



## Parenting groups, how long is enough?

### The efficacy of a community-run Parents Plus Early Years Program as a preschool parenting intervention of modifiable duration

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**Abstract**

Evidence shows that low-intensity community parenting interventions are effective in addressing child behavioral problems. This study aims to examine the effectiveness of the Parents Plus Early Years (PPEY) parenting intervention delivered as a single workshop or a seven-week course to a non-clinical community sample by trained preschool practitioners. A between groups, repeated measures, matched pairs design was used. 121 parents of preschool aged children participated in a PPEY seven-week course (N=89) or a single workshop (N=32). Participants were compared pre-intervention and seven weeks later on measures of child difficulties and prosocial behavior and parental satisfaction and stress. A paired samples t-test found that parents reported the seven-week intervention significantly improved child prosocial behavior. Both group formats significantly improved child difficulties, parental satisfaction, and stress. The seven-week group demonstrated significantly greater improvement in parental stress and satisfaction than the workshop group. Effect sizes showed that while both groups were beneficial, the seven-week group produced greater parent-reported gains. Findings suggest that single session parenting workshops are beneficial, though the longer courses are likely to facilitate a greater magnitude of change. Further study using a control group and follow-up testing is suggested.

**Introduction**

Behavior problems are the most common reason for referral to psychological and psychiatric services in childhood (National Institute for Health and Clinical Excellence, 2006). Research suggests that parenting which involves inconsistent or harsh discipline, ineffectual commands, low warmth and punishment, and little positive parental involvement plays a significant role in the development and maintenance of child behavioral problems (Campbell, 1995; Hipwell et al., 2008). The shift from focusing purely on interventions targeting the child's undesirable behavior to interventions focused on changing parenting behavior comes from the understanding that parents can act as agents of children's behavior change (Kaminski, Valle, Filene, & Boyle, 2008). A meta-analysis of 30 parenting programs and 41 child-focused programs found that for children under the age of 12,

parenting interventions were significantly more effective than child-focused programs (McCart, Priester, Davies, & Azen, 2006). The majority of parenting programs adopt a behavioral and social learning approach, which argues that children and adolescents' externalizing behaviors are attained and maintained through interaction and modelling from others in the environment (Wierson & Forehand, 1994). Parenting interventions based on behavioral and social learning theories have been repeatedly shown to be effective in reducing child behavioral difficulties (Chu, Farruggia, Sanders, & Ralph, 2012).

Parenting programs are the most commonly used mode of intervention for addressing behavioral problems in children (Carr, 1999). Group-based parenting programs have been found to significantly reduce childhood behavioral problems, develop parenting competencies, improve parent-

child interactions and prosocial behavior, and reduce parental stress (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2012; Furlong et al., 2012). Parent stress is significantly related to child internalizing and externalizing behaviors and could create a negative affective environment, which may sensitize children and have a deleterious effect on their social behavior (Anthony et al., 2005). Prosocial behavior is a significant socialization goal for many parents (Knafo & Plomin, 2006). Parents' warmth and use of reasoning, induction, and autonomy support as opposed to power assertive discipline are related to children's empathy and prosocial behavior (Clark & Ladd, 2000). Group parenting interventions have been found twice as effective as individual therapy in reducing behavioral problems in children (McCart et al., 2006), making them a cost effective way of meeting the needs of greater numbers of parents and children.

#### *Parents Plus Program*

Typically delivered over 8 to 12 weeks, the Parents Plus Early Years (PPEY) Program (Sharry, Hampson, & Fanning, 2013) was developed as an intervention for parents of preschool children, aged 1 to 7 years, referred to child mental health services, with behavioral, emotional, and developmental problems. The PPEY is one of three Parents Plus Programs targeting different age groups, with corresponding programs for parents of 6- to 11-year-olds (Sharry & Fitzpatrick, 2008) and adolescents aged 11 to 16 years old (Sharry & Fitzpatrick, 2012). The PPEY is a manualized parenting course that uses DVD footage of real parent-child interactions. The program covers Positive Parenting topics (e.g., child-centered play and communication, encouraging and supporting children, helping children concentrate and learn) as well as Positive Discipline topics such as establishing rules and routines, managing tantrums, misbehavior, and solving problems.

A number of studies have shown that the Parents Plus Programs are effective

in reducing childhood behavior problems and associated parental stress in clinical settings for a variety of age groups (e.g., Behan, Fitzpatrick, Sharry, Carr, & Waldron, 2001; Coughlin, Sharry, Fitzpatrick, Guerin, & Drumm, 2009; Quinn, Carr, Carroll, & O'Sullivan, 2007). In particular, the PPEY Program has been shown to reduce conduct problems, hyperactivity, and parental stress and to help parents move significantly closer to their goals when conducted in a clinical setting by mental health professionals (Griffin, Guerin, Sharry, & Drumm, 2010); however, many parents display limited attendance with clinic-based programs and are less likely to complete treatment (Kazdin, Mazurick, & Bass, 1993), with some parents reporting feeling stigma attached to attending child and adolescent mental health services (Bradby et al., 2007). To overcome these challenges, there is growing interest in delivering community-based parenting programs (Hand, Ní Raghallaigh, Cuppage, Coyle, & Sharry, 2012; Kilroy, Sharry, Flood, & Guerin, 2011; McGiloway et al., 2012).

Preventative versions of the Parents Plus Program in the community have been found effective in improving parental stress and satisfaction and reducing parent-reported behavior problems in preschool and school-aged children (Kilroy et al., 2011; Hand, McDonnell, Honari, & Sharry, 2013). Thorell (2009) found a community-based group parenting program significantly reduced child problem behaviors and parental stress for a non-clinical group, but not a clinical group in comparison to waitlist controls. In contrast, Gerber, Sharry, Streek, and McKenna (2014 submitted) found that both a clinical and non-clinical group demonstrated significant improvements in parent-reported child and parental difficulties following a PPEY group intervention. A possible explanation is that parents in Thorell's (2009) clinical group had higher levels of psychiatric problems and therefore may have experienced more difficulty with implementing the strategies taught in the program. These findings provide support for the utility of the

Parents Plus Program as a preventative model of parenting intervention when delivered by varied professionals. By locating the training program to the community, it has the advantage of removing the logistic and psychological barriers that clinic-based programs may pose (Thorell, 2009).

A comprehensive population approach to promotion, prevention, and early intervention in mental health may be a way to meet the needs of non-clinical groups before more ingrained difficulties develop. A population approach to parenting interventions, unlike a clinical high-risk approach, involves the use of multiple settings, disciplines, and service delivery modalities across different tiers of need (Sanders & Prinz, 2008). An example of this approach is seen in the Triple P parenting programs principle of program sufficiency by which parents differ in the strength of intervention they may require (Turner & Sanders, 2006). The effectiveness of Triple P parenting interventions delivered as individual face-to-face, group, or self-directed programs of different intensity have been demonstrated in numerous studies (Sanders, 2008).

While some parents and families require intensive interventions, there is increasing evidence that low-intensity interventions are also effective (Lim, Tormshak, & Dishion, 2005; Morawska, Haslam, Milne, & Sanders, 2011). For example, following a single session community-based parent consultation, Sommers-Flanagan (2007) found that parents reported less stress and more competence handling their children's behaviors. Similarly, brief 2- to 4-hour group interventions have been found to increase parents' ability to build positive relationships with their children, reduce child behavior problems, and improve parental self-efficacy (Morawska et al., 2011; Lim, Tormshak, & Dishion, 2005). Kling, Forster, Sundell, & Melin (2010) compared the effectiveness of 11 Parent Management Training practitioner-assisted group sessions (PMT-P) or a single

instructional workshop followed by self-administration (PMT-S) of the training material for parents of children with conduct problems. While both group formats improved parent competence and reduced child conduct problems, PMT-P was superior on measures of child conduct problems (Kling et al., 2010). These findings have implications for large scale dissemination of parenting interventions through different means of delivery (Kling et al., 2010). There is an urgent need to develop and evaluate brief, effective interventions that have the advantage of wider dissemination and access within the community (Lim, Tormshak, & Dishion, 2005).

The aim of this study is to compare the effectiveness of the PPEY group parenting intervention when delivered as a seven-week intervention or as a brief 2.5 hour group workshop to a non-clinical community sample. This study hypothesizes that parents whose children have difficulties in the normal range can benefit from the PPEY intervention when delivered in a community setting. Furthermore it is hypothesized that both a seven-week and a brief dosage controlled PPEY group intervention will be effective in producing positive parent reported gains post intervention, with the former treatment of longer duration achieving greater gains.

## Methodology

### *Design:*

This study employed a between groups, repeated measures, matched pairs design. Participants were parents who either completed a seven-week PPEY group or a single group workshop (2.5 hours). Parent completed measures were collected at Time 1, pre, and Time 2, post intervention. Matched participants were compared on post intervention Strengths and Difficulties Questionnaire (SDQ) total difficulties, prosocial behavior, parental satisfaction, and parental stress measures.

*Participants:*

As part of the Fingal Parenting Initiative (FPI), a series of single session parenting workshops and seven-week parenting courses based on the PPEY program were run throughout the Fingal region of Dublin, Ireland. The programs were delivered in local preschools and community venues by trained childcare workers and community professionals. All facilitators attended a two-day training in the PPEY Program, received a full manual for program delivery, and attended monthly group supervision as the courses were delivered. The interventions were open to all parents and guardians of children aged up to 7 years within this region and did not operate on a referral basis. Participants were randomly recruited through advertisements within participating early years and preschool services, at local primary schools, and through social media and relevant childcare committee websites.

The current study compares the outcomes for 35 parents who attended single session workshops with a matched sample of parents who attended the full seven-week parenting course. Participants in the seven-week intervention were a subset of a previous study (Gerber et al., 2014 submitted) as part of the FPI (N=363). Of the 363 participants, 260 had sufficient data at Time 2 to be included in the analyses. Participants who did not complete data at Time 2 were excluded from the final analyses, representing a drop-out value of 28%. These participants were matched with workshop participants (N=35) on baseline SDQ total difficulties, prosocial behaviour, age of child, and gender of parent. This resulted in a sample of N=121, seven-week intervention (N=89) and dosage controlled workshop (N=32). All participants were mothers (Mean age=35.65) of children aged between 1.80-5.60 years (M=3.47 years) (male N=67, female N=54). Unmatched participants had 20 fathers present in the seven-week group and only 1 in the workshop group; these were removed to control for the influence of parent gender

on outcomes. Participants' children held no mental health diagnosis and were not in receipt of clinical services at the time of this study.

*Measures:***The Strengths and Difficulties**

**Questionnaire (SDQ).** The SDQ is a 25-item screening instrument assessing positive and negative behavior of children and adolescents aged 4 to 16 years (Goodman, 1997). The questionnaire was completed by the primary caregiver. The SDQ yields scores on five subscales: emotional problems, conduct problems, hyperactivity, peer problems, and prosocial behavior. Scores from the four difficulties subscales are combined to provide a total difficulties score between 0-40. SDQ mean total difficulty scores have been found to closely predict prevalence of clinical levels of child mental disorder at a population level (Goodman & Goodman, 2011). The psychometric properties of the SDQ are well established with a high internal consistency and test-retest reliability and strong criterion validity for predicting psychological disorders (Goodman, 2001).

**The Kansas Parental Satisfaction Scale (KPS).**

The KPS is a three-item measure of parental satisfaction with themselves as a parent, the behavior of their child, and their relationship with their children (James et al., 1985). Parents respond on a seven-point scale ranging from "extremely dissatisfied" to "extremely satisfied". Scores of 15 or less indicate low parental satisfaction (DeCato Murphy, Donohue, Azrin, Teichner, & Crum, 2003). The scale has good concurrent validity and has been found to have significant correlations with the Kansas Marital Satisfaction Scale and the Rosenberg Self Esteem Scale (.23 to .55) (James et al., 1985).

**The Parental Stress Scale (PSS).** The PSS is an 18-item self-report measure of parental perceptions of positive and negative components of parenthood (Berry & Jones, 1995). Respondents agree or disagree with items in terms of their typical

relationship with their child on a five-point scale with the instrument yielding a total score ranging from 18-90. Higher scores on the scale indicate greater stress. The PSS has been reported to have high internal reliability and good convergent and divergent reliability (Berry & Jones, 1995).

**Parents Plus Early Years Program.** The PPEY Program (Sharry, Hampson, & Fanning, 2013) was conducted over seven weeks or distilled into one 2.5-hour workshop for the dosage controlled group. The manualized program included positive parenting topics (e.g., child-centered play and communication, encouraging and supporting children) and positive discipline topics (e.g., establishing rules and routines, managing misbehavior, and solving problems) (Kilroy et al., 2011).

*Procedure*

This study was approved by the FPI and Fingal Children’s Services Committee. In conjunction with the FPI, two-day training workshops with an accredited trainer were offered to participating preschool and early years practitioners in the Fingal childcare committee catchment area. Each participant received the program manual, DVD, and information about the research protocol. Facilitators were required to complete weekly self-evaluation checklists, planning and review forms, and attended regular supervision to ensure treatment fidelity. Facilitators were encouraged to produce two personal video clips of a group session with reflective notes about their own practice for discussion at group supervision. Forty-five PPEY groups were delivered in various locations across the Fingal region. All parents attending the PPEY Program were invited to participate in the research. Each participant was given an information sheet outlining the purpose of the study, and if they agreed to participate, to sign an informed consent form. Participants were then invited to complete the research measures before and after completion of the program. Participants attended either the seven-week or the single dosage controlled

workshop (2.5 hours) PPEY group. Parents attending the single session workshop completed post-intervention questionnaires seven weeks after the workshop to match the data collection time of the longer parenting course. Attendance did not depend on participation in the research study. Data were collated and analysed using the Statistical Package for Social Sciences (SPSS, V20).

**Results**

Participants who completed the seven-week PPEY intervention were matched with dosage controlled participants who attended a single PPEY group workshop on baseline SDQ total difficulties, prosocial behavior, age of child, and gender of parent. Participant demographics can be seen in Table 1.

Table 1  
*Matched participant breakdown*

	<b>Seven-week group</b>	<b>Workshop group</b>
<b>Guardian Type</b>	Mother (N=89)	Mother (N=32)
<b>Guardian Age</b>	M=34.96 (SD=7.27)	M=37.34 (SD=4.29)
<b>Child Gender</b>	Male=55 Female=34	Male=12 Female=20
<b>Child Age</b>	M=3.38 (SD=0.96)	M=3.70 (SD=1.08)

The magnitude of impact of both interventions was compared using paired samples t-tests and effect sizes to identify how each group changed. A series of independent samples t-tests were conducted on all measures of interest, and identified no significant baseline difference between groups. The means (standard deviations), paired samples t-test results, and effect sizes are summarized for all measures in Table 2.

Table 2

Summary of paired samples t-test results and effect sizes pre/post intervention

Measure	Seven-week group (N=89)				Workshop group (N=32)			
	T1 Mean (SD)	T2 Mean (SD)	T value	Effect size	T1 Mean (SD)	T2 Mean (SD)	T value	Effect size
<b>SDQ total difficulties</b>	11.08 (3.84)	8.80 (5.15)	5.442**	.25	10.59 (3.78)	9.59 (4.22)	2.273*	.14
<b>Prosocial</b>	6.76 (2.03)	7.73 (1.84)	-4.139***	.16	6.72 (2.18)	7.13 (2.02)	-1.256	.05
<b>PSS</b>	39.59 (8.11)	34.72 (7.68)	6.262***	.32	41.66 (8.43)	40.56 (8.44)	0.940	.03
<b>KPS</b>	15.00 (2.44)	16.85 (2.51)	-7.010***	.38	13.97 (2.49)	15.00 (2.43)	-3.102*	.24

Two tailed \*p<.05, \*\*p<.005, \*\*\*p<.0005

A paired samples t-test identified a significant decrease in the seven-week group's total difficulties from Time 1 (M=11.08, SD=3.84) to Time 2 (M= 8.80, SD=5.15),  $t(88)=5.442$ ,  $p<.005$  (two-tailed), effect size .25 (large), partial eta squared. There was also a significant decrease in the workshop group's total difficulties from Time 1 (M=10.59, SD = 3.78) to Time 2 (M=9.59, SD=4.22),  $t(31)=2.273$ ,  $p<.05$

(two-tailed), effect size .14 (large), partial eta squared. An independent samples t-test identified no significant difference between groups' Time 2 scores,  $p=.435$ . However, the effect size of the seven-week group (.25) is larger than the workshop group (.14). This represents a clinically relevant difference of .11 in magnitude of effect.

A paired samples t-test identified a significant increase in the seven-week group's prosocial scores from Time 1 (M=6.76, SD=2.03) to Time 2 (M=7.73, SD=1.84),  $t(88)= -4.139$ ,  $p<.0005$  (two-tailed), effect size .16 (large), partial eta squared. There was a mean increase in the prosocial scores of the workshop group from Time 1 (M=6.72, SD=2.18) to Time 2 (M=7.13, SD=2.02), with a small effect size (.05). An independent samples t-test identified no significant differences in Time 2 scores between groups  $p=.12$  however, the effect size of the seven-week group (.16) is larger than the workshop group (.05), representing a clinically relevant difference of .11 in magnitude of effect

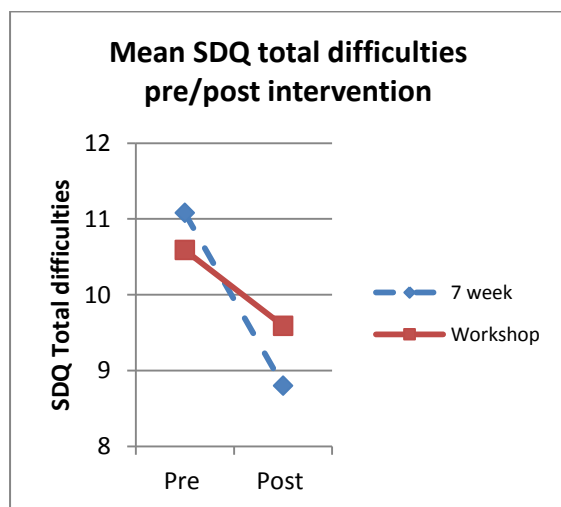


Figure 1. Mean SDQ total difficulties pre/post intervention

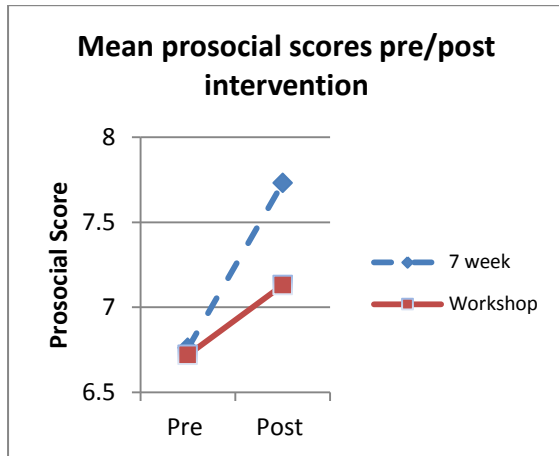


Figure 2. Mean SDQ prosocial scores pre/post intervention.

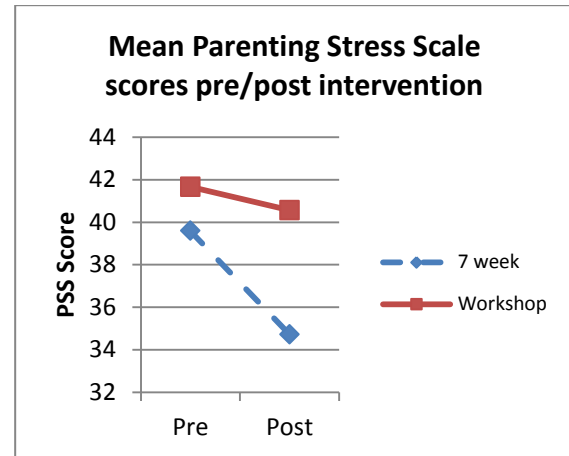


Figure 3. Mean parenting stress pre/post intervention

Two outliers were removed from the seven-week group's PSS responses. A paired samples t-test identified a significant decrease in the seven-week group's parental stress from Time 1 (M=39.59, SD=8.11) to Time 2 (M=34.72, SD=7.68),  $t(85) = p < .0005$  (two-tailed), effect size .32 (large), partial eta squared. There was a mean decrease in the workshop group's PSS score from Time 1 (M=41.66, SD=8.43) to Time 2 (M=40.56, SD=8.44), effect size .03 (small), partial eta squared. An independent samples t-test identified a significant difference in Time 2 PSS scores for the seven-week group (M=34.72, SD=7.68) and the workshop group (M=40.56, SD=8.44),  $t(116) = -3.574$ ,  $p < .05$ , effect size .09 (moderate), partial eta squared. The effect size of the seven-week group (.32) is larger than the workshop group (.03). This represents a clinically relevant difference of .29 in magnitude of effect.

Six outliers were identified and removed from the seven-week (N=5) and workshop (N=1) groups' KPS responses. A paired samples t-test identified a significant increase in the seven-week group's parenting satisfaction from Time 1 (M=15.00, SD=2.44) to Time 2 (M=16.85, SD=2.51),  $t(79) = -7.010$ ,  $p < .0005$  (two-tailed), effect size .38 (large), partial eta squared. There was also a significant increase in the workshop group's parenting satisfaction from Time 1 (M=13.97, SD=2.49) to Time 2 (M=15.00, SD=2.43),  $t(30) = -3.102$ ,  $p < .05$ , effect size .24 (large), partial eta squared. An independent samples t-test identified a significant difference between groups' Time 2 KPS total scores. The seven-week group had a greater increase in parenting satisfaction (M=16.85, SD=2.511) than the workshop group (M=15.00, SD=2.436),  $t(109) = 3.511$ ,  $p < .05$ , effect size .10 (moderate), partial eta squared. The effect size of the seven-week group (.38) is larger than the workshop group (.24). This represents a clinically relevant difference of .14 in magnitude of effect.



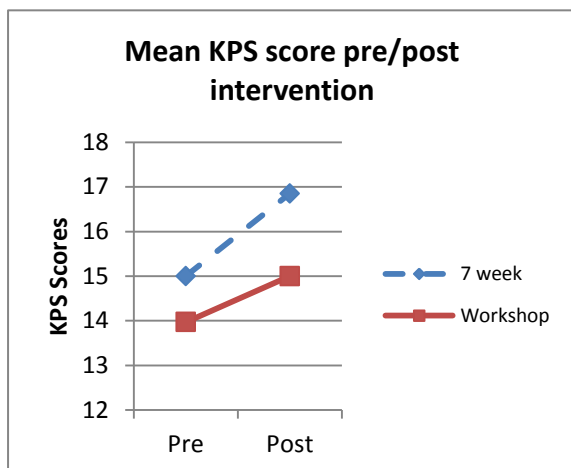


Figure 4. Mean parenting satisfaction pre/post intervention.

## Discussion

The aim of this study was to assess the effectiveness of the PPEY group parenting intervention when delivered in a non-clinical community sample by trained preschool teachers and to compare the relative effects of a seven-week intervention and a single workshop (2.5 hours). This study hypothesized that parents whose children are within the normal range of difficulties would benefit from the PPEY intervention when delivered in a community setting. Furthermore, it was hypothesized that both a seven-week and a single dosage controlled PPEY group would be effective in producing positive parent-reported gains post intervention. The results of this study support these hypotheses. Both community-run PPEY group formats demonstrated improvements in parent-reported child total difficulties, prosocial behavior, parenting stress, and parental satisfaction. Furthermore both PPEY group formats significantly reduced parent-reported child total difficulties and significantly improved parenting satisfaction. This supports the findings of Kilroy et al., (2011) that a preventative version of the PPEY program in the community was effective in reducing parent-reported behavior problems in preschool and school-aged children and Hand et al., (2013) who found the Parents Plus Children's Programme delivered in

community settings significantly improved measures of child behavior, parental stress, and parent satisfaction. These findings demonstrate that both the seven-week and single workshop PPEY group intervention may be effective early interventions as part of a community-led approach to child and adolescent mental health.

Reaching sufficient numbers of parents in need with widely available, empirically-supported parenting interventions requires a community-led population approach (Hand et al., 2013). A population approach seeks to break down parents' sense of isolation, increase social and emotional support from others in the community, and publicly acknowledges the importance and difficulties of parenting (Sanders, 2008). The current study's findings that both group formats improved parental satisfaction and stress demonstrates the PPEY Program's ability to provide a source of emotional support for parents as they navigate the challenges of parenting. These findings in a non-clinical community sample are similar to those of Thorell (2009), who found a community-based group parenting program was effective in reducing conduct problems, hyperactivity, impulsivity, daily problem behaviors, parental stress, and lack of perceived parental control for non-clinical groups. These findings highlight the importance of early community interventions over a short period of time as an option which can have significant positive effects on child behavior problems and parental well-being in non-clinical groups.

On all measures used in the current study, the effect sizes showed that, while both groups demonstrated improvements in response to the PPEY interventions, they did so to different degrees. The seven-week intervention demonstrated a greater, clinically relevant, magnitude of effect than the single workshop across all measures of interest. This suggests the magnitude of improvements gained from the PPEY group is dependent on the intensity of intervention received, with the workshop

group demonstrating dosage response effects. This supports the findings of Kling et al. (2010) that a single instructional workshop was slightly less effective than 11 practitioner-assisted parenting sessions. Although slightly less effective, a single workshop may still be a warranted alternative for some families as part of a cost effective first option in a stepped care approach (Kling et al., 2010). The largest effect size for both groups in the current study was found for parenting satisfaction, suggesting both intervention formats were effective in promoting parenting satisfaction; however the largest difference between intervention effect sizes was for parenting stress, with results suggesting the seven-week PPEY intervention was much more effective in reducing parenting stress than the single workshop. Consequently, a single workshop may not be sufficient for parents experiencing high levels of stress.

The findings of the present study are limited by a number of factors. As few fathers participated in the study, they were removed to control for the impact of gender. Reyno and McGrath (2006) suffered a similar limitation and argued that using maternal report measures to assess treatment outcomes may have resulted in a treatment bias effect. Consequently, as only maternal parent data were used, the impact of the intervention cannot be generalized to fathers; however, the effects of treatment bias should be the same across the two intervention groups and therefore cannot account for the differences between groups. A second limitation of this study is the lack of a control group receiving no intervention, which limits clarification regarding dosage effects and what may constitute a Hawthorne effect. Finally, the lack of follow-up data means maintenance of gains over time cannot be assessed. Further studies utilizing bigger groups of both mothers and fathers, a no treatment control group, and the collection of follow-up data would address these limitations.

Overall, the findings in this study demonstrate that both PPEY interventions

of different intensities are effective in promoting positive change in parent-reported child difficulties, parent stress, and satisfaction, with the magnitude of change dependent on the intensity of intervention received. The large effect sizes found in the present study for both groups support the moderate to large effect sizes of the community PPEY group in Hand et al's., (2013) study, indicating a practical application for the findings. The current study, combined with previous research, demonstrates that brief single session and group parenting interventions in community samples are effective in increasing parents' ability to build positive relationships with their children, reducing parent-reported child behavior problems and use of dysfunctional parenting, and improving parental self-efficacy, satisfaction, and stress (Sommers-Flanagan, 2007; Morawska et al., 2011; Lim, Tormshak, & Dishion, 2005). This shows that minimal intervention parenting programs are effective in promoting positive behavioral changes in parents and children (Reyno & McGrath, 2006). By following the principle of program sufficiency by which parents differ in the strength of intervention required, this tiered approach can maximize efficiency, contain costs, avoid waste and over servicing, and ensure the program has wide reach in the community (Turner & Sanders, 2006).

### **Relevance for Community Psychology Practice**

Given that child and adolescent mental health services are unlikely to meet the needs of all children with mental health problems in communities, preventative and more accessible programs are needed (Kilroy et al., 2010). Possibly one of the most important tasks for the future concerns the role of family-centered research in the development of policy that effectively supports larger scale implementation of empirically-supported interventions (Spoth, Kavanagh, & Dishion, 2002). The present study demonstrates that

by offering PPEY interventions in the community, families may be afforded greater opportunities to receive early intervention in managing parent and child difficulties. This would reduce the barrier of long waiting lists for clinical intervention. A community, population approach requires the provision of brief, targeted support for parents with low to moderate levels of need to prevent the development of more significant problems (Sanders, 2008). Such interventions may be appropriate for contemporary families, who are balancing multiple responsibilities, such as single parenting and career demands (Lim, Tormshak, & Dishion, 2005). By providing group PPEY interventions of modifiable duration in the community, parents with these multiple responsibilities may be able to receive cost effective support based on their needs and their availability.

### Conclusions

The current study demonstrates that, given the lack of brief parenting interventions currently available and their apparent effectiveness, there is an urgent need to develop and evaluate brief parenting interventions that can be delivered in a timely and cost-effective manner. The present study greatly adds to the evidence base surrounding the efficacy of a stepped care, population approach to community PPEY parenting interventions. In this way, the PPEY program can utilize the minimum necessary intervention to effect early, positive change in parent and child difficulties – before they become more ingrained and difficult to treat.

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