

## Positive Parenting Is Key to Preventing Child Maltreatment

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**Presenters:** Cheri Shapiro, Ph.D., Research Assistant Professor and Project Director of Building Connections at the University of South Carolina; Christie Ferris, Director of Prevent Child Abuse Florida, the Ounce of Prevention Fund of Florida in Tallahassee; and Mary Kay Falconer, Ph.D., Senior Evaluator at the Ounce of Prevention Fund in Florida.

Catherine Nolan: [0:00] My name is Catherine Nolan, and I'm the director of the Office on Child Abuse and Neglect here in the Children's Bureau. I think at this point many of you have been on our webinars over the last year, but for those of you who are new, my office is in the Children's Bureau, which is part of the Administration for Children and Families at the Federal Government U.S. Department of Health and Human Services here in Washington, DC. So I am just really pleased and grateful to be able to welcome you to our Prevention Subcommittee-hosted webinar.

The topic today is Positive Parenting Is Key to Preventing Child Maltreatment. We are sharing the efforts today, and happy to be doing that with our colleagues from the Health Resources Services Administration Maternal and Child Health Bureau, and they will really have the lead on sharing the information about the work they are doing around child maltreatment and injury prevention.

In a few minutes, you'll be hearing from Stephanie Bryn. Stephanie oversees MCH's Injury Prevention Activities, and she'll be moderating the rest of the call after the welcome. We have enjoyed working with Stephanie over the years. She has been just wonderful to work with and very active with our Federal Interagency Workgroup on Child Abuse and Neglect. In her role of moderator she will be introducing the other presenters for this call.

But before we get started, I just wanted to share again for those of you have not been on the calls before, a little bit of background on this webinar. This is actually our tenth informational call/webinar hosted by the Prevention Subcommittee of the Federal Interagency Workgroup on Child Abuse and Neglect. As some of you know, the Office on Child Abuse and Neglect has the lead on Federal interagency collaborative efforts related to child abuse and neglect. And this is under our CAPTA legislation—the Child Abuse Prevention and Treatment Act.

There has been a Federal Interagency Workgroup on Child Abuse and Neglect since the '80s, and over the years, and currently, there are over 40 different Federal agencies represented in our group.

We've talked a lot about prevention over the years, and last year we finally decided to formalize a Prevention Subcommittee as a way to bring together the Federal staff from the different agencies who share a common interest in child maltreatment prevention.

And so as such we have staff from the CDC; as we said earlier, Maternal and Child Health Bureau; the Substance Abuse Mental Health Services Administration; the National Institutes of Health; the Department of Defense Family Advocacy Program; the Office of Head Start; Child

Care Bureau here in ACYF; the Office of Special Education over at the Department of Education; ACF's Office of Planning, Research, and Evaluation; and the U.S. Department of Agriculture Extension College Program, just to name a few of our partners.

David Lloyd [director of the Family Advocacy Program] at the Department of Defense has been a very active member of our workgroup and the Prevention Subcommittee for a number of years. In fact, he's one of the early, early members of the Federal Interagency Workgroup.

So as part of the work of the subcommittee, we all agreed that there was a lot of great work happening at each of our agencies that we wanted our various grantees and other partners to know more about. And so as a subcommittee we agreed to host a series of informational conference calls.

Our hope is that through these calls we can learn more about each other's work and in so doing we can promote greater connections across our systems and programs at the national, State, and local levels. And of course the end result being that if we could be more coordinated in our efforts, we can end up with the result that we have much better services for our children and our families in terms of keeping them safe.

In terms of today's webinar we've been very excited about the level of interest. We have over 400 people registered for this webinar, and a number of folks from several of the programs across the country, including practitioners, policymakers, and researchers. We're also pleased and happy to acknowledge that some of our Regional Office staff and other Federal staff are joining as well. We've been happy and exited about the diversity on the various calls we've had to date, and we enjoy the discussions that we really engage in once the presentations are through on each webinar.

So just a couple of logistical notes for all the participants today. This call is being recorded and will be posted along with the slides after this webinar. The call is operator-assisted, so you will need to notify the operator if you have a question.

With that, thank you again for joining us, I look forward to our conversation today, and I will now pass this along to Stephanie to do introductions and moderation. Stephanie?

Ms. Bryn: [05:11] Thank you very much, Catherine, for that great introduction, and today we're going to have some great conversation and speakers talking about positive parenting and how it is very key in preventing child maltreatment and child abuse and neglect.

As you can see from this slide, this is a coordinated and collaborated effort. The Children's Safety Network, a resource center funded by the Maternal and Child Health Bureau at HRSA; the Association of Maternal and Child Health Programs, which is our parent agency and association; and STIPDA, the State and Territorial Injury Prevention Director's Association, have all collaborated with us to bring this webinar to you. And the Prevention Subcommittee of course has worked hard to do this.

Here with me in Rockville, Maryland, is Malia Richmond-Crum, from the Children's Safety Network.

As you can see from this next slide, child abuse and neglect, and child maltreatment is a huge problem. And the latest statistics from the U.S. database, the National Child Abuse and Neglect [Data System], shows what the problem is. And this is a just-published report online at the beginning of April, and it was rolled out at the 17th National Child Abuse and Neglect Conference in Atlanta. And you can see that the highest rates of abuse are in the youngest children. And that abuse and neglect happens early in a child's life, and so the huge importance for prevention, and today especially, and focusing on parenting when it comes to maltreatment.

[06:57] As you can see in the next slide with regard to the victims of maltreatment and it's a little hard to read but neglect and multiple maltreatments, physical abuse, sexual abuse numbers we don't want to see. And also that 13 percent if the victims were victims of multiple maltreatment, and we don't want to see these statistics, we want to see them reduced.

As you can see from the next slide, the types of child maltreatment involved in child fatalities. And again, multiple maltreatment. Slightly more than one-third of the fatalities were caused by multiple forms of maltreatment. And you can see that about 34 percent is accounted for with regard to neglect, and also physical abuse.

In the next slide we see that about 80 percent of the time parents are the perpetrators, or a relative of the child. So that nearly 39 percent of the victims were maltreated by their mother acting alone; 18 percent were maltreated by their father acting alone; and parents statistically are likely to be the perpetrator, and this is why parental support, programs that focus on prevention, can be so beneficial to our work.

And if we can help individuals become better parents through a variety of ways—and we'll be discussing that later in this webcast—we can go a long way in preventing child abuse before it begins. And we know that all these statistics are only the tip of the iceberg, because we know that child maltreatment is underreported.

So with regard to long-term repercussions, we know that physical health—and it may manifest itself in, for instance, heart disease, skeletal fractures, lung disease, impaired brain development perhaps from injury, liver disease, sexually transmitted infections, obesity, and many, many other physical repercussions.

Again, mental and emotion manifestations could be depression, anxiety, eating disorders. Things that we need to prevent for our children and for young children especially.

Behavioral: we might look at substance abuse, smoking, sexual promiscuity, sexual perpetration, or revictimization.

There was actually a report mentioned today on the radio, that it's a new report from SAMHSA, where it talks about, there are numbers of children in substance abusing families. And I think we all need to look for that report, reported out from SAMHSA today.

So child abuse costs approximately \$104 billion each year, according to a [2007] report from Prevent Child Abuse America. So when we're talking about child abuse and neglect prevention, we're also talking about prevention of many other public health issues.

Now I want to mention the Surgeon General's workshop. This was in the year 2005, and I was lucky to get to kind of listen in on it. I just want to put it out there today for something thinking that we were doing together when the surgeon general, Richard Carmona, brought people together. The focus was on integration of child health, human development, and public health systems; and again, it's the collaboration that we were talking about, and that we're used to doing now, working together. The influence of parents, family, community, and society, and how important that is, and how it shapes what goes on.

The focus also was on formative and operational systems change, and we knew we needed to really put that out as a focus. We also talked about parenting, family, community, societal innovation, and opportunities for prevention. And those intersections where we can reach families, where we can reach out as a community and as a society. We also wanted to make sure that this became a public health national priority.

Now the next slide will show that there were 10 emergent themes. And I just want to quickly run over the themes. We wanted to try to put a human face on child maltreatment. Do a better job of putting that human face. We knew we needed to integrate and to involve comprehensive systems, and make sure their intersections worked, and the collaboration worked. We also wanted to talk about child well-treatment education, and early childhood skill-building for parents.

And let's go to the next slide. Sustainable programmatic efforts, cooperation among organizations, and other collaborative themes that showed up in our discussion. So the Federal agencies working in this area have been mentioned before: the OJJDP, the CDC, Indian Health Service, HRSA, and the ACF, to name just a few.

And I want to go to the next slide, where it shows that the Maternal and Child Health Bureau is working in early childhood comprehensive systems. And I think we've had actually a Prevention Subcommittee call on this, but I do want to showcase that the Maternal and Child Health Bureau, Head Start, the Child Care Bureau at ACF, and FANSA [Food and Nutrition Science Alliance] now have joined at the Federal level to work together into integration of system and support, and strengthening of our systems and of our work that we do.

I want to go to state MCH program activities very quickly before we get to our speakers, and showcase some of the things we do at MCH; and you'll see that home visiting is still important to the work we do, and substance abuse prevention, shaken baby syndrome prevention, and child death review, where we support the system of child death review in the nation, and help improve the system at the State and local levels.

The next slide shows some State performance measures. These are States that have actually stepped forward, 10 States, to say that they will use their public health and MCH dollars and staff to address child maltreatment at the State and local levels, and I wanted to showcase those States.

The next slide talks about protective factors and approach, and this is really what we're going to get into today. And I want to quickly move to our speakers, so I'll keep this up very briefly for you, and many of you in the field know these important components and pillars of what we want to do for the protective factors.

Now our speakers are here today to speak about positive parenting. And I want to mention that the Triple P—Positive Parenting Program—will be spoken about, and the Circle of Parents. And without much more time taken away, I would like to introduce our speakers, and then I will send the speaker over to Cheri Shapiro.

Dr. Cheri Shapiro, research assistant professor and project director of Building Connections at the University of South Carolina, will be our first speaker. Christie Ferris is the director of Prevent Child Abuse Florida, the Ounce of Prevention Fund of Florida in Tallahassee; and with [Christie] is Mary Kay Falconer, Dr. Falconer, the senior evaluator at the Ounce of Prevention Fund in Florida.

And I'd like to now turn the speaker ship over to Dr. Shapiro, Cheri Shapiro.

Dr. Shapiro: [15:16] Hello. I'm delighted to be asked to present to a national audience and thrilled to be here. I think one of the critical pieces that we need to think about are the words just spoken regarding coordination and collaboration. Because it's clear that no one agency, organization, or professional has the lock on parenting; nor does any one particular group have all of the answers necessary to help prevent child maltreatment. It requires excellent coordination and collaboration.

And my presentation today, on the Triple P-Positive Parenting Program system of interventions, I'd like folks to think about that as a potential organizing framework, and a way to operationalize the type of collaboration necessary in order to blanket a community with intervention services and supports to help potentially reduce rates of child maltreatment.

I need to first acknowledge two incredibly important individuals: Dr. Ron Prinz, and Dr. Matthew Sanders. They are the principal investigators for the Triple P System U.S. population trial that I'll be speaking about later in the talk, and that is the project that I spend most of my time coordinating during the day. Dr. Matthew Sanders is also, along with his colleagues, the creator of the Triple P system of interventions.

And in order to begin, I'm going to be moving relatively quickly through background information on Triple P, and then speak directly about implementation issues, and ending with a specific example from the population trial.

Triple P initially, it is the Triple P system of intervention. And when I'm speaking about it today, I'm going to use the term "Triple P." Here in South Carolina, PPP is probation, pardon, and parole, so it's very important to be clear about what we're speaking of.

Triple P is much more than just a program, and that is probably the most important take-home point about Triple P. It is a multilevel system of interventions that are designed specifically to work synergistically, and to provide a model for population parenting, family, and support. As I noted before, it can be a way to conceive of a framework for communities and organizations that want to make evidence-based parenting interventions a core part of what they are already doing.

In addition, underscore the fact that it's not just a singular program. All parts of Triple P, all levels of intervention, and the different programs encompassed within the system of intervention,

are based on the same set of core principles that underlie all intervention content, and all of our delivery strategy.

Now to give you a visual of the system of intervention, I'm going to be speaking specifically today about five levels of intervention that form the core Triple P system. Level 1, or Universal Triple P, are media and communication efforts designed to blanket an entire population. And you can conceive of a population at a national, State, local, or organizational level. Even a single school could be considered a population.

That is the use of median information strategies to disseminate messages supportive of positive parenting, including tips and bits of advice, as well as basic information, using television, radio public service announcements, print media such as newspapers, but also including community events or school newsletters.

When you think about a system of interventions, the base, or Universal Triple P, is designed to provide access to this information for all parents within that community. Now some parents want and desire and they need more intervention, or more intensive services. So a slightly higher level of intervention is represented by Selected Triple P, or Level 2—this is comprised of basically single-time or one-shot parenting advice or intervention, but that can be delivered in either an individual family or large-group method.

There are three specific Triple P seminars that are designed to be delivered to very large groups of parents. We've done that on our trial for groups up to 200 families at a time.

For parents who want and need more intervention, and intervention characterized by active skills practiced within sessions with a provider, we move to Primary Care Triple P. That is a brief parenting intervention, including active skills training, designed to focus on a single issue, or a developmental stage that a parent with a young child may be facing. Such as toilet training, or bedtime issues, mealtime issues, noncompliance—those are just some examples of the specific issues that can be targeted through brief intervention, at either a Level 2 or a Level 3 of Triple P.

Moving beyond that, Standard Triple P, or Level 4, is broad-based parent skills training. Parents at this level of intervention are exposed to a range of parenting strategies, between 17 and 25 different strategies, that they then put together in order to address the issues that they would like to address with their children. Parents do learn about all of those strategies, and then learn how to put them together to address the problems that they would like to see change.

Level 5, Triple P Enhanced, is not a level that stands alone. For families who want or need more intervention beyond Level 4—and by the way, Level 4 interventions can occur at either a group or an individual family level—Level 5 Triple P are enhanced intervention services designed to target issues that may be getting in the way of parents implementing strategies they learned at Level 4. This can include difficulties with partner communication, or conflict around parenting strategies; it can include parental stress or mild levels of depression; and it can even include... there is another version at this level specifically for families where maltreatment has already been indicated.

The goal of the system of intervention is to provide parents destigmatized access points for good parenting information and support. And so these levels encompass multiple-delivery context.

Ranging from media outlets to schools or child care centers, primary health-care services, such as health clinics or physician offices, but even to be accessible to individuals who are parents at work, or through specialty services such as mental health.

In addition, I'm going to focus my comments today on the Core Triple P Program, which is all five levels of the intervention specifically for children in the 0 to 12 age range. Because not all children obviously fall within that age range, there are a number of program variants that have been created. For example, Teen Triple P for older children.

Stepping Stones Triple P is the core program, but designed for parents of children with developmental disabilities; Pathways Triple P are additional sessions designed specifically for families where maltreatment has been indicated. For example, Lifestyle Triple P is designed for parents who have children who are overweight, and that is probably one of the newest programs that's coming online within the Triple P system.

There are several core principles that underlie all Triple P interventions that are important to understand. The reason that there are multiple levels of intervention is because one size does not fit all. The principle of minimal sufficiency drives the provider to do only that much that is necessary in order to make the changes that families would like to see with themselves and with their children, beginning with the least amount of intervention, and then moving on to add more intervention to that only as is necessary.

Many parents can have needs for information and support met, for example, through media outlets such as television, and they may not need face-to-face services; other families do. But we also make the assumption that it's a smaller number of families who require more intensive services.

Another core principle of Triple P is the self-regulatory framework. Parents are in charge. The entire goal of the Triple P system of interventions is to help improve parent confidence and competence to manage and select their goals for their own child.

So we focus on a goal of wanting parents to feel that they have the ability to manage their own children in the different situations they encounter on a daily basis. That they feel well-prepared to address the problems that they'd like to address and select those problems; that they know which strategies they can apply to help address those issues; they can monitor their application of those strategies; they can use problem solving strategies when things aren't maybe going so well.

But that they have a sense, at the end of the intervention, whatever level that it is, that they are able to move forward to manage the issues they think are important for their children, and to promote their children's development in areas that they would like to see developed.

One of the other issues that distinguishes the Triple P system, is that throughout the system of intervention these core principles of positive parenting that you see underlie every Triple P strategy that is taught. These core principles include creation of a safe and engaging environment ... children who are safe and engaged with interesting activities are much less likely to either come to harm or to behave in ways that are problematic; responsive learning environment refers to parents being able to respond to child-initiated requests; using assertive discipline—not only

knowing what to do when there's a problem, but being confident to act immediately, and have the skills to act immediately so situations don't escalate.

Reasonable expectations—this refers to providers and parents having reasonable expectations. Parents for themselves and for their children; but like many aspects of the Triple P System, there's a parallel process here going on. So that providers also needing to understand these principles and work with them, and having reasonable expectations about what can be accomplished.

Finally, taking care of oneself. We understand that if parents are unable to have their own needs met, they're much less likely to be able to provide a safe environment, an engaging environment, and to be responsive when their children do approach them.

So once more, all strategies in Triple P derive from this same set of core principles.

Now because our focus today is on implementation, I'm going to go right to that. And I'm going to cover a range of topics, but I'll be doing these one at a time.

I'm going to start with community and organization preparation. Because Triple P is a system of interventions, it's very important to decide within an organization, or an agency, or a community, what it is that Triple P might be able to provide for that group; and to help everyone understand the system of intervention and which levels of intervention might be most appropriate for the situation within the community or organization.

We also know from our work that it's very important to have, prior to implementation, some assistance and provision of support for agencies, organizations, and communities, to help set up for a successful implementation. That includes managers and supervisors having a good, clear understanding of what the interventions entail, and how they can support their staff in delivery of those services. It helps to have an idea of what your target population is, how many families would you like to serve, and how would you like to serve them.

And, because Triple P can be implemented, and ideally is implemented, as a system of intervention, there may need to be somewhat more formal agreements between partners within a community about who's going to deliver which services to whom.

The implementation process for the system begins with professional training. Triple P is not a train-the-trainer model. There are multiple elements of Triple P that are designed to help the model be true to its origins and true to the numerous studies that have demonstrated efficacy and effectiveness of Triple P in changing parent and child behavior for the better. That level of implementation rigor extends to the training, which is also guided by manuals and delivered in a fashion that maintains ongoing quality control.

So the initial training process is with the groups and organizations who within a community are prepared to deliver Triple P and want to utilize it with the families that they serve. When we've implemented the system, typically many more providers are trained at levels 2 and 3—the Brief Intervention levels—because those levels of intervention can reach the most families.

Levels 4 and 5 are reserved for those types of service delivery sectors where longer term or more intensive contact with families is able to occur. For example, at Level 4 it might be 8 or 10 sessions; if there's enhanced versions added at Level 5, that could bump it up to 15 or 20 sessions in total.

Once providers are trained, then Universal Triple P media and communication strategies can be launched to help blanket an area with messages supportive of positive parenting, and to provide advice and support for parents who are managing a whole range of common daily developmental issues. We can think of that as anticipatory guidance in print or media, but that's extended then by Level 2-3 providers, who can provide that excellent, on-the-spot, anticipatory guidance and support for single or mild problems or issues.

Once the universal strategies are put into play, it's also true that they include a call to action. That is, parents who are hearing messages about positive parenting need to know where to turn if they would like more information or advice. So that is one of the primary reasons for having a group of providers trained prior to launching a universal strategy for disseminating positive parenting messages for Triple P.

Finally, Selected Triple P, or the large parent group presentation, can occur, again, to help increase awareness and availability and accessibility of excellent parenting information advice for a larger group of parents.

Within an area and across the nation there are multiple places, State and local organizations who are working to implement Triple P, and a variety of organizations can take the lead in a population-level rollout of Triple P. For our U.S. population trials that I'm going to be speaking about, our funding came from the Centers for Disease Control and Prevention, in order to help us focus specifically on child maltreatment. So in that case it's a governmental agency or entity. But multiple agencies or entities can take lead roles.

[32:13] Typically, within an area or a large organization such as with a school district, there's typically some entity that works and serves as a Triple P coordinator who helps pull together the stakeholders, help oversee enrolling providers in training, managing the courses, and linking providers to each other. The coordinator is the person through which the media and communication strategies for Universal Triple P can flow, and a linking point for coordination and collaboration of individuals and organizations who are providing services with that particular area. A coordinator can also provide support by convening a supervisory network for individuals who deliver Triple P.

Within Triple P, consultation and technical assistance is provided prior to training, during training, and during implementation. That level of support is helpful in order to make the best use of resources, and learn from other organizations' experiences how to best implement multiple levels of intervention at once.

I do want to speak about quality assurance. Every intervention within the Triple P system, and every level of intervention that providers are trained in, from Level 2 all the way up to Level 5, has a manual to accompany delivery of services. Every manual has checklists in the back to

assure fidelity to delivery of the elements of the session that make up that level of the intervention.

We also work to support peer support networks and supervisors' networks within areas that are implementing Triple P, and there is access to an international practitioner network for individuals who are accredited to provide Triple P services.

Evaluation also is a critical part of implementation. And again, every level and program variant of Triple P has assessment measures that are built right into the manuals for delivery of each level of service. So that folks don't need to go out and find assessment measures, they're already included. They can be copied, and there's scoring information included in each of the manuals.

The provider network also allows access to downloadable versions of the measures, and tools to create a database for your particular organization based on those particular measures. But of course the data, how it's aggregated, and how it's used for evaluation, will be driven by what the local leadership hopes to accomplish. And by that, can select the measures or series of measures that they think most accurately capture what they'd like to measure.

So to pull it all together, in my last couple of minutes, I'm just going to touch base about the U.S. Triple P System Population Trial that we're doing here in South Carolina. Our goals for the trial were to implement all five levels of the core Triple P system within a number of target counties here in South Carolina in order to promote positive parenting, and to make positive parenting strategies and support services available on a countywide basis.

Because our aim was population level change, our goal was to test the population penetration of the system, and we assessed impact at a population level rather than at an individual family level, which is more typical of clinical trials. And our goal, again funded by the CDC, was to help reduce child maltreatment.

Within South Carolina when we began the trial, much like we're facing right now, there were significant cuts to social services and family mental health services. We have a variety—as many States do—systems where multiple agencies and disciplines support families. But those systems may not be that well connected or coordinated, thus the work of the ECCS across our nation; and we have excellent school service providers, very experienced, usually more than 10 years of experience, but may have experienced inadequate training and preparation to do parent consultation with evidence-based parenting intervention methods and limited exposure to evidence-based parenting programs.

So within the trial, 18 counties were collected initially, and then 9 were randomly assigned to receive the Triple P system of intervention—that was levels 1 through 5. Our comparison counties had systems or services available as usual, and we matched counties on several key variables prior to randomization. And it's safe to say that none of these counties had prior exposure to Triple P before the trial began.

Our target population was all of the families with at least one child in the birth up to age 8 age range that are in the targeted counties, again, nine different counties; families, again, were served by multiple systems, that you see here.

In order to start implementation, we looked into our counties and identified all of the stakeholders that were working across child-serving systems. With children ages 0 to 10, we chose to seek out those systems that served children in those age ranges because many systems don't artificially stop serving kids at age 7 or age 8. Even though our interest was in the younger kids 0 to 7, we wanted to access systems who served children through that middle to late childhood period.

We introduced the system of intervention agency by agency, organization by organization, group by group, holding a number of meetings to teach people about Triple P, and to teach them about the different levels that were available, so decisions could be made about which level of Triple P an agency or organization felt was the best match for them to deliver, and then determining which staff to attend training.

Staff then were oriented to the training; we conducted training with many more providers being trained at the lower levels of brief intervention, which is most flexible, and a smaller number of intervention is trained at higher levels of intervention. From that group we selected providers who were excellent at implementing Triple P services, and trained them to also provide the parenting seminars. And our trial staff provided the consultation and support and use of Triple P. Our trial was also able to provide the parent materials that are key to Triple P implementation with families.

We launched our Universal Triple P strategies through the trial once we had a pool of providers trained in these counties, and we did this in nine counties all at the same time. Our goal was to give parents easy access to Triple P by touching providers across disciplines and by training a very large number of providers in many settings where parents typically and naturally go.

So over the course of the main conduct of the trial, we've run 102 Triple P professional training courses, and have trained 857 service providers, about 80 percent of which went all the way through the training process to become accredited Triple P providers. And the providers, service providers that we've worked with, cross all service sectors. Child care, preschools, mental health systems, social services, elementary schools, churches, nongovernmental organizations, or quasigovernmental organizations, as well as advocacy groups and our health-care system.

Our strategies, the Universal Triple P strategies that we used, were broad and multifaceted, ranging from radio, to local newspaper stories, community events, distribution of newsletters through schools, and we tried to engage a large number of parents through the more minimal levels of service delivery in order to increase access by all parents to excellent parenting information and advice.

And happily, we can report—this was just published in January in *Prevention Science*—we were able to increase awareness of Triple P in our target counties by a significant amount. These results are after the first 2 years of full programming. We believe that we have reached a great number of parents of young children; this is through direct interviews with providers that we've trained. We have evidence of prevention of child maltreatment in our target counties, with substantiated cases increasing much more in the comparison counties as compared to the target counties, and we were able to decrease out-of-home placements in our target counties and able to decrease the number of injuries that were occurring to young children in the target counties.

Our lessons learned, in my last 30 seconds—program use by providers and population exposure is really influenced by the level of support providers receive in the workplace to deliver intervention, and by practitioner beliefs and being confident and competent in delivering services to parents. And it is true that organizational commitment is essential. Not all organizations have the capacity to implement Triple P and need initial coaching and support in program delivery.

This is true of delivery of any evidence-based parenting support intervention, not just Triple P.

I've included references for you for the main population trial, and a cost study that we've done, and finally, information, if you're interested in implementation of Triple P. The contact is Triple P America. You can also find them fairly easily just through Google. Just Google Triple P America.

And with that, I end my portion of the presentation, and would like to turn things over to both Christie Ferris and Mary Kay Falconer with Ounce of Prevention in Florida.

Ms. Ferris: [0:43:08] Thanks, Cheri. I'm just going ahead and getting up my screen here. [long pause] OK. Is that up?

Response: Yes.

Ms. Ferris: [0:43:39] OK, great. Hi. My name is Christie Ferris, and I am the director of Prevent Child Abuse Florida here at the Ounce of Prevention Fund, and with me I have Dr. Mary Kay Falconer who is our senior evaluator, and I'm going to be talking about the Circle of Parents Mutual Self-Help Parent Support Group and what we're doing in Florida. And then Mary Kay is going to be talking about our evaluation efforts of the support group.

Well, first, just to get started, Circle of Parents is a national network of nonprofit organizations and parent leaders that are dedicated to using the Mutual Self-Help Support Group model to strengthen families and communities. The Circle of Parents is a primary and secondary prevention program. It's open to anybody that's in a parenting role that is looking to learn more about parenting or parenting skills, child development, or community resources, or to meet other parents that are in their community.

There's not a screening or assessment on the family to join a group, and they don't need to meet any eligibility criteria. But the groups are located in community settings, and Circle of Parents groups can be a part of an existing program that's serving families, or they can be formed as a standalone program, independent of any program.

The Circle of Parents National Organization was formed after a successful collaborative partnership project of Prevent Child Abuse America, and the National Family Support Roundtable, which was made possible by the Children's Bureau [and] Office of Child Abuse and Neglect. And at the end of that grant cycle, on October 1st, 2004, Circle of Parents became their own 501c3 national organization.

The Circle of Parents Mutual Self-Help model is a flexible one. It is designed to meet the needs of the parents that they serve that are coming to their group. This is a big difference between a structured parent education class and a support group. There's not a curriculum to follow, it is

parent driven, but there are critical elements and four components that each group must include to maintain the integrity of the model.

Circle of Parents definitely uses a strength-based approach and recognizes that parents have taken a courageous step in seeking out this service for improving their parenting skills, or learning ways to stimulate their child's development. And you can see up on the screen there are some of the different characteristics that are common in all Circle of Parents groups, although it is flexible to meet the needs of the community.

The Circle of Parents have guiding principles that are practiced in the support groups within the State network but also throughout the national network. In Florida, we really aim to create this environment throughout our statewide network to be able to role-model the way in which we want parents to feel when they attend a Circle of Parents group. We really want to establish trust and leadership within the group, a shared leadership approach throughout, not just the Circle of Parents group, but within the statewide network. And we definitely encourage the parenting in the present, and dealing with what is going on now in their own families.

Circle of Parents definitely promotes parent leadership, it is the cornerstone of the Circle of Parents Program. There is a national Parents as Leaders team that contributes to the national network on a consistent basis on a host of different activities, including the strategic planning process, the development of parenting materials at the group level. In the local group setting parent leadership is encouraged on many different levels because the role of the parent leader is constantly evolving.

Leadership roles can begin within a program, such as leading the parent support group, and then evolve within our train and support and training into larger leadership roles within the organization and in the community.

A parent leader may eventually advocate for a systemic change on behalf of children and families. And meaningful parent leadership occurs when parents gain the knowledge and skills to function in meaningful leadership roles and represent a parent voice to shape the direction of their families, their programs, and their communities. But the model is based on practices that are parent-centered, parent-led, and parent-driven.

To delve a little bit more specifically into the Florida Circle of Parents Network, we are currently funded through the Department of Children and Families to maintain 40 groups throughout the State. We currently have 46, and this represents a reduction in the number of groups. We did have 57 at one point, but because we're not funded to provide any funding to the local group level, we've seen a reduction based on programs cutting back in some of the services that they are providing to families, unfortunately.

Some of the services that we do offer are training, such as facilitator training to all new groups, and those that have experienced turnover, so that there is a trained facilitator that can attend the group. We have specialized training on a quarterly basis on many different topics, such as developing a parent leader, running a children's program, adolescent development, shaken baby syndrome, cultural competence, and many others, and if the topic is suggested then we can definitely create a training to meet the needs of the local community.

We provide resources such as parenting tip sheets, parenting booklets, children's program kits, and we also have a resource library that's full of safety information, fatherhood initiatives, and the local groups can check out videos from our resource library to play them in the group.

The national office supplies us with facilitator manuals and children's program manuals. And they provide pocket-sized parent handbooks that the parent leader teams developed for parents that attend the groups that give an overview of what parents can expect from attending a Circle of Parents Group, as well as places to jot down community resources.

Circle of Parents is in the middle of a grant cycle that they were awarded through the Administration for Children and Families through its Office of Family Assistance and its Responsible Fatherhood grant. Florida was awarded this grant, called Partners for Kids: United Hands Make the Best Families, in years 1 and 3 of the project, and we're in the middle of year 3 right now.

The grant award was designed for Circle of Parents to partner with the Home Visiting Program to create support groups, specifically aimed for engaging fathers, and also training them on the Conscious Fathering curriculum through the collaboration. So in Florida we were able to partner with our Healthy Family Florida Program, and provide these specialized services in six counties, whose families are participating in the Healthy Families Home Visiting Program. The Healthy Families sites were also provided a training on father-friendly policies and practices according to the National Fatherhood Institute, which is the national partner on the grant.

Here you'll see one of the classes that was taking place in Florida at one of the Healthy Family sites, and the objective—this is an actual Conscious Fathering class—and the objectives of the class are to provide encouragement to expectant fathers, to provide basic infant care skills, to provide an understanding of the bonding process, and provide resources to support their efforts. We also educate them on shaken baby syndrome.

The mothers can attend, and you can see they really get a big kick out of it. And then following the classes, they're engaged in ongoing support groups specifically for new and expectant dads. So that has been really successful here in Florida so far, and we've really learned a lot about the father engagement process through this. So it's been real exciting.

And here is where I'm going to turn the presentation over to Mary Kay to talk about what we've learned through these different support groups in Florida.

Dr. Falconer: [53:10] Thank you, Christie. I apologize if I sound a bit congested today. I managed to catch a flu bug this weekend. Since I'm far along in the recovery, I'm sure it's not [inaudible]. Fortunately, the webinar method of communication is the perfect prevention practice, and will protect all of you from my flu, anyway. Christie is the exception because she is sitting right next to me. So hopefully she'll be all right.

I also wanted to clarify that I am actually in the research and evaluation system unit at the Ounce of Prevention Fund of Florida.

Our unit had the opportunity to conduct an evaluation of the Circle of Parents groups over 2 fiscal years, actually: 2004 to 2005, and then 2005 to 2006. Most of what we are sharing with you today refers to the 2005–2006 fiscal year.

Circle of Parents support groups present some unique challenges in evaluation work. Ensuring anonymity of the respondents is just one. The open participation, which allows the parents to attend steadily over multiple months or more infrequently is another. Completing questionnaires occurs as part of the group process, generally; it's not always conducive to the proper administration of the self-report tool, and can also be disruptive in the group session.

Referring to the last bullet on this slide: incentives were available to the groups that participated in the evaluation. But I think it's important to clarify that their participation was not mandated.

The next slide shows us the measurement domain for the performance that we were required actually to measure as part of the State contract for the funding of Florida Circle of Parents. Targets were actually specified in the contract with the State. The first year it was 60 percent improvement in each of those measurement domains; in the second year, they increased the amount to 65 percent.

With the exception of the support system awareness and use domain during the 2004–2005 year, the program achieved the expected targeted levels. The program was able to respond to the lower performance in that one domain in the first fiscal year that we did the evaluation by encouraging more parent support groups to bring information about community resources to the group session, and that just helped draw more attention to that focus in the parent support group.

The next slide explains what was on the evaluation questionnaire. It is important for you to know that we did use a retrospective pretest format for the performance domain, as required in the State contract. For those of you who are not familiar with that format, I just will clarify that this does break from the conventional method of a pre- and a postadministration of the tool and asks the respondents for a before and after comparison during one administration of the tool. We also collected responses on some of the other items that are listed on this particular slide.

The next slide shows you the format that was included in the questionnaire. This is only a subset of the items that we had. We actually included about 21 items similar to this, and I want to clarify that we certainly included instructions on the micro scale that was used, with 5 being the most frequent or always, and 1 was the never, so that they were to evaluate the frequency in the before, in the during, or after participation.

There were multiple items assigned to each measurement domain in this list, so we thought you might be interested in seeing the wording of some of those items. And I want to note that we were in the process of changing this format because we felt it did not really work that well in some respects; but the evaluation funds were allocated for another purpose at that time by the State agency. So we weren't actually able to complete that process. I don't understand this slide.

This slide is sharing our measure of the participant's previous experience with violence. We decided to go with a measure that did not require each participant to identify the actual type of experience they had, just if they had experienced at least one of those listed. We felt that this was less intrusive and lowered the sensitivity of this particular item among our participants.

However, as a footnote, I would like to state that some other States have asked for more specificity on this type of question and have not experienced resistance to answering the question.

OK, moving to some of the findings now. And again, most of what we'll be showing you in the next two slides is basically descriptive statistics. I would like to note, though, for the second bullet there, the percentage of respondents growing up in a home where abuse or neglect occurred was 37 percent; but in that item, again, we were monitoring pretty closely their reactions to that question, and 15 percent were either unsure on that item or did not answer the question. So I thought you might be interested in knowing that.

Let's move to the next slide here.

It was of interest to us to know that a high percent of the respondents learned about the support group from Healthy Families Florida staff, and that 13 percent learned about the support group from another participant, a family member, or friend; also that learning parenting tips and ideas was the reason for joining the parent support group—that was identified by the highest percentage of respondents.

In this slide we provide a graph that I consider to be an analytical look at the data. It displays the relationship between the percent of the participants that improved in each domain by the number of sessions attended. And what we're seeing here is the general trend that improvement was higher as the number of sessions attended increased.

Because the Ounce of Prevention Fund is also committed to evaluating the programs we fund and operate, and with the challenge we face of not having any funding for continuing our evaluation of the Circle of Parents support group, the Ounce of Prevention Fund took the lead in comparing Florida's results with three other Circle of Parents' State evaluation results.

There were several similarities between the evaluations and some of the research designs in the data collection methodologies. In fact, we did even share questionnaires with each other in the development of the tools early on. Evaluations in all four States: some participants improved in multiple domains related to healthy parenting practices and social functioning.

The article that highlights this comparison is cited on the last slide. I guess we should have mentioned the fact Prevention Brief was done by the Ounce of Prevention Fund. What you saw there—Prevention Brief was actually another publication that we released on the evaluation results for the four States. But the journal article, which is on this slide—sorry, we backtracked there—included the States of Florida, North Carolina, Washington, and Minnesota. The citation is listed right there, and I would like to certainly like to recognize the other authors in this effort, in particular Dr. Mary Haskett from North Carolina State University, who did the work for North Carolina's Circle of Parents evaluation.

As a wrapup in my comments here, in the spring of 2008 the Circle of Parents network formed a research committee; Linda McDaniels with the Parent Trust for Washington Children, and Kathy Cisco in Connecticut cochaired that particular committee. We identified the Protective Factors Survey as a tool we would like to use in future evaluation work in the comparisons of cross-state programs. As articulated in the article, the need for more rigorous evaluation is certainly

recognized—rigorous in design and possibly measurement. We are just looking for the right opportunity to make that happen.

So that concludes my comments. We're going to be going to questions, I guess, at this time, or discussion?

Moderator: [1:01:59] Thank you. If you'd like to ask questions, please press star 1 on your touch-tone phone. Please unmute your line and record your name clearly when prompted. Your name is required to ask your question. Once again, that is star 1 on your touch-tone phone. One moment please. [long pause]

Our first question is from Pamela. Your line is open. You may ask your question.

Pamela: [1:02:40] I just wanted to comment and say thank you so much for such an informative presentation this afternoon.

Response: Thank you.

Moderator: [1:02:51] Our next question is from Mark. Your line is open.

Mark: [1:02:56] Yes, hello, and thank you as well. I really enjoyed the presentations, I found them very informative. I do have a question about the implementation of Triple P. I'm wondering how it works with existing models that different agencies are invested in. Different parenting models I'm thinking; for example, Love and Logic, or Parenting 1-2-3, or say, other programs like Healthy Families, and what kind of cooperation or additional training you give them, or do they have to abandon those programs, or can they use them side by side?

Dr. Shapiro: [1:03:35] Oh, that's an interesting and excellent question. I think what's probably very important to understand is that there is inherent flexibility built into the various levels of Triple P intervention. The level that has perhaps the most flexibility would be represented by Primary Care Triple P, or possibly even Selective Triple P at Level 2. Those are more brief interventions designed to focus on specific problem behaviors or issues that parents may encounter while they may be involved in another program.

One example specifically here in South Carolina, a number of parent educators are trained and do deliver Parents as Teachers (PAT) to many families that they serve. And then within their contact with those families, families may raise concerns about a specific behavioral or developmental issue or problem for which PAT may not have materials or support. So they might engage in a brief Triple P intervention, and then move back to their ongoing work with PAT.

For other interventions that have a more extended delivery model, it's probably important to help organizations make decisions and distinctions about which level of Triple P they'd like to provide.

So, for example, if someone is providing Level 4 Triple P, which is 10 sessions delivered to an individual family to cover a range of parenting strategies—or it may be an 8-week group

delivery with a small group of parents—within the delivery of that intervention, it's probably best to stick to the way that it is suggested to deliver. Otherwise it can be kind of confusing.

I think the other thing we wanted to do is maintain fidelity to the model, to assure that the higher likelihood that the positive results that have been achieved through the delivery of Triple P can be achieved. And if it's mixed with other models at a more intensive delivery level, you may not be actually certain about what you're delivering.

So I know that answer may not be 100 percent satisfactory, but there are some levels of Triple P that would be more flexible. But again, to take home the important point, that the Triple P system of intervention is designed to work synergistically. But that doesn't mean any single organization would deliver all levels of Triple P. You have to make that choice based on what your specific goals are for your organization, what your service providers are comfortable and capable of doing, and what makes the most sense for the families that you serve.

So those all have to be taken into account when you're selecting the programs that you might wish to implement.

Moderator: [1:06:56] Thank you. The next question is from Christopher Brown. Your line is open.

Mr. Brown: [1:07:02] Can everyone hear me?

Response: Yes.

Mr. Brown: [1:07:05] OK, great. Sorry. The technology sometimes confuses me.

A couple of things—this is for both presenters. And then a second question for the second presenter. Which the first question is: When you did your analysis, did you look at the impact of Triple P and also Circle of Parents on fathers as opposed to mothers? And then, there are a lot of evaluators today who are advocating a retrospective pretest in favor of a pre- and posttest. And we've experienced this as well—I'm with the National Fatherhood Initiative, by the way.

Because what we find sometimes is that parents can overestimate their knowledge, or certain attitudes, or beliefs they have around parenting. And only when they go through the program do they realize that they didn't know as much, for example, as they thought they did. And that can have a negative impact on evaluation data.

So I wonder if the presenters could speak to those two questions.

Dr. Shapiro: [1:08:21] I can do it very quickly for Triple P, and then hand it over to Christie and to Mary Kay.

For Triple P the population trial results that I presented are only outcomes that we have collected based on population indicators of child maltreatment prevention and related indicators of child maltreatment, so we did not in this trial make specific assessments of either mothers or fathers.

We trained individual organizations to deliver Triple P services to the families and individuals that they were already serving. So any evaluation data completed within organizations was kept within organizations, and we did not collect that ourselves. So I think with that I'll pass it on to Christie and Mary Kay.

Ms. Ferris: [1:09:13] Well, for the first question, the impact on fathers, we had a very low sample size of males that returned the, completed the questionnaires and returned them, and so, I mean, that was one of the reasons for us to apply to the National Circle of Parents for the Fatherhood Award, because we did recognize that we wanted to engage a larger percentage of dads that were either coming to group, or even coming with the moms to the group.

And then can you repeat the second question? I'm sorry, Christopher.

Mr. Brown: [1:09:48] Sure, no problem. Just out of curiosity, just purely from an academic standpoint, there are quite a few evaluators I've talked to in recent years who are starting to advocate a retrospective pretest, as opposed to a pre- and posttest, because oftentimes within this context, parents overestimate, let's say, their knowledge when they begin a program. And it's only after they get into the program that they realize: Wow, my gosh, I didn't know as much as I thought I did. And that can negatively affect, you know, comparisons of pre- and postdata.

Dr. Falconer: [1:10:33] Yes. We're aware of the emergence of interest in the retrospective pretest format. We felt it fit what we needed for the parents of workgroups, but it is controversial. I mean, there are some that will not adopt the retrospective pretest format, and definitely would prefer and pre- and postadministration of the tool.

There was an article that was released in a recent journal of the American Evaluation Association, and that was not a very complimentary of the retrospective pretest, but it was a totally different service area. And again, they do list all of the potential problems with the retrospective pretest. You might look at that, and get some more understanding, or better understanding, of recent research that's been published on that topic.

But we like the retrospective pretest. We think it works well for our needs, and we'd like to see more validation done of it. So, hopefully, that'll happen in the near future.

Mr. Brown: [1:11:37] Would it be possible for you to send me a link to that study?

Dr. Falconer: [1:11:42] Yes, I can send you the site. So do you want to ...

Mr. Brown: [1:11:47] Yes. Let me just give you my email address. It's [patbrown@fatherhood.org](mailto:patbrown@fatherhood.org). And I'm just curious as to whether—and I'm not sure whether you can reveal this or not—but if ... decided to apply for the CBC grant to take an evidence-based parenting program and create a version of it for fathers.

Dr. Falconer: [1:12:20] Which evidence-based program did you select? or do you not want to reveal that? Did you say you selected one for that purpose?

Mr. Brown: [1:12:29] No, we didn't. But we were interested in applying for it, obviously.

Dr. Falconer: [1:12:33] Oh, OK. You were interested in applying, yeah.

Mr. Brown: [1:12:35] But based on some conversations we had with the program officer, that, it was clear that they wanted to look at a general parenting program that was evidence-based, and then create a modification of that for fathers. And given the fact that Triple P has received funding from the CBC before, I was just curious as to whether they might have applied for that grant.

Ms. Ferris: [1:13:05] We did submit an application. [laughter]

Dr. Falconer: [1:13:11] It's been so long ago. Yeah, we did.

Ms. Ferris: [1:13:15] Yeah. With basically the ... what we learned from the Fatherhood Grant with Circle of Parents and Healthy Families, and see that it's working well, and we are able to engage from that, so we would like to look at evaluating some of that work. So I don't think we'll know for awhile, though, if we received it.

Mr. Brown: [1:13:33] Gotcha. OK. Well thanks for that.

Dr. Shapiro: [1:13:36] I'd like to take that question just to expand it for the Triple P intervention. The system of intervention. From Level 2-3 on up, the manuals do include evaluation measures that are designed to be used in a pre- and posttest fashion. So just to clarify.

Moderator: [1:13:58] Thank you. Our next question is from Peg Winsloff, your line is open.

Peg: [1:14:04] Thank you for taking my call. I noticed on one of the slides that there was a reference to workplace used for Triple P. I'm wondering how this is used in the workplace.

Dr. Shapiro: [1:14:19] Thank you. That's again, a great question. A number of the program variants on that slide are currently under development, and some of those have reached the stage where the formal materials are developed, and training is available, and providers are implementing. In the workplace that functions more like an EAP [employee assistance] program and some of the early work that was done with this.

For example, teachers or educators were allowed or given the opportunity to access the Triple P parenting group services during work hours. So that the focus was on the teachers as they, in their dual roles, in their role as a parent. So that the workplace provided a venue for access for parenting support and parenting education. And so that's what is meant by "workplace Triple P."

Because it's, again, one of the key issues that Triple P has been designed in its—from its inception as a system, is to make parenting support and education much more accessible by a much larger group of parents. Because without many, many parents having the opportunity to participate, we will never reach the level of population penetration of parent education and support necessary in order to bring down the alarming rates of child maltreatment that we started our discussion today with.

Moderator: [1:15:58] At this time we have no further questions in the queue.

Jean Nussbaum: [1:16:02] Hey, I actually have. This is Jean, and I have a couple of questions that have been sent to me by people participating in the call. If you could hold on one moment.

OK, the first question that came in was: how—and this is in regarding to Triple P—how does this program deal with parents who are hardwired for abusing their child and are not interested in changing their own behavior?

Dr. Shapiro: [1:16:34] You know, that's a very, again, excellent ... it's an excellent question on an important point. Parents make decisions about how they parent every day and on a regular and daily basis. And it's important for parents and interventions that work with parents to encourage early and open discussion about what the issues are that they see with their children, and more importantly, to have early discussions about what they see to be the potential causes or contributors to the issues in their children that they may wish to address.

And by understanding and then staging with a shared understanding with parents about what the problems are, and what the potential causes of those problems are, that paves the way for shared understanding of what intervention would be coming in the next several [inaudible] about intervention, and shared ideas and beliefs around that intervention.

And in any situation—and this is not Triple P-specific—in which parents may have little desire to participate in intervention services or to make changes, then it can be assumed that they're not going to participate. Or participate at a minimal level or, basically, not at all.

So it's important to tackle this issue right up front in working with parents: What are your goals? what is it that you would hope to achieve? And where you go from there does depend on where parents are at the point that they would encounter a potential provider of services.

Ms. Nussbaum: [1:18:36] The next question I have is in regard to foster care parents. And this question was: When do you lose a child if bonding or nurturing has not occurred, and by what age? And the followup was ... what is meant by that is a lack of bonding, how the lack of bonding may affect the child, or affect the child with a disorder.

Dr. Shapiro: [1:19:11] Well, that's a fairly complex question. Because children obviously coming into a foster care setting are coming in for some reason. And that could be a combination of neglect, or abuse, or unfortunately both.

I think it's critical for parents to understand where the child may be, and to help formulate what their goals would be in acting in a parenting role. What are the issues that are most problematic for their child, and how can that be addressed?

I can't tell you if and when the window "closes." We know that parenting strategies and intervention, when consistently applied over time, can help lead to positive changes in children's behavior over time. Whether there is a process that would prevent that from occurring, I'm not sure. It may set the level of change that you might expect. But it's been demonstrated that well-applied parenting strategies to support children's positive functioning, and good evidence-based behavioral parent management strategies can help support positive changes in children with a wide range of problems or areas of exceptionality.

Ms. Nussbaum: [1:20:44] OK. The next question that I received asks: How does Triple P compare to Meld? I don't know if you're...

Dr. Shapiro: [1:20:53] I'm not sure I can answer that because I don't know what Meld is.

Ms. Nussbaum: [1:20:57] OK. I'll see if I get a follow-up to that.

Dr. Shapiro: OK.

Ms. Nussbaum: [1:21:04] Another question I have is: How can an agency get trained in Triple P?

Dr. Shapiro: [1:21:10] The contact point for all training that occurs in the U.S. is the company called Triple P America. And the best way to contact them would be to get on Google and Google Triple P America. I'm going to try to pull up my presentation again to give you the exact phone number, and I've got it ... right here. There are two ways to contact: [www.triplep.net](http://www.triplep.net); or 803.451.2278—that is the Triple P America office that's in charge of implementation and training and Triple P resource materials for parents here in the U.S.

Ms. Nussbaum: [1:21:58] OK. The next question I have is: What do you recommend as far as a targeted marketing strategy prior to the universal marketing to bridge the 9- to 12-month delay in order to get the word out?

Dr. Shapiro: [1:22:12] Ah, that's interesting. What we chose to do was wait in the trial until at least a small number of providers were trained. So in the trials, it was actually about 5 or 6 months of training providers before we launched our universal media strategies. The launch of the media strategies could occur in a shorter timeframe if the training timetable is shorter, if that makes sense. So if a large number of providers are trained in a short period of time, once those folks are ready to receive families for services, you could launch the universal campaign at that time.

The way that we began also may be helpful in that we started our strategies with newspaper articles and radio PSAs [public service announcements] that just provided basic information on what Triple P was, and basic introduction to positive parenting strategies. And then articles became more in-depth as time progressed.

Triple P America does have already produced materials for the media, including radio PSAs and articles that can be delivered directly to newspapers. So that can help with the rollout of a universal strategy.

So it doesn't necessarily have to be 9 to 12 months. It will depend on the implementation plan in that particular agency or community.

Ms. Nussbaum: [1:23:50] Thank you so much. The next question that came in is: How prescriptive were they in designing who in what profession, in what levels, and how many were trained in each county? Did they allow this to unfold naturally based on interest and word of mouth?

Dr. Shapiro: [1:24:08] That's again, a great question. I would say it was an extremely natural process, in that we had a clear idea at the outset of the trial. When we went into these counties, our first job was just to identify the multiple child-serving agencies that we could identify. And South Carolina is not a very large State, and it's possible to create lists that are fairly inclusive of folks that touch parents of young children.

But the process unfolded very naturally from that point. And word of mouth—providers talking to providers, parents talking to providers, organizations talking to each other—has resulted in our building over the course of the trial, and our reach expanding into more and more agencies and organizations within these counties.

So we absolutely did not set out with a set number of providers of x-type of discipline that we were going to contact for training. It was much more open-ended than that.

Ms. Nussbaum: [1:25:19] Thank you. I'm aware of the time, and it's 4:29, and we said that the call would go to 4:30, and I know that people have very limited time. I wanted to know from our presenters if they were willing maybe to stay on the line for another 5 minutes to answer a couple more questions? Or if not, if you posed the question to me through the chat function, I will make sure that you get an answer via an email. So do you think folks have maybe another 5 more minutes or so? Or do people need to go?

Ms. Ferris: [1:25:47] We're set. We're OK to stay.

Dr. Shapiro: [1:25:50] Yes. It's fine with me as well.

Jean Nussbaum: [1:25:52] OK, thank you. We have a lot of questions that have come in. The next question is: Were other outcomes measured besides the reduction of child abuse and neglect? For example, improved parenting skills, parent/child relationships, connections with other services, or school readiness?

Dr. Shapiro: [1:26:09] Within the trial we did not measure those other excellent areas. It would have been great to have the ability to do that. But because there have been multiple published trials in the peer review literature on the implementation of Triple P with different populations, different ages, measuring all of those key domains of parenting and child behavior, and functioning in multiple arenas, we chose not to focus on that in the population trial.

Our interest, again, in the population trial was fairly, fairly focused on moving population level parameters of child maltreatment, and in large part, due to the goals of our funder, and that being the goal of implementation of the system.

So we did not measure those domains in this particular trial.

Ms. Nussbaum: [1:27:05] Thanks. Someone asked: Can we get a sense of the cost for Triple P to support or implement it in a location?

Dr. Shapiro: [1:27:16] The cost varies greatly, depending on what the local implementation plan is. So it's not really possible for me to give just a cost  $x$  amount. So the important bits about, and the reality about, implementation and what it would cost would depend entirely on what levels of

the system an agency or organization would like to implement. And that cost information is available through Triple P America.

Ms. Nussbaum: [1:27:52] OK. Someone wanted to know what the website was for Circle of Parents, and if you could repeat that information.

Ms. Ferris: [1:28:00] Sure. The Florida Circle of Parents is located under [www.ounce.org](http://www.ounce.org), and there is also a national Circle of Parents website that you can find if there is a State network member where you live, and that is [www.circleofparents.org](http://www.circleofparents.org). But if you're specifically looking for the Florida one, it's at ounce.org.

Ms. Nussbaum: [1:28:30] Great. And then the next question is: Does Florida have demographics on the parents who participate in Circle of Parents? Especially, how many parents have been involved in the child welfare system? What percentage are actually recipients of Healthy Families Florida?

Ms. Ferris: [1:28:45] That sounded like four questions to me. [laughs]

OK, so the first one: we do collect demographics on who's attending our Circle of Parents groups. Although the participants remain anonymous, we do have data collection via a web data management system. And we serve about 2,100 families a year through the Circle of Parents.

Healthy Families serves about 13,000 families a year in Florida, and we've made creating Circle of Parents support groups and the Healthy Family Florida Program a priority here, 1) because we're located in the same office, and we work very closely together; but 2) because we have recognized the benefits of having an individualized home visiting program adding a parent support group component.

And they do surveys and assessments on the participants each year, and the parents themselves said that they were looking for more opportunities to meet other parents in the program. So 2,100 families—about 60 to 70 percent of those would be Healthy Families participants.

As far as the child welfare system, we do track if there's a Healthy Families child that enters the system while in the Healthy Families program. And Healthy Families has very strict outcomes when it comes to evaluating their program, and they do a match-up against the Child Welfare database here in Florida, and I believe it's 97 to 98 percent.

Dr. Falconer: [1:30:40] There was just a change in the definition. You know, we look very good. But, yeah, we have a very systematic system for monitoring child maltreatment in the home visiting program.

Ms. Nussbaum: [1:30:52] All right, thanks. And I have a question that's come in I think that both groups could speak to this question. Someone said that the major roadblocks is regarding the destigmatization of parenting education. And is there a single piece of advice that you can give parent educators around this issue?

Ms. Ferris: [1:31:16] Well, this is Christie, and just from my perspective, and through Prevent Child Abuse America's research on reframing the issue of child abuse and neglect, we really try

to concentrate on what it takes to promote healthy child development in your families and in your communities, and what communities can do to really support families and make sure children are safe, and healthy, and nurtured. And not focus so much on what the parent is maybe not doing right, or maybe what the parent could be doing better, or the problem. But it's really focusing on what does it take for children to develop to their fullest potential and create healthy space, nurturing experiences? And stimulating their development along the way.

So that's the frame that we go out and that we go through with all of our trainings, with all of our materials, and all of our public awareness campaigns.

Dr. Shapiro: [1:32:14] Yes, and I think through implementation of the system of Triple P interventions, our goal is to help parents see and hear good parenting advice and information everywhere that they go. And if parents are surrounded by opportunities for learning ways to help promote children's positive development, then that is part of the process through which seeking of parenting information can be destigmatized. If all parents see something in a grocery store, or see something on television.

For example, England has launched, for 2 years running, a reality TV series based on delivery of Group Triple P. The series is called Driving Mom and Dad Mad, developed by ITV in Great Britain. And they introduced, through that venue, along with the television episodes following the course of a number of families through Group Triple P intervention, they also put up on the website for the television station downloadable tip sheets that address the topics that are covered, or that are touched upon.

Research has demonstrated improvements in parent/child functioning through delivery of parenting information through large-scale media outlets. And when you can reach that level, that alone sends a very powerful message. And the goal is on helping parents become more confident and competent, not making food for entertainment by showing just how extreme or how negative parents can be.

Ms. Nussbaum: [1:33:52] Thank you. And I am aware of the time, so if your question hasn't been answered at this point, you should look for an email with a response in the next week or so. Catherine, did you have some closing remarks?

Ms. Nolan: [1:34:06] Yes, thank you, Jean. First of all, I want to thank all of our presenters. It was just really great to hear from all of you, and I learned a lot. I know the basics of what was presented, but it was great to hear much more indepth information. And the questions also from all the participants—thank you for joining us today to all the participants, but particularly for all the questions, they were great questions.

I just wanted to remind everybody that, as Jean had said earlier, this entire webinar will be available, and the slides will be available also. So if you want to go back and relook at some of the things, or share it with colleagues, whatever, we really enjoy using this technology and getting the word out there.

I especially want to thank Jean, on my staff—as always, you've done a great job with coordinating this webinar, and fielding the questions, and being the troubleshooter for us behind the scenes; and also to the folks at Child Welfare Information Gateway at our National Resource

Center that supports our CBCAP agencies for posting the information, and again, to all of you for participating.

I just wanted to let you know that we will be hosting another webinar next Wednesday, May 6, [2009] from 3:00 to 4:15 p.m., and at that time our colleagues from the FRIENDS National Resource Center will share information about using qualitative data in program evaluation. And so if you're interested in signing on for that particular webinar, please get in touch, please email Jean Nussbaum.

OK, everyone thanks so much, and enjoy the rest of your day. Bye-bye.

Moderator: And this concludes today's conference call; at this time everyone may disconnect.

[End webinar audio.]