships' domain indicated positive change since the FAST program. The strongest positive response was in relation to the question 'Do you get more support or help from the people in your life/family?' Just under half of all responses (48.9%) in the 'child behaviour'

Families and Schools Together Galiwin'ku (FAST Galiwin'ku)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									domain indicated a positive change because of the FAST program. The positive changes noted were fairly general and were not tied to a particular issue. The least positive change (40.7 %) was reported in the 'parent involvement in education' domain. Teachers were generally unable to identify changes that had occurred in children. Of 13 children, teachers were able to attribute positive changes in three children directly to their participation in FAST. Comments about *behaviour* came from those who had direct involvement in the school. Their observations suggested that there was a clear difference for some children who had attended FAST. In particular they commented on children listening to their teachers and teasing other children less.

Family Literacy Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Jay & Rohl (2005)	Aims to increase parental awareness of the literacy practices of their homes and communities and their awareness of young children's literacy development	Child development Family relationships	Non-controlled trial Pre-post measures	Groups of parents	Preschool classroom	Number of sessions – 6 Duration of sessions – 2.5 hours Frequency of sessions – not indicated Total duration of program – 10 weeks	Parents (n = 9) Description – families living in a low socio-economic area with children considered to be at risk of literacy difficulties and school failure Sex – F = 100% Age – not indicated	None	Descriptive – At the end of the program the parents reported that they had gained new knowledge, had become more aware of the literacy practices of their homes and how these might influence their children's literacy development, and had experienced some change of behaviour.

Food Cent$									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Bassett, Lloyd, King (2003)	To increase knowledge about healthy dietary intake, food selection and preparation, and grocery expenditure	Safety and physical wellbeing Basic child care	Non-controlled trial	Not indicated	Not indicated	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 5) Description – mothers with a mental illness and registered with a rehabilitation service Sex – F = 100% Age – not indicated Children (n = not indicated) Age – <5 years	None	Descriptive – The participants spoke about regulating better what their children were eating and said that, instead of buying chips and lollies, they were buying more fruit and vegetables. It can be tentatively concluded that the Food Cent$ programme had a positive effect on spending patterns, with a movement away from spending money on the 'eat least' group of foods. Participants considered that there had been an actual change in their shopping and cooking habits. They believed that they were buying and eating more foods from the 'eat most' group and less from the 'eat least' group. The greatest change occurred between the 'eat least' group and the 'eat moderately' group. All three of these participants showed a movement away from purchasing foods in the 'eat least' group to purchasing foods in the 'eat moderately' group.

Fun not Fuss with Food									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Fraser, Wallis and St John (2004)	To improve children's problem eating and mealtime behaviours	Child Behaviour Parent-child relationship	Non-controlled trial Two pre measures, post-follow-up measures	Groups of parents	Not indicated	Number of sessions – 1 Duration of sessions – 2.5 hours Frequency of sessions – once Total duration of program – 2.5 hours	Parents (n = 75) Description – parents of children with an eating or mealtime problem or at risk of developing a problem Sex – not indicated Age – not indicated Children (n = 75) Description – children with an eating or mealtime problem or at risk of developing a problem Sex – M = 54.7% Age – 5 years or younger = 84.7%	None	Statistically significant – Significant effect for time across the four measurement periods with an over decrease in mean total problem eating and subsections of maternal attitudes and feelings, child behaviour compliance and manual/oral motor development. Significant decrease overtime in the percentage of children with clinical eating and mealtime behaviour. Non-significant – No significant change in total problem eating across the one month prior to intervention.

Gibbs, Waters, Robinson, Young & Hutchinson (2012)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Gibbs, Waters, Robinson, Young and Hutchinson (2012)	To influence parent poison safety awareness and behaviours	Safety and physical wellbeing	Non-randomised comparative trial Post measures	**Parent networker** Groups of parents	**Parent networker** Maternal Child Health Centre	**Parent networker** Number of sessions – 1 Duration of sessions – 90 minutes Frequency of sessions – once Total duration of program – 90 minutes	**Parent networker** Parents (n = not indicated) Description – parents attending a playgroup at a maternal child health centre Sex – F = 100% Age – not indicated	**No true control**	Descriptive – Parents in the parent network group reported changing their safety practices after the discussion with the networker, as well as sharing the safety information with others. All parents in the network group recalled the information relayed about poisons, whereas none of the parents in the health nurse group recalled the poison story relayed in the intervention.

Gibbs, Waters, Robinson, Young & Hutchinson (2012)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Maternal Child Health Nurse Individual parents	**Maternal Child Health Nurse** Maternal Child Health Centre	**Maternal Child Health Nurse** Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once Total duration of program – not indicated	**Maternal Child Health Nurse** Parents (n = 5) Description – parents attending maternal child health visit Sex – not indicated Age – not indicated		

The Gordoncare Parenting Orders Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Brown (2008)	To provide support sevices to help families overcome contact problems	Family relationships, parent-child relationship	Non-controlled trial Post-measure	Individual parents (and individual other family members)		Number of sessions – 6 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 6 weeks	<u>Parents</u> (n = 83) Description – court orders were a requirement for eligibility to the program and families had a history of of repeated returns to settle contact disputes. Sex – not indicated Age – not indicated <u>Children</u> (n = 58) Sex – not indicated Age - not indicated	None	<u>Descriptive</u> – The average number of returns to court prior to the family entering the program was 10 (with one family having returned 25 times). After the program, only 3% of families reported a return to court.
				Groups of children		Number of sessions – 6 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated			

Great Kids Program

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Staiger, Buckingham, Crosbie, Carr, Evans, Zyskind, Mitchell, Tucci (2006)	Program aims to support parents to review and change their patterns of communicating with their children which promotes more respectful interactions and encourages children's positive self identity. It aims to identify and address the sources of unhelpful and hurtful attitudes held by parents. It also works to establish new relationship context for children and their parents	Parent-child relationship Family relationships Child development	Non controlled trial Pre-post-follow-up (2 months) measures	Groups of parents	not indicated	Number of sessions – 6 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 39) Sex – F = 36 Age – ranged from 23-53 years of age with the mean age of participants being 37.4 years	None	Statistically significant – Parent/s reported a significant reduction in Family Conflict after attending the program. Parents became significantly more confident in parenting, more aware of how their own upbringing and behaviour influences their parenting, and better able to listen, understand and connect with their children. Parents reported making significant changes as a result of attending the program. Analysis revealed that parents were significantly more hopeful (that things would improve) at the end of the program. Maintenance of effect – Gains were maintained at 2-months follow-up. Non-significant – Although not statistically significant. Parent/s reported an increase in Family Cohesion and Family Expressiveness after attending the Great Kids Programs.

Great Kids Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
	through facilitating opportunities for positive exchanges.								

Homeless and Parenting Program Initiative (HAPPI)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Toucan Consulting SA Pty Ltd, (2003)	To increase the well-being of families and children who are homeless or at risk of homelessness	Basic child care, safety and physical wellbeing, parent-child relationship, child development, child behaviour, family relationships	Non-controlled trial Post measure	Unclear	Unclear	Number of sessions – unclear Duration of sessions – unclear Frequency of sessions – unclear Total duration of program – unclear	Parents (n = 130) Sex – F = 122 Age – 49% in their 20's, range = teenager - >50 years Children (n = unclear) Sex – not indicated Age – not indicated	None	Descriptive – Given the short term of its operation, it has been difficult to identify successful graduates of HAPPI from the statistics. However, workers from many agencies report significant gains and high levels of optimism for families as a result of HAPPI's intervention. Improving the knowledge and skills of parents regarding the wellbeing of their children was a goal for 89% of families. 82% of these families were identified by 39 their referring workers as gaining a moderate to high level of achievement in regard to this goal. Improving and enhancing relationships between parents and their children was a goal for 89% of families. 76% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Increasing the participation of parents and their children in case management processes was a goal for 47% of families. 91% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal.

Homeless and Parenting Program Initiative (HAPPI)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Improved skills, knowledge and understanding of parenting strategies was a goal for 89% of families. 87% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Increased awareness by parents of child development issues, and long-term implications of poor child health was a goal for 78% of families. 93% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Improved relationships between parents and children was a goal for 89% of families. 87% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Increased support of the needs of children was a goal for 89% of families. 80% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Increased access to and use of specialist support services for both parents and children was a goal for 68% of families. 71% of these families

Homeless and Parenting Program Initiative (HAPPI)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Increased support systems developed by parents was a goal for 68% of families. 70% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. A reduction in generational homelessness was a goal for 53% of families. 54% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Improvement in school participation, including school attendance was a goal for 63% of families. 67% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Basic life skill taught to children eg hygiene, health, nutrition, grooming, conflict resolution, problem solving was a goal for 47% of families. 67% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal.

Homeless and Parenting Program Initiative (HAPPI)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Improved feedback from children regarding their feelings of safety in the home environment was a goal for 23% of families. 45% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Improvement in attachment levels of parents with their child/ren was a goal for 89% of families. 59% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Capacity of parents to set appropriate limits for their child/ren was a goal for 89% of families. 53% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Extent of physical care and supervision was a goal for 68% of families. 77% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Extent of emotional care of child/ren was a goal for 89% of families. 41% of these families were identified by their referring workers as gaining a

Homeless and Parenting Program Initiative (HAPPI)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									moderate to high level of achievement in regard to this goal. Parent's capacity to meet their own support needs was a goal for 78% of families. 44% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal. Parent's motivation to participate in service provision was a goal for 89% of families. 59% of these families were identified by their referring workers as gaining a moderate to high level of achievement in regard to this goal.

Hauck, Hall, Dhaliwell, Bennet & Wells (2011)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Hauck, Hall, Dhaliwell, Bennet and Wells (2011)	To increase maternal confidence and competence in settling and sleep techniques	Family relationships Child behaviour Basic child care	Non-randomised controlled trial Contemporary usual care control group Pre, post measures	Individual mother-infant dyads	Parenting centre	Number of sessions – 1 Duration of sessions – 6 hours Frequency of sessions – once Total duration of program – 6 hours	Parents (n = 93) Sex – F = 100% Age – mean = 32.88 years Children (n = 93) Description – infants experiencing sleeping and settling issues Sex – not indicated Age – mean = 20.11 months	Parents (n = 85) Sex – F = 100% Age – mean = 32.80 years Children (n = 85) Description – Sex – not indicated Age – mean = 21.45 months	Statistically significant – *Intervention Group:* Perceptions of maternal competence and confidence increased significantly. A significant decrease in postnatal depression and anxiety. Time to settle the baby at night decreased significantly. Significant decrease in infant night waking at 4 weeks , with 17 mothers reporting less night waking. Mother's bedtime strategies involved significantly less active physical comforting and less settling by movement. *Control Group:* The control group changed their bedtime behaviour strategies, with significantly less active settling and passive physical comforting strategies as well as more encouragement of autonomy strategies. Perceptions of maternal competence increased significantly but confidence remained unchanged. A significant decrease in postnatal depression and anxiety.

Hauck, Hall, Dhaliwell, Bennet & Wells (2011)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									There was a significant reduction in time to settle the baby and in night waking. *Comparative Results:* Day stay mothers demonstrated significantly higher perceptions of confidence and competence than the control group. Infant sleeping and settling and maternal anxiety and depression did not differ from control group mothers. Non-significant – There was no significant difference between groups for time to settle the infant at night or the number of night waking. No difference in the EPDS depression scores and Anxiety Subscale scores between groups. There was no difference between groups on encourage autonomy, passive physical comforting and social comforting.

Hawes & Dadds (2005); Hawes & Dadds (2007)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Hawes & Dadds (2005) Hawes & Dadds (2007)	To improve child behaviour	Child behaviour	Non-controlled trial Pre-post-follow-up (6 months) measures	Parents	Psychology clinics of two universities	Number of sessions –1 Duration of sessions – 1.5 hours Frequency of sessions – once off	Parents (n = 56) Children (n = 56) Description – young boys with conduct problems aged between 4-8 years Sex – M = 100% Age – mean = 6.29 years	None	Maintenance of effect – The rate of ODD diagnosis fell to 19% on completion of treatment, with subsequent relapse among the sample seeing 35% diagnosed at 6 month follow-up. Descriptive – Participants high in callous-unemotional (CU) traits demonstrated poorer outcomes at follow-up than those low in CU traits. Boys with high CU traits were less responsive to discipline with time-out than boys without CU traits and reacted to this discipline with less affect. CU scores dropped post treatment for a subset of the sample.
				Parents	Psychology clinics of two universities	Number of sessions – 9 Duration of sessions – 1 hour Frequency of sessions – weekly Total duration of program – 10 weeks			

Hey Dad!									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Beatty & Doran (2007)	To support Aboriginal fathers in their parenting role in order to establish better outcomes for the next generation of Aboriginal children	Family relationships Child development Parent-child relationship	Non controlled trial Post measures	Groups of parents	Not indicated	Number of sessions –not indicated Duration of sessions – not indicated Frequency of sessions – weekly program, series of workshops or a two day or weekend program Total duration of program – not indicated	Parents (n = 56) **Demographics are for 31 men for whom enrolment forms were submitted** Description – Indigenous fathers Sex – M = 100% Age – mean age = 30 years	None	Descriptive – Evaluation questions about whether the intervention had enhanced their parenting, communication, conflict resolution and relationship skills as well as their social connections were answered by the vast majority in the affirmative.

Horn of Africa Parent Support Group									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Centre for Community Child Health, The Royal Children's Hospital (2011)	To increase social support for families, parent's knowledge of disabilities, awareness of disability services and parental confidence to access disability services	Family relationships	Non-controlled trial Post measure	Groups of families	Community centre	Number of sessions – unclear Duration of sessions – 2 hours, also an annual camp Frequency of sessions – weekly Total duration of program – unclear	Parents (n = unclear) Sex – not indicated Age – not indicated Children (n = not indicated) Sex – not indicated Age – not indicated	None	Descriptive – The group has provided an opportunity for participants to increase their social connections, however the nine month period does not appear to have been long enough for participants to make contact with each other independently of the sessions. All participants have increased their knowledge and understanding of disability. Participants have increased their understanding of the capabilities and potential of children with disabilities. All parents have increased their awareness of disability services. All parents have increased confidence in accessing disability services.

It Takes Two to Talk									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Pennington, Thomson, James, Martin, & McNally (2009)	To improve interactions between children who have motor disorders and their parents	Parent-child relationship	Non-controlled trial Pre-mid-post-follow-up (4 months)	Groups of parents	Community setting	Number of sessions – 7-8 Duration of sessions – 150 minutes Frequency of sessions – not indicated	<u>Parents</u> (n = 11) Description – parents of children with cerebral palsy Sex – F = 100% Age – not indicated <u>Children</u> (n = 11) Description – children with wide-ranging motor impairments reflecting the population of children with cerebral palsy Sex – M = 8 Age – 1-3 years	None	<u>Maintenance of effect</u> – Changes were maintained 4 months later. <u>Descriptive</u> – After training, mothers initiated less and produced more responses and fewer requests. Children produced more initiations, as well as more requests and provisions of information, after training. Mothers' linguistic output did not change in amount or complexity. Mothers' views of parenting did not change.
				Individual parent-child dyads	Home	Number of sessions – 3 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – 13 weeks			

Karitane Residential Family Care Unit									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Phillips, Sharpe and Nemeth (2010)	To reduce maternal psychological symptomatology and infant behaviour disturbances	Child behaviour, family relationships Basic child care	Non-controlled study **Study 1** Pre-post-follow-up measures **Study 2** Pre-post measures	Unclear	Residential family care unit	Number of sessions – 1 Duration of session – 5-day residential stay Total duration of program – 5 days	**Study Group 1** Parents (n = 104) Description – 27% of group were classified as depressed at admission Sex – F = 100% Age – mean = 30.9 years Children (n = 104) Sex – M = 53.6% Age – mean = 5.86 months **Study Group 2** Parents (n = 147) Description – 31.3% met the criteria for major or minor depression, 34.7% met criteria for at least one anxiety disorder and 49.7% met criteria for any disorder (depression or anxiety) Sex – F = 100%	None	**Study 1** Statistically significant – The intervention was associated with significant decreases in the amount of time that infants were unsettled, decrease in the number of night waking, and increases in the total amount of sleep time. These changes were seen for infants of mothers who scored above and infants of mothers who scored below the Edinburgh Postnatal Depression Scale (EPDS) threshold for major depression. The intervention was associated with significant improvements in maternal depression, anxiety and parenting stress: improvements were evident for both women who scored above and women who scored below the EPDS threshold for major depression. These results were clinically significant. Descriptive – The proportions of participants who scored above the EPDS threshold for major depression fell from 26% at baseline, to 11% at 1 month, and 7% at 3 months. **Study 2** Statistically significant – All infants, whether or not their mother was

Karitane Residential Family Care Unit									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							Age – mean = 31.37 years Children (n = 104) Sex – M = 51.7% Age – mean = 5.44 months		diagnosed with a depressive or anxiety disorder, experienced significant increases in the amount of sleep time, decreases in the amount of unsettled time and decreases in the number of night waking over the course of the 5 day admission.

Kids in Focus									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Berry, Stoyles & Donovan (2010)	To improve parents' perceived parent-child relationship and decrease parental acrimony	Parent-child relationship, family relationships	Non-controlled trial Pre-post measures	Group of parents	Family relationship centre	Number of sessions – 1 Duration of session – 2.5 hours	Parents (n = 27) Sex – F (n = 17) Age – not indicated	None	Statistically significant – A moderate improvement in perceived parent-child relationship Non-significant – No change in parental acrimony

Let's Start: Exploring Together									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Robinson, Zubrick, Silburn, Tyler, Jones, D'Aprano, McGuinness, Cubillo, Bell & Stock (2009) Robinson, Tyler, Jones, Silburn & Zubrick (2011)	To reduce levels of child behaviour problems	Child behaviour Parent-child relationships Child education	Non-controlled trial Pre-post-follow-up measures	Groups of parent-child dyads	Darwin - family centre, childcare centre. Remote communities: school, preschool, women's centre, childcare centre	Number of sessions – 10 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 10 weekly	<u>Parents</u> (n = total not indicated) Description – parents of children in the program Sex – not indicated Age – not indicated <u>Children</u> (n = 225) Description – Aboriginal children from Tiwi Islands and the mainland, as well as children from all cultural backgrounds in Darwin, and targeted indigenous clusters Sex – M = 65% Age – mean = 5 years, range = 4-6 years	<u>None</u>	<u>Statistically significant</u> – Significant pre to post reductions in intervention group's problem and risk taking behaviours according to teacher and parent reports. <u>Maintenance of effect</u> – Significant improvements in problem and risk taking behaviours were maintained at 6-week follow-up.
				Groups of parents	As above	Number of sessions – 10 Duration of sessions – 50 minutes Frequency of sessions – weekly Total duration of program – 10 weeks			

Let's Start: Exploring Together									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Groups of children	As above	Number of sessions – 10 Duration of sessions – 50 minutes Frequency of sessions – weekly Total duration of program – 10 weeks			

Marshall & Swan (2010)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Marshall and Swan (2010)	To assist parents to help with their children's mathematics learning	Parent-child relationship Child development	Non-controlled trial Pre-post measures	Group of parents	University	Number of sessions – 6 Duration of sessions – 45 minutes Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 15) Description – parents who were bringing their children to a maths clinic Sex – not indicated Age – not indicated Children (n = not indicated) Sex – not indicated Age – not indicated	None	Statistically significant – A significant change in parents' confidence about assisting their children in mathematics. Descriptive – Only three parents in Survey A expressed confidence in helping with place value concepts, whereas 11 (65%) felt more confident at the end of workshops. On the topic of fractions 50% of respondents in Survey A either lacked some confidence, or had none at all. By the second survey, no respondents ticked either of those boxes. The numbers for 'very confident' and 'fairly confident' went from six (37.5%) to thirteen (76.5%).

Masada Private Hospital's Mother Baby Unit (MPHMBU)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Fisher, Rowe & Feekery (2004)	Training in infant care and settling strategies. Infants are assisted to develop an age-appropriate feed, play and sleep routine	Basic child care Child behaviour	Non-randomised controlled trial Historical Pre-post-follow-up (1 and 6 months) measures	Individual parent-infant dyads	Hospital	Not indicated	<u>Parents</u> (n = 59) Description – mothers with infants aged <12 months who present with mild to moderate depression, generalised anxiety and severe maternal exhaustion Sex – F = 100% <u>Children</u> (n = 59) Description – infants with dysregulated behaviour with frequent waking overnight, short and infrequent daytime sleeps and prolonged crying Age – 4-12 months	None	<u>Statistically significant</u> – Infant temperament was significantly more difficult than population norms and most had dysregulated sleep. One month after treatment, total infant crying and fussing, frequency of night-time waking, and sleep and feeding dysregulation were significantly reduced. <u>Maintenance of effect</u> – Changes sustained at 6 months.
				Groups of parent-infant dyads	Hospital	Not indicated			

Mental Health Positive Parenting Program

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Phelan, Lee, Howe & Walter (2006)	To help parents with mental illness learn new parenting strategies	Child behaviour Child development Parent-child relationships Family relationships	Non-controlled trial Pre-post measures	Groups of parents	not indicated	Number of sessions – 6 Duration of sessions – 2.5-3 hours Frequency of sessions – weekly Total duration of program – 6 weeks	<u>Parents</u> (n = 19) Description – parents with a mental illness or mental health problem that impacts parenting Sex – F = 86% Age – mean = 32.3 years, range = 19-55 years <u>Children</u> (n = 31) Description – children in families of parents completing the intervention Sex – not indicated Age – mean = 4.75 years	None	Description – there was a pre to post decrease in behavioural intensity and problem, with fewer children in the clinical range at post compared to pre. There was a pre to post improvement in parenting style, with fewer parents in the clinical range for laxness, over-reactivity and verbosity at post compared to pre. The majority (about 85% and higher) or the 14 satisfaction survey respondents rated the program highly.
				Individual parents	Home	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program –4 weeks			

Mental Health Positive Parenting Program

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Phelan, Howe, Cashman & Batchelor (2012)	To reduce child behavioural problems and dysfunctional parenting strategies	Child development, parent-child relationship	Non-controlled trial Pre-post measures	Groups of parents	Community Health Centre	Number of sessions – 6 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – 10 weeks	Parents (n = 86) Description – self-reported a mental health problem Sex – F (n = 78) Age – mean = 32.6 years Children (n = 86) Sex – M (n = 53) Age – mean = 4.9 years, range = 2-10 years	None	Statistically significant – Parents reported significantly lower scores on the Eyberg Child Behaviour Inventory (ECBI) for both the problem subscale and the intensity subscale. Parents reported significantly lower scores on each of the Parenting Scale (PS) subscales: laxness, over-reactivity and verbosity. Significantly fewer parents scored their parenting styles and children's behaviour in the clinical range.
				Individual parents	Home	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program – 10 weeks			

Mildon (2008)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Mildon (2008)	To deliver an enhanced assessment-based behavioural parent training (BPT) intervention to parents with an intellectual disability to reduce child problem behaviours	Child behaviour, parent-child relationship	Non-controlled trial Pre-post – follow-up measures	Individual parent-child dyads	Home	Number of sessions – unclear Duration of sessions – 1 hour Frequency of sessions – weekly Total duration of program – unclear	Parents (n = 5) Description – parents with an intellectual disability Sex – F (n = 4) Age – 43, 36, 31, 41 and 23 years Children (n = 27) Sex – M = 100% Age – 4 years 1 month 4 years 6 months 5 years 3 months 4 years 8 months 2 years 2 months	None	Significant – Significant improvements in the children's behaviour for all families post intervention. Follow-up – Improvements in the children's behaviour was sustained in all cases during follow-up observations. All parents maintained either all or some of the intervention strategies during follow-up. Descriptive – The intervention was effective in improving the child's behaviour during one valued family routine. These positive effects were replicated across five parent–child dyads. Parent training resulted in improvements in parent–child interactions Before training the parents'use of positive behaviour such as contingent attention and specific praise was limited and their use of consistent, non-corporal discipline strategies was non-existent. After training, the parents began providing their children with positive or neutral attention for behaviour other than problem behaviour and began

Mildon (2008)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									providing specific praise for compliance or starting an activity either independently or with a parent or sibling. The parents began to use positive discipline strategies in response to both low-intensity and high-intensity problem behaviour.

Mildon, Wade & Matthews (2008)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Mildon, Wade & Matthews (2008)	To combine the delivery of evidence-based parent education technology for parents with an intellectual disability with two strategies aimed at promoting the contextual fit of the intervention with these families	Child behaviour	Non-controlled trial Pre-post-follow-up measures	Individual families	Home	Number of sessions – 12 Duration of sessions – 90 minutes Frequency of sessions – weekly Total duration of program – 6 months	Parents (n = 24 from 19 families) Description – parents with an intellectual disability Sex – F = 19 Age – range of mothers = 20-49 years, range of fathers = 30-49 years Children (n = 19) Description – a target child Sex – M = 14 Age – range of target children = 6 months -6 years	None	Statistically significant – Significant pre to post decrease in parenting daily hassles and child behaviour intensity and problem. Significant pre to post improvements on the quality of the home environment. Maintenance of effect – Decrease in parenting daily hassles and child behaviour intensity and problem maintained at 3 month follow-up. Improvements on the quality of the home maintained at 3 months (for the infant/toddler subscale only). Non-significant – A non-significant pre to post increase in parental competence. Descriptive – There was a pre to post reduction in the number of children with clinical levels of behaviour problem and intensity. Overall, there was a high level of satisfaction with the program.

Ngaripirliga'ajirri

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Robinson and Tyler (20060	To address youth social problems, child behavioural concerns and encourage assertive non aggressive parenting	Child behaviour Child development Parent-child relationships Family relationships	Non-randomised controlled trial Waitlist controls (with very little data collected) Pre-post measures	Groups of children	For one of the communities, program was delivered in a school. Location not indicated for other communities	Number of sessions – 8 Duration of sessions – 1 hour Frequency of sessions – weekly Total duration of program – 8 weeks	Parents (n = 54) Description – parents of children referred to the program Sex – F = 47 Age – not indicated Children (n = 54) Description – Aboriginal children from three Tiwi communities on Bathurst and Melville Islands; referred to program by teachers or parents due to behavioural problems Sex – not indicated Age – in grades 4-6 = 100%	Parents (n = not indicated) Children (n = 14) Description – waitlisted children from three Tiwi communities on Bathurst and Melville Islands; referred to program by teachers or parents due to behavioural problems Sex – not indicated Age – in grades 4-6 = 100%	Statistically significant – Significant pre to post declines in teacher ratings of intervention child behaviour intensity and problem Maintenance of effect – Teacher reports of significant declines in intervention children's behaviour intensity and problem maintained at 6 months. Non-significant – Non-significant decline in parents' reporting on intervention children's behaviour intensity and problem. Non-significant pre to post improve for waitlist children but not intervention children on teacher reports of behaviour intensity. Descriptive – Teacher and parent reports showed decreases in problem behaviours at school and at home, which maintained at 6 months for 40% of children. Up to 80% of parents reported improved communication with the intervention child.
				Groups of parents	As above	Number of sessions – 8 Duration of sessions – 1 hour Frequency of sessions – weekly Total duration of program – 8 weeks			

Ngaripirliga'ajirri									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Groups of parent-child dyads	As above	Number of sessions – 8 Duration of sessions – 40 minutes Frequency of sessions – weekly Total duration of program – 8 weeks			

Once Upon a Circus									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Social Compass (2011)	To promote play as a fundamental family activity and use circus, storytelling, and literacy to develop key childhood development skills such as confidence, communication and perseverance in order to build strong, resilient communities	Parent-child relationship, family relationship	Non-controlled trial Post measure	Unclear	Community centres, primary schools	Number of sessions – three playgroups = 10, one playgroup = 20 Duration of sessions – 1.5 hours Frequency of sessions – weekly Total duration of program – three playgroups = 10 weeks, one playgroup = 20 weeks	Parents (n = unclear) Sex – unclear Age – unclear Children (n = unclear) Sex – unclear Age – unclear	None	Descriptive – Over 75% of participants who were questioned in relation to social connection pointed out that they had become more socially connected to other parents both in the program and (to a lesser extent) in their community. The overwhelming response from parents with regard to the difference the program has made to their children is that is has increased their levels of self-confidence and interns generally commented that they had observed over the life of the program that children become more outgoing. Children and adults became more confident speaking to others in the group social circus skills, literacy and numeracy, social development and educational development had all increased – generally across the four groups. There are numerous reports from all those involved in the program that suggest stronger bonds are being developed between parents and children. There was some anecdotal evidence suggesting some increased access to resources through the relationships and friendship built up over the life of the program.

P5-Participatory Program Promoting Pleasurable Parenting									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Hastings and Ludlow (2006)	To improve parenting self-efficacy and confidence in relation to child behaviour management	Child behaviour Parent-children relationship	Non-controlled trial Pre-post measures	Groups of parents	Community child health centre	Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 8 weeks	Parents (n = 65) Description – any parents Sex – F = 92% Age – mean = 37.24 years, range = 25-65 years Children (n = not indicated) Description – not indicated Sex – M = 60% Age – mean = 6.41 years, range = 1-13 years	None	Statistically significant – Significant pre to post reduction in behaviour intensity and problem scores. Significant reduction in intensity and problem of oppositional, in attentive and conduct related behaviours. Analysis of clinical and nonclinical groups (behaviour) found significant reduction in behaviour intensity and problem only for the clinical group. Further analysis showed significant effect for children in the 90th%ile for behaviour and no effect for those below it. Descriptive – Parents reported that the program helped the way their family interacts. 21% indicated that they implemented the strategies in the program and 18% reported that the program increased their confidence. Responses regarding the program were positive, with 94% stating they would recommend it and only 2% reporting they would not recommend.

Parenting Eating and Activity for Child Health (PEACH) with Parent Skills Training									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Magarey, Perry, Baur, Steinbeck, Sawyer, Hills, Wilson, Lee & Daniels (2011)	To target parents as the agents of change for implementing family lifestyle changes to reduce adiposity in children	Safety and physical wellbeing	Randomised controlled trial Contemporary alternate treatment Pre, post, follow-up (12, 18, 14 months) measures	Groups of parents	Hospital	Number of sessions – 12 Duration of sessions – 90-120 minutes Frequency of sessions – not indicated	Parents (n =85) Sex – not indicated Age – not indicated Children (n = 85) Description – prepubertal moderately obese children Sex – m = 38 Age – 5-9 years	Parents (n = 84) Sex - not indicated Age – not indicated Children (n = 84) Description – prepubertal moderately obese children Sex – M = 37 Age – 5-9 years	Statistically significant – There were significant reductions in BMI z score and waist z score for both groups. Maintenance of effect – There was a 10% reduction in z scores from baseline to 6 months that was maintained to 24 months (for both groups) with no additional intervention. Non-significant – Overall, there was no significant group effect . Descriptive – This study demonstrates that a relative weight loss of ~10% is achievable and can be maintained for up to 2 years in moderately obese perpubertal children and provides support for a parent-only approach. There is some suggestion that the addition of parenting skills training may improve short-term treatment outcomes, but this group effect was not maintained.
				Individual Parents	Home-Telephone	Number of sessions – 4 Duration of sessions – not indicated Frequency of sessions – tapered frequency (weekly, bimonthly, then monthly) Total duration of program – 6 months			

Plutzer & Spencer (2008, 2011)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Plutzer & Spencer (2008) Plutzer & Keirse (2011)	To reduce severe early childhood caries	Safety and physical wellbeing	Randomised controlled trial – see below Participants knew about group allocation prior to consent and pre measure, with 0.8% opting out of intervention into control Intervention group all received written information in two rounds and then were randomised to receive structured telephone consultation and more	**Written information only** Individual parents	**Written information only** Handed to participant or mailed	**Written information only** Number of sessions – 3 Duration of sessions – not applicable Frequency of sessions – prenatally, 6 months postnatally, 12 months postntally Total duration of program – varied depending on time joined program	**Written information only** Parents (n = 109) Description – women in 5th to 7th month of pregnancy Sex – F = 100% Age – not indicated Children (n = 109) Description – newborns Sex – not indicated Age – not indicated	Parents (n = 209) Description – women in 5th to 7th month of pregnancy Sex - F = 100% Age – not indicated Children (n = 209) Description – newborns Sex – not indicated Age – not indicated	Statistically significant – At 12-month dental examination, the control group had a significantly higher incidence of severe early childhood dental caries than the intervention group (written information and written information plus phone consult). Non-significant – At 12-month dental examination, there was no significant difference in the incidence of cavities between the intervention group (written information and written information plus phone consult) and the control group. There was no significant difference in the incidence of severe early childhood caries between the group receiving telephone consultation and the group receiving written information alone. Descriptive – Most parents rated the written information as good or very good. The reduction in frequency of severe early childhood caries attributed to the intervention was twofold greater in two-parent than one-parent families (twofold lower relative risk of caries in two-parent

Plutzer & Spencer (2008, 2011)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
			written information or more written information alone Pre-post measures (although pre was after randomisation, but before intervention). Does not appear to have assessed same variables at pre and post.	**Written information plus telephone consultation** Individual parents	**Written information plus telephone consultation** Home	**Written information plus telephone consultation** Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once Total duration of program – not indicated	**Written information plus telephone consultation** Parents (n = 123) Description – women in 5th to 7th month of pregnancy Sex – F = 100% Age – not indicated Children (n = not indicated) Description – newborns Sex – not indicated Age – not indicated		families). Intervention produced a greater reduction in absolute risk of caries in one-parent than two-parent families because of high incidence of caries in children from one-parent families.
				Individual parents	Handed to participant or mailed	Number of sessions – 3 Duration of sessions – not applicable Frequency of sessions – prenatally, 6 months postnatally, 12 months			

Plutzer & Spencer (2008, 2011)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						postntally Total duration of program – varied depending on time joined program			

Relatewell									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Family Relationship Institute Inc. (2011)	To support parents to use strategies to reduce negative parent-child interactions, to promote strong, functional and well supported families and promote healthy milestone development in children	Parent-child relationship, child behaviour, family relationships	Non-controlled trial Pre-post-follow-up measures	Groups of parents	Not indicated	Number of sessions – 2 Duration of sessions – 7 hours Frequency of sessions – daily Total duration of program – 2 days	Parents (n =50) Description – couples having difficulties managing their child(rens) behaviour Sex – F = 50% Age – not indicated Children (n = not indicated) Sex – not indicated Age – not indicated	None	Significant – Parents reported significant change in child(rens) behaviour. Maintenance of effect – 45/50 indicated enhanced parenting competencies. Changes in parenting behaviour continued to improve over the 12-month follow-up period. There was no significant difference between post-evaluation/follow-up variables, indicating that gains in attendance were maintained to the 12-month mark. Descriptive – Parents expressed that they gained invaluable strategies in dealing with difficult child behaviour other than yelling/hitting. Parents expressed that they felt more empowered by the group and were able to view their child(rens) behaviours more normatively and with less frustration – 80% of participants left with a sense of understanding that it is normal for child(ren) to try to get what they want. Parents reported more positive parenting behaviour and an enhancement in parenting competencies.

Relatewell									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
									Parents perceived their children to be less difficult, more accommodating and more settled.

Sing & Grow									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Nicholson, Berthelsen, Abad, Williams & Bradley (2008)	To promote positive parent-child relationships and children's behavioural, communicative and social development	Parent-child relationship Child behaviour Child development	Non-controlled trial Pre-mid-post measures	Group of parent-child dyads	On the premises of the referring agency	Number of sessions – 8-10 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program – 10 weeks	Parents (n = 358) **General disadvantage group** Parents (n = 167) Description – families facing general social and economic disadvantage Sex – F = 96.4% Age – mean = 32.7 years Children (n = 167) Sex – F = 46.4% Age – mean age = 23.5 months **Young parent group** (n = 96) Parents (n = 96) Description – young parents (defined by government services as those aged 25 years or younger) Sex – F = 97.9% Age – mean =	None	Statistically significant – Significant improvements were found for therapist-observed parent and child behaviours, and parent-reported irritable parenting, educational activities in the home, parent mental health and child communication and social play skills. Descriptive – Improvements were similar across the three client groups.

Sing & Grow									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							23.9 years Children (n = 96) Sex – F = 51.0% Age – mean = 15.6 months **Child with a disability** (n = 95) Parents (n = 95) Description – parents of a child with a disability Sex – F = 96.8% Age – mean = 34.9 years Children (n = 95) Sex – F = 45.3% Age – mean = 34.1 months		

Sawyer & Glazner (2004)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Sawyer and Glazner (2004)	To provide assessment and education to parents of children diagnosed with cystic fibrosis (CF)	Child development Family relationships	Non-controlled trial Post measure	Groups of families	Hospital (residential unit separate from the clinical areas)	Number of sessions – one Duration of sessions – 5-day residential program Total duration of program – 5 days	Parents (n = 30) Description – both parents of the child attended the program Sex – F = 50% Age – not indicated Children (n = 15) Description – infants with cystic fibrosis Sex – not indicated Age – mean = 17 months, range = 6-30 months	None	Descriptive – At the end of the 5 days, parents reported that they felt capable of managing the day-to-day requirements of CF and knew how to elicit additional support if required. Parents did not rate long-term issues (confidence to manage the child's CF at home and concern about future coping) as confidently. One hundred percent of families endorsed the timing of the assessment and education program immediately after the diagnosis.

Skilled Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Costin and Chambers (2007)	To deliver parent management training (PMT) as a treatment for primary school-age children with Oppositional Defiant Disorder (ODD) and comorbid disorders (Attention Deficit Hyperactivity Disorder and affective disorders) in a public-health-oriented community-based setting	Child behaviour	Non-controlled trial Pre-post measures	Not indicated	Community mental health clinic	Number of sessions – 8 Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 94) Sex – F = 81% Age – not indicated Children (n = 94) Sex – F (n = 76) Age – mean = 9 years, range = 5-13 years	None	Statistically significant –Statistically and clinically significant reductions of child behavioural symptoms across all measures utilised. Significant results for the comorbidity groups (ODD/ADHD and ODD/ADHD/ Affective) for 5 of the 7 child behaviour symptoms measures. Descriptive – A clear reduction in group means for child behaviour symptoms over time, with a significant main effect for Time. Treatment was as effective, and in some cases more effective, for the comorbid groups than the ODD alone group. Boys with comorbid ADHD were as successful as those without a comorbid condition in reducing rated behaviour problems following PMT. There were general improvements across time for all three groups (ODD, ODD/ADHD and ODD/ADHD/ Affective).

Skilled Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Costin, Lichte, Hill-Smith, Vance, & Luk (2004)	Two programs: **1) Skilled Parenting Program**: aims to change parent controlled contingencies so that the child's pro-social behaviour are rewarded and aversive behaviours	Child behaviour Parent-child relationship	Non-controlled trial Pre-post measures Two programs 1) Skilled Parenting Program 2) Perceptive Parenting Program	**Skilled Parenting Program** Group of parents	**Skilled Parenting Program** Not indicated	**Skilled Parenting Program** Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 8 weeks	**Skilled Parenting Program** Parents (n = 22) Children (n = 22) Description – child was of primary school age and met the diagnostic criteria of ODD as defined by DSM-IV Sex – M = 91%	None	Statistically significant – For both programs significant improvement was shown between the pre and post measures for parenting stress and child behaviour scores. Significant decreases were found for conduct problems following the skilled parenting group. Non-significant – No significant decrease in conduct problems for the Perceptive Parenting group.

Skilled Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
	are systematically ignored or punished **2) Perceptive Parenting Program:** uses a cognitive approach that targets parental perceptions, or cognitive schema, and their emotional responding to child misbehaviour			**Perceptive Parenting Program** Group of parents	**Perceptive Parenting Program** Not indicated	**Perceptive Parenting Program** Number of sessions – 8 Duration of sessions – 2 hours Frequency of sessions – weekly Total duration of program – 8 weeks	**Perceptive Parenting Program** Parents (n = 18) Children (n = 18) Description – child was of primary school age and met the diagnostic criteria of ODD as defined by DSM-IV Sex – M = 94%		

Starting Points									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Hill, Hill and Moore (2008)	To increase parenting confidence	Not indicated	Non controlled trial Pre-post-follow-up measures	Groups of parents	Not indicated	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 74) Description – parents of children aged 0-4 Sex – F = 75.2% Age – median range = 30 – 34 years Children (n = not indicated) Description – not indicated Sex – not indicated Age – not indicated	None	Statistically significant – Significant pre to post reports of parenting confidence across cognitive behavioural/cognitive and emotive domains. Maintenance of effect – Most significant improvements were maintained.

Symon, Marley, Martin & Norman (2005)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Symon, Marley, Martin & Norman (2005)	To improve sleep performance in newborn infants	Child behaviour Basic child care	Randomised controlled trial Contemporary usual care Post-follow-up (3 months) measures	Individual parents	Hospital	Number of sessions – 1 Duration of sessions – 45 minutes Frequency of sessions – once off Total duration of program – 45 minutes	Parents (n = 137) Description – inclusion criteria included delivery at 36-42 weeks gestation Sex – not indicated Age – not indicated Children (n = 137) Sex – F = 53% Age -2-3 weeks old	Parents (n = 131) Description – inclusion criteria included delivery at 36-42 weeks gestation Sex – not indicated Age – not indicated Children (n = 131) Sex – F = 50% Age – 2-3 weeks old	Statistically significant – Total sleep time was 15 hours or more per 24 hours on 62% of recorded days in the intervention group, compared with 36% in the control group. Maintenance of effect – Sleep improvement was maintained at 3-month follow-up. Non-significant – There were no significant difference in crying time between the groups. Descriptive – At 6 weeks of age, intervention infants slept a mean 1.3 hours per day more than control infants, comprising 0.64 hours more night sleep and 0.58 hours more daytime sleep.

The Time 2B Healthy Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Jones, Wells, Okely, Lockyer, & Walton (2011)	To make behavioural changes and promote healthy weight for overweight or at risk of overweight, preschool-aged children	Safety and physical wellbeing Child behaviour	Non-controlled trial Pre-post measures	Individual parents	Home	Number of sessions – 5 Duration of sessions – each session is completed over a two week period Frequency of sessions – fortnightly Total duration of program – not indicated	Parents (n =47) Sex – F = 98% Age – not indicated Children (n = 47) Description – aged between 2 and 5 years and overweight or at risk of being overweight (i.e., one of both parents are overweight) Sex – not indicated Age – 76% three- and four-year-olds	None	Descriptive – All aspects of parental knowledge and parental and child behaviour tested changes were in the hypothesized direction (i.e., a greater number of parents agreed or strongly agreed with the statements at follow-up compared with baseline).

Together Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Burke, Soltys, & Trinder (2008)	To teach parents to reinforce prosocial behaviour instead of reinforcing aggressive or coercive	Child behaviour Parent-child relationship	Non-controlled trial Pre-post and 3-month follow-up measures	Group of parents	School or community agency	Number of sessions – 10 Duration of sessions – 2 hours Frequency of sessions – weekly	Parents (n = 44) Sex – mostly F Age – 27-62 years Children Sex – M = 60% Age – 5-11 years	None	Statistically significant – Significant pre-program to post-program changes in children's internalising and externalising behaviour problems with a moderate effect size. Significant decreases in both internalising and externalising behaviours.

Together Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
	behaviour and how to reduce problem behaviour			Individual parents	Telephone	Number of sessions – up to 2 Duration of sessions – not indicated Frequency of sessions – before and after program			The program significantly decreased dysfunctional parenting styles across time. Significant increase in parental satisfaction from pre to post test. Maintenance of effect – A very low number of parents returned their three month follow-up questionnaires, which meant that it was not possible to determine the longer-term effectiveness of the program beyond the end of the 10-week intervention. Descriptive – For the externalising scale, all children who initially scored in the borderline range at pre-test, and 64% of the children who scored in the clinical range at pre-test had improved following the program. No children scored worse on the externalising scale following the program.

Together Parenting Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
				Group parents and partners, support people, or children's teachers	Schools or community agency	Number of sessions – up to 2 Duration of sessions – not indicated Frequency of sessions – before and after program Total duration of program – 10 weeks			For the internalising scale, 75% of children who were ranked borderline at pre-test had improved following the program. Two children who scored in the normal range on the internalising scale at pre-test had worsened by post-test.

Tooth Smart Programme									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Cashmore, Noller, Johnson, Ritchie, & Blinkhorn (2011)	To stabilize existing carious lesions and prevent new caries in children	Safety and physical wellbeing	Non-controlled trial Post measures	Individual families	Hospital dental clinic	Number of sessions – 4 Duration of sessions – 20 minutes to 1 hour Frequency of sessions – tri-monthly Total duration of program – 12 months	Parents (n = 14) Sex – F = 10 Age – not indicated Children Age – under 5	None	Descriptive – Most parents felt that the intervention had been successful in increasing the frequency and quality of their child's tooth brushing. Some parents reported that increased brushing reduced their child's dental pain, which, in turn improved the child's quality of life. Conversely most had found it hard to control their child's snacking on sugary foods and drinks.

Tresillian Family Care Centre Program									
Study	**Program aims**	**Outcomes**	**Mode**	**Setting**	**Dose**	**Design**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Don, McMahon and Rossiter (2002)	To reduce unsettled behaviour in young infants through an individualised multidisciplinary residential program	Child behaviour Basic child care	Individual parent-child dyad	Family care centre – residential stay unit	Total duration of program – 5 days and 4 nights	Non-controlled trial Pre-mid-follow-up measures	Parents (n = 109) Sex – F = 100% Age – not indicated Children (n = 109) Description – infants aged < 20 weeks Sex – not indicated Age - < 20 weeks	None	Statistically significant – By day 4 of the admission, the mean duration of unsettled (fussing, crying) behaviour had decreased significantly and mean sleeping time and awake and content times both increased significantly. Maintenance of effect – The decrease in unsettled behaviour was maintained 1 month after discharge. Changes were maintained regardless of age of infant or severity of the unsettled behaviour. Descriptive – Changes were particularly marked for very unsettled infants. Mothers perceived their infant to be less difficult than prior to admission.

Tweedle Child and Family Health Service residential Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Rowe and Fisher (2010)	To make parenting enjoyable, to increase confidence and develop safe, effective child rearing practices	Basic child care Family relationships Child behaviour Parent-child relationships	Non-controlled trial Pre-post-follow-up measures	Groups of parents	Hospital	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated	Parents (n = 79) Description – mothers admitted to Tweedle program for postnatal assistance Sex – F = 100% Age – mean = 32.2 years Children (n = not indicated) Description – children admitted to Tweedle Sex – not indicated Age – mean = 33 weeks	None	Statistically significant – Significant pre to post improvements on all measures of maternal psychological function (anxiety, irritability, depression, clarify of thinking, fatigue, functional efficiency). Significant pre to post reduction in infant crying and fussing. Maintenance of effect – Improvements in maternal psychological function maintained at 6 months. Non-significant – Decrease in infant crying and fussing between post and follow-up was not significant. Descriptive – Proportions of mothers with clinical levels of depression decreased overtime. Those with clinical depression at 6 months were more likely to have had high admission scores. Infants were sleeping linger during and day and waking less frequently at night after the program. Maternal confidence increased from pre to post, and then again at 6 months.
				Individual parents	Hospital	Number of sessions – not indicated Duration of sessions – not indicated Frequency of sessions – not indicated Total duration of program – not indicated			

Queen Elizabeth Centre's Residential Program									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Treyvaud, Rogers, Matthews and Allen (2009)	To improve mother's behaviour during parent-child interaction and improve self-reported well-being (depression, anxiety and stress)	Parent-child relationship family relationships child behaviour	Non –controlled trial Pre-post-follow-up measures	Individual parent-child dyads and groups of parent-child dyads	Early parenting centre	Number of sessions – 1 Duration of session – 5 day residential stay Total duration of program – 5 days	Parents (n = 44) Sex – F = 100% Age – mean = 31.3 years Children (n = 44) Description – majority of children had sleeping difficulties Sex – not indicated Age – not indicated	None	Statistically significant – There was significant improvement in depression, anxiety, stress and parental confidence (parental satisfaction and efficacy). Significant improvements in mother reported difficult child behaviour (82% of which related to sleeping or settling difficulties). Maintenance of effect – Improvements for anxiety and stress were maintained at one month. Descriptive – Improvements were observed in mothers' overall parenting behaviour during videotaped interactions after attending the program. Decline in the average frequency of maternal identified difficult child behaviour from the "1-10 times per day" to "1-3 times per month" category. Decline in the average seriousness of the difficult child behaviour from the "severe" to "mild" category. Few changes in observed child interaction behaviour over the program week.

Weiskop, Richdale & Matthews (2005)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Weiskop, Richdale and Matthews (2005)	To reduce sleep problems in children with fragile X syndrome (FXS)	Child behaviour Basic child care	Non-controlled trial Pre-post-follow-up measures	Individual parents	Home, university clinic (two sessions)	Number of sessions – 5 Duration of sessions – not indicated Frequency of sessions – sessions 2-4 weekly, session 5 occurred 5 weeks after session 4 Total duration of program – 7 weeks	**Study Group 1** Parents (n = 12) **Demographic information (except parent sex) is for both study groups** Sex – F (n = 6) Age – F mean = 35, M mean = 38 Children (n = 6) Description – five children with autism and one with Asperger syndrome with sleep difficulties Sex – M (n = 10) Age – mean = 5 years 1 month, range = 1 year 1 month to 9 years 1 month **Study Group 2** Parents (n = 10) **Demographic information (except for parent sex) is for both study groups**	None	Descriptive – Of the six common sleep variables, four changed: pre-sleep disturbances, falling asleep alone, night waking and co-sleeping. In study 1 improvements were maintained at the three and 12 month follow-ups. In study 2, most improvements were maintained at the three month follow-up. Most parents perceived an improvement in their child's sleep. Little or no improvement occurred for early morning waking or night rocking and there was insufficient evidence to support a change in sleep latency or duration.

Weiskop, Richdale & Matthews (2005)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
							Sex – F (n = 7) Age – F mean = 35, M mean = 38 <u>Children</u> (n = 7) Description – children with fragile X syndrome Sex – M (n = 10) Age – mean = 5 years 1 month, range = 1 year 1 month to 9 years 1 month		

What Were We Thinking! (WWWT)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Fisher, Wynter, & Rowe (2010)	To promote confident parental caretaking, optimise functioning in the intimate partner relationship, improve infant manageability and reduce common postnatal mental disorders in women	Child behaviour Family relationships Basic child care	Non-randomised controlled trial Historical usual care Pre-post follow-up (6 months) measures	Groups of families	Maternal and child health centres	Number of sessions – 13 Duration of sessions – not indicated Frequency of sessions – weekly Total duration of program – 13 weeks	Parents (n =189) Description – couples with healthy firstborn infants Sex – F = 100% Age – mean age = 31.62 years Children (n =189) Sex – F = 48.9% Age – approximately 4 weeks old	Parents (n = 210) Description – couples with healthy firstborn infants Sex – F = 100% Age – mean age= 30.2 years Children (n =210) Sex – F = 52.7% Age – approximately 4 weeks old	Statistically significant – In the group without a psychiatric history, the absolute risk reduction associated with the intervention was 14% and the relative risk reduction was 48%. For participants with no psychiatric history, being in the intervention group was associated with a significantly reduced odds of a diagnosis of a mental disorder Descriptive – At the end of the intervention program 94% of women reported increased understanding of infant sleep needs, 83% an increased understanding of infant temperament, 93% an increased understanding of infant sleep and settling strategies, 72% could now talk more effectively about parenting with their partners and 66% already reported increased confidence in infant care.

Appendix 12. Data extracted from programs rated as Not Effective in the REA (data extracted from papers and program rating checklists)

Not effective programs were rated as follows on the evidence of effectiveness checklist:

	Evidence of effectiveness criteria	Well supported	Supported	Promising	Emerging	No Effect	Concerning Practice
1.	No evidence of risk or harm	☐	☐	☐	☐	☒	
2.	If there have been multiple studies, the overall evidence supports the benefit of the program	☐	☐	☐			
3.	Clear baseline and post measurement of outcomes for both conditions	☐	☐	☐			
4.	At least **two** RCTs have found the program to be significantly more effective than comparison group. Effect was maintained for at least **one** study at **1 year** follow-up.	☐					
5.	At least **one** RCT has found the program to be significantly more effective than comparison group. Effect was maintained at **6 month** follow-up.		☐				
6.	At least one study using some form of contemporary comparison group demonstrated some improvement outcomes for the intervention but not the comparison group			☐			

	Evidence of effectiveness criteria	Well supported	Supported	Promising	Emerging	No Effect	Concerning Practice
7.	There is insufficient evidence demonstrating the program's effect on outcomes because: a) the designs are not sufficiently rigorous (criteria 1-6) OR b) the results of rigorous studies are not yet available				☐		
8.	Two or more RCTs have found no effect compared to usual care OR the overall weight of the evidence does not support the benefit of the program					☒	
9.	There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect on participants						☐

Bartu, Ludlow & Doherty (2006)

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Bartu, Ludlow & Doherty (2006)	To increase breastfeeding and immunisations rates and reduce drug use in illicit drug-using mothers	Safety and physical well-being Child development	Randomised controlled trial Contemporary alternate treatment control group Pre-mid-post measures	Individual parents	Home	Number of sessions – 8 Duration of sessions – 1-2 hours Frequency of sessions – visits at week 1, 2 and 4, then monthly Total duration of program – 6 months	Parents (n = 76) Sex – F = 100% Age – median = 27 years	Parents (n = 76) Sex – F = 100% Age – median = 25 years	Non-significant – No significant differences were detected in immunisations at two months, four months or six months post-partum. Descriptive – The median duration of any breastfeeding was ten weeks for the control group and eight weeks for the intervention group. Drug use increased in both groups at 6 months.

Toddlers without Tears

Study	Program aims	Outcomes	Design	Mode	Setting	Dose	Participants		Main findings
							Intervention	Comparison	
Hiscock, Bayer, Price, Ukoumunne, Rogers and Wake (2008) Bayer, Hiscock, Ukoumunne, Scalzo and Wake (2010)	To prevent child behaviour problems, improve parenting and maternal mental health	Child behaviour Family relationships Parent-child relationship, Child development	Randomised controlled trial with cluster randomisation Contemporary usual care control Pre-post-follow-up measures	Individual parents	Maternal and child health centre	Number of sessions – 1 Duration of sessions – not indicated Frequency of sessions – once at 8-month maternal and child health visit Total duration of program – 7 months	<u>Parents</u> (n = 328) Sex – F = 100% Age – mean = 33.0 years <u>Children</u> (n = 329) Sex – M = 50.2%	<u>Parents</u> (n = 401) Sex – female = 100% Age – mean = 33.3 years <u>Children</u> (n = 404) Sex – M = 52.2%	<u>Non-significant</u> – No significant impact on externalising behavioural problems in 2-year-olds or on maternal mental health. <u>Maintenance</u> – Intervention mothers continued to report lower levels of unreasonable developmental expectations. Behavioural scores in the intervention and control group were similar. The mean scores for harsh/abusive and nurturing parenting, and maternal mental health (stress, anxiety and depression), were similar between the two groups. <u>Descriptive</u> – At 18 months, mean harsh discipline and unreasonable developmental expectations scores were similar in both groups. By 24 months, intervention mothers reported less harsh discipline and unreasonable expectations than control mothers. Mean scores for nurturing parenting were similar in the two groups at both 18 and 24 months. The mean maternal depression, anxiety and stress subscale scores were not markedly different between
				Groups of parents	Maternal and child health centre	Number of sessions – 2 Duration of sessions – 2 hours Frequency of sessions – at 12 and 15 months Total duration of program –			

Toddlers without Tears									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
						7 months			the two groups at either 18 or 24 months. The mean (raw) externalising and internalising scores were similar in the two groups at both 18 and 24 months.

Wake, Tobin, Girolametto, Ukoumunne, Gold, Levickis, Sheehan, Goldfeld, & Reilly (2011)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Wake, Tobin, Girolametto, Ukoumunne, Gold, Levickis, Sheehan, Goldfeld, & Reilly (2011)	To improve children's language development outcomes at 2 and 3 years and reduce behavioral problems	Child development Child behaviour	Cluster randomised controlled trial Contemporary usual care Pre-post-follow-up (24 and 36 months) measures	Groups of parents and parent-child dyads	Local community centre	Number of sessions – 6 Duration of sessions – 1.5 hours with parents and last 30 minutes with parent-child dyads Frequency of sessions – weekly Total duration of program – 6 weeks	Parents (n = 158) Sex – F = 100% Age – not indicated Children (n = 158) Description –toddlers with slow early development of expressive vocabulary Sex – F = 48% Age – mean = 18.1 months	Parents (n = 143) ex – F = 100% Age – not indicated Children (n = 143) Description – toddlers with slow early development of expressive vocabulary Sex – F = 52% Age – mean = 18.1 months	Descriptive – The authors found little evidence of a difference between the intervention and control groups. More specially, there was little evidence that the intervention improved vocabulary, language or behavioural outcomes when delivered as a preventive programme to toddlers identified by population based screening as being at risk of language delay by virtue of having few or no spoken words at 18 months.

Wakefield, Banham, McCaul, Martin, Ruffin, Badcock & Roberts (2002)									
Study	**Program aims**	**Outcomes**	**Design**	**Mode**	**Setting**	**Dose**	**Participants**		**Main findings**
							Intervention	**Comparison**	
Wakefield, Banham, McCaul, Martin, Ruffin, Badcock & Roberts (2002)	To encourage parents to impose bans on smoking in the home	Safety and physical wellbeing Child development	Quasi-randomised controlled trial (allocated to group by week attending clinic) Contemporary usual care control group Pre-post meaures	Individual parents	Telephone	Number of sessions – 2 Duration of sessions – not indicated Frequency of sessions – monthly Total duration of program – 1 month	<u>Parents</u> (n = 128) Description – parents (of children as described below) attending outpatient clinics Sex – F and M Age – mother mean = 31.3 years, father mean = 34.4 years <u>Children</u> (n = not indicated) Description – children with asthma aged 1 – 11 years who resided with at least one parent who was a smoker Sex – male = 58.6% Age – mean = 5.5 years	<u>Parents</u> (n = 136) Description – parents (of children as described below) attending outpatient clinics Sex – F and M Age – mother mean = 35.3 years, father mean = 35.2 years <u>Children</u> (n = not indicated) Description – children with asthma aged 1-11 years who resided with at least one parent who was a smoker Sex – M = 66.2% Age – mean = 5.2 years	<u>Non-significant</u> – There was a non-significant relative increase in bans on smoking in houses and cars and on more restrictive provisions in the intervention group compared to the usual care group. Declines in parental cigarette consumption were observed for both groups and there were no significant differences. Children's urinary cotinine levels decreased in the controls and increased in the intervention but these differences were not significant. No intervention parents and 3 usual-care parents quit smoking over the course of the study but these were not significant differences.