
**An Evaluation of a Group Intervention
for the
Parents of Youth Offenders**

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of the requirements for the Degree
of
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Abstract

Youth offending is an issue that receives attention at many levels, and which crosses the already broad domains of justice, education, mental health and social services. The role of parents in the development of antisocial behaviour, and their responsibilities with regard to addressing the consequences of this, are controversial. This article reviews a selection of interventions for managing teenage behaviour, and specifically criminal offending. A trend emerges from this review whereby the most effective treatments for young offenders are those that achieve change within the family system, not just the young person. The current study examined the effect of implementing Group Teen Triple P, one of a suite of well established and effective behavioural parent training programmes, with the parents of teenagers who had been recently involved in offending. The group was a collaborative partnership between Presbyterian Support, a non-government organization, and Child, Youth and Family Services, the national, statutory provider of care and protection and youth justice services. The six participating families had previously been involved with one or both of these agencies. Participants completed questionnaires and interviews at three data collection points, and the researcher also took part in aspects of the intervention. The results indicate positive changes within some of the participating families, but are inconsistent due to the drop-out rate and the reluctance of participating parents to consistently implement the skills and strategies learned. This unexpected but nevertheless important finding necessitated further consideration of the reasons why it occurred, and these are discussed in the context of earlier research into variables which influence attendance and adherence to parent training interventions. This study offers insights into the provision of behavioural parent training programmes with vulnerable, fragile or high-risk families.

Chapter 1 Introduction

Youth offending is a social concern that receives attention at many levels: in the frequent media reports about young people's involvement in alcohol and drug use, in motor vehicle offences and other antisocial behaviour, in the comprehensive body of literature regarding interventions, and in the range of social policy and legislation determining the way in which young offenders are managed. The extent to which parents are accountable for their teenagers' antisocial behaviour is controversial both in regard to the antecedents that have contributed to its development, and in regard to applying appropriate consequences for that behaviour.

The importance of involving parents or caregivers is well recognised in the research into interventions for young offenders (e.g. Andrews & Dishion, 1995; Henggeler & Lee, 2003). It is also a consideration that is influencing legislative and policy initiatives pertaining to youth justice (New Zealand Government, 2010).

The research described in this thesis sought to examine the effects of a behavioural family intervention for the parents of teenagers who had recently been involved in criminal offending. It sought to explore whether this kind of intervention was of benefit to these 'high risk' families.

The Development of Antisocial Behaviour

Research into the development of anti-social behaviour problems distinguishes between two broad categories of children with behaviour problems. Firstly there is a group who have been exhibiting difficult or non-compliant behaviour since early childhood. This group has been referred to as "life course persistent" (Moffitt, 1993), "persisters" (McLaren, 2000) or

“early onset” (Patterson, Reid & Dishion, 1992). The second group consists of teenagers who only begin to engage in anti-social behaviour during adolescence. This group has been referred to as “adolescence limited” (Moffitt, 1993), “desisters” (McLaren, 2000) or the “late onset” group (Church, 2003).

Fergusson and Horwood’s (2002) analysis of their data from the Christchurch Health and Development Study identified five developmental trajectories with regard to antisocial behaviour. Firstly, the *low risk* group, who engaged in few or no antisocial behaviours in their childhood assessments and few offences during their teenager years (less than two offences between the ages of 14 and 20 years). This trajectory was followed by 41% of boys and 71% of girls.

The second group was labelled the *early onset adolescent limited group*. It included young people who were reported to engage in low rates of antisocial behaviour between the ages of 8 and 12 but who engaged in a small amount of offending during their teenager years. This offending peaked at around 13 years and declined from about age 17 after they finished school. This trajectory was followed by 15% of boys and 21% of girls.

The third group, the *intermediate onset adolescent limited group*, were mostly reported not to have childhood conduct problems but who began offending somewhat later with a peak around age 17 years and declining soon after. The rate of offending for these teenagers was higher than it was for the second group over the period 14 to 20 years. This trajectory was followed by 10.3% of boys and 3.7% of girls.

The antisocial behaviour of the teenagers in this group often occurred only in certain contexts, such as with peers, and not in others, such as school. For some of these young people that there was disagreement between parents, teachers and other associates about the severity of the problem. This meant that the young person maintained some supportive

relationships and this may have functioned as a protective factor against developing a more entrenched pattern of crime.

The fourth group, the *late onset adolescent offenders*, had a relatively low rate of conduct problems in middle childhood and a relatively low rate of offending prior to age 17, but an increased risk of offending between the ages of 17 and 20 years. This trajectory was followed by 25% of boys and 2.4% of girls.

The fifth group were children who engaged in high rates of antisocial behaviour throughout childhood. They generally showed high rates of offending between the ages of 11 and 17 (averaging 141 self-reported offences between the ages of 14 to 20 years) with some decline at around 21 years. This group, which Fergusson and Horwood referred to as the *chronic offenders*, contained 9.4% of the boys and 2.1% of the girls.

The distinctions between these five groups of youth offenders probably arise as a result of different sets of risk factors and have implications for the type and intensity of intervention or treatment that should be provided. Across all groups it is notable that fewer girls than boys engage in teenage offending. Fergusson and Horwood's (2002) analysis suggests that Moffitt's (1993) adolescent limited group may consist of several subgroups, including a group of young people who experiment with antisocial behaviour during their teenager years but who do not continue into adulthood. The early onset group has the poorest prognosis with regard to making pro-social changes prior to adulthood. This is consistent with McLaren's (2000) analysis which found that people with life course persistent antisocial behaviour experienced a higher number of risk factors from an early age, whereas those whose offending was adolescence limited were more likely to be influenced by substance abuse and by mixing with an antisocial peer group.

The current research sought to study families with teenagers in the range of adolescent limited categories described above, on the grounds that the prognosis for the family

relationships of these young people might be improved if parents were provided with education and support before a pattern of offending was well established.

Youth Justice: The New Zealand Context

“Recent prevalence statistics from the United States, the United Kingdom, and New Zealand indicate that antisocial behaviours manifest in up to 15% of young people” (Curtis, Ronan & Borduin, 2004, p. 411). A 2002 report on antisocial behaviour in New Zealand youth notes an 80% increase in apprehensions of young people over the previous decade (Curtis, Ronan, Heiblum, Reid, & Harris, 2002). An apprehension does not always involve an arrest and, due to diversionary measures used in youth justice, most apprehensions will not result in a prosecution. Recent New Zealand statistics report that the apprehension rate for 14-16 year olds was highest in 1996 at 1,926 per 10,000 population (for the corresponding age cohort) declining to 1,592 in 2008 (Ministry of Justice, 2010).

Interventions for antisocial behaviour in New Zealand are offered in a variety of contexts ranging from prevention strategies being offered to ‘at risk’ youth and their families in school or community settings, to comprehensive, specialised programmes offered by mental health or youth justice services (Curtis, et al., 2002). Perhaps the most widely studied of these is parent management training and some of these programmes are reviewed below.

In New Zealand, the principles and procedures for youth justice are legislated under the Children, Young Persons, and their Families Act (1989). At the core of this system is the Family Group Conference. A meeting involving the young person, family members, staff of Child, Youth and Family Services (CYFS) and other relevant parties such as victims of a crime or Police. Family Group Conferences (FGC) are intended to provide a restorative and culturally appropriate approach to justice by encouraging participants to contribute to decision making, diverting young people from courts and custodial punishments and placing the

emphasis on reconciliation, repairing harm and “restoring the balance in the community affected by the offending (Maxwell & Morris, 2006). Introduction of the Children, Young Persons, and their Families Act in 1989 formalised the pre-existing dual emphasis of welfare and justice responses in addressing youth offending. The provision for Family Group Conferences in this legislation was an innovation that has attracted international interest (Maxwell & Morris, 2006). A review of research regarding the causes of, and interventions for, youth offending notes that while it is sometimes assumed that the rate of youth offending has increased more rapidly than overall crime over recent years, the number of young people passing through the criminal justice system has actually fallen. Possible explanations for this are that diversionary measures are working effectively or that fewer offenders are committing more offences (Kurtz, 2002).

The youth justice system in New Zealand deals with offenders aged between 14 and 16 years. The age of criminal responsibility is 10, but children under the age of 14 cannot be prosecuted for offences other than murder or manslaughter. Anyone over the age of 16 is treated as an adult.

An underlying intention of the Children, Young Persons and their Families Act is to encourage police to take a low-key response to youth offending unless it poses a risk to others. Where further intervention is considered necessary, youth offenders are referred to the Police Youth Aid section whose officers implement further diversionary measures such as a warning in the presence of parents, an apology to a victim, or a requirement for community work. These measures result in a significant percentage of young offenders being kept out of the broader judicial or welfare systems and the more formalised processes, such as the FGC described above.

There are recent initiatives within the youth justice arena that indicate a growing awareness of the influence that parenting skills and attitudes have on the development and

treatment of antisocial behaviour. An example of this is the contractual agreement between Presbyterian Support and the Sydenham CYFS Youth Justice team. This began in 2008 and provides parents with access to counselling or social work support to address parenting attitudes or practices that are contributing to their teenager's offending or other challenging behaviour. Based on a telephone survey of parents who had received this service, it was considered to be effective in supporting the engagement of parents in the interventions that were being sought for the young person, as well as strengthening the parent's confidence in their own skills for coping (Beri, 2010).

From October 2010, the New Zealand Government introduced the 'Fresh Start' package – legislation which extends the scope of the Youth Court and its judges to provide 12 and 13 year-old offenders with a range of interventions intended to address the causes of offending. Amongst these are compulsory orders for parents to attend parenting skills training as well as mentoring programmes or alcohol and drug rehabilitation for the young offender (New Zealand Government, 2010). This initiative is congruent with the present project in considering the context of youth offending and the fact that dysfunctional parenting practices and family relationships are a major risk factor for the development or perpetuation of youth offending.

Parental Factors

Extensive research has been undertaken into the extent to which parent-child relationships contribute to the development of antisocial behaviour and offending by children and young people. Two theories, attachment theory and social learning theory, have been the most influential in recent years, and have influenced the development of various parent education programmes (Scott, 2008).

Attachment theory holds that the quality of care (i.e. ensuring physical safety, emotional security, protection and responsiveness toward the child) provided to a child leads to a secure or insecure attachment to a parent or caregiver. While an insecure attachment in itself does not cause emotional or behavioural problems, the 'disorganised' type of insecure attachment has been associated with risk for psychopathology (Scott, 2008).

According to social learning theory, children's life experiences and interactions are the major influence on their behaviour. In particular, if a child receives attention for behaving in certain way, he or she are more likely to repeat that behaviour than if they were ignored or punished. Social learning can be applied not only to physical behaviour but also to emotions, attitudes and cognitions (Scott, 2008).

These overarching theoretical frameworks describe patterns of interaction between parents and children, which in turn are influenced by features within the particular environment such as the mental or physical health of individuals, poverty, intergenerational relationships, and even genetic factors (Kurtz, 2002; Scott, 2008).

Parenting style is another concept that has influenced the development of parenting interventions. Baumrind (1991) observed interactions between parents and their children at ages 4, 9 and 15 years in an attempt to identify determinants of adolescent competence or substance use. Based on this research, Baumrind proposed four parenting typologies based on varying combinations of warmth (versus conflict or neglect) and control: authoritative (high warmth, positive/assertive control), authoritarian (low warmth, high conflict and coercive, punitive control), permissive (high warmth and low control) and neglectful/disengaged (low warmth and low control) (Scott, 2008). Baumrind's research found that authoritative parents had the greatest success at protecting their adolescents from problem drug use, and in generating competence.

These typologies are an appealing and easy to understand way of describing the ways in which parental factors influence children's behaviour and development. The concepts of warmth and control can be related to both attachment and social learning theories, and to the underlying principles of many parenting interventions.

Parenting Programmes for the Parents of Teenagers

Several parent management training programmes, originally designed for the parents of young children with persistent behaviour problems, have been adapted for the parents of teenagers. The following is a review of a selection of these.

Triple P – Positive Parenting Programme. The Triple P – Positive Parenting Programme is a suite of programmes which aim to promote positive, caring relationships between parents and their children, and to help parents develop effective management strategies for a variety of issues related to their children's behaviour and development (Sanders, Markie-Dadds & Turner, 2003). The parent training methods used in Triple P have consistently been shown to be effective, and have been adapted over time for use in a variety of settings and with varying populations and age groups (de Graaf, Speetjens, Smit, de Wolff & Taveccio, 2008; Nowak & Heinrichs, 2008; Ralph & Sanders, 2004; Sanders, et al., 2003; Sanders et al., 2004).

Triple P is a form of behavioural family intervention based on social learning principles – the foundation which has the strongest empirical support of any intervention for younger children with persistent conduct problems (Sanders, et al., 2003). Triple P can be provided at several levels of intensity and has been adapted for use with specific populations such as indigenous ethnic groups or the parents of children with disabilities. A meta-analysis of the programme, based on 55 different trials, indicates that while effect sizes have varied, often

showing smaller effects for the less intensive forms, the various forms of the programme tend to produce reliable reductions in child misbehaviour following parent training (Nowak & Heinrichs, 2008). A similar conclusion was reached by de Graaf et al. (2008) who reviewed the impact of Triple P on parenting as measured by the Parenting Scale or Parent Sense of Competency measures.

One strength of the Triple P programme is that its content can be adapted to meet the needs of particular groups or communities. There has been plentiful research on the use of both Triple P and Incredible Years, which is a similarly well-established and efficacious behavioural family intervention programme, with groups of parents who are considered to be at greater risk for abusing or neglecting their children due to lack of adequate knowledge and resources for parenting (e.g., Hughes & Gottlieb, 2004; Lees & Ronan, 2008; Sanders et al., 2004).

Sanders et al. (2004) conducted a randomized groups experiment to explore the effects of adding specific components of 'attribution retraining' and 'anger management' to the standard Group Triple P programme. In this study comparisons were made between a group who completed the manualised Group Triple P of four group sessions and four individual telephone conversations, and a group who completed an 'enhanced' version which included four additional sessions targeting the additional risk factors. Both groups of participants showed statistically significant improvements from pre to post intervention on several measures relating to risk of child abuse, parenting (style, satisfaction and efficacy), parental conflict and child behaviour.

At the end of training those in the experimental group showed significantly greater improvements, at post-intervention, than those completing the standard treatment on measures of parental blame and parental unrealistic expectations. However, by follow-up, those in the standard condition had 'caught up' with those in the experimental group and there was no

significant difference in scores. There were no short term differences on measures of parental anger or global anger although the experimental group showed a trend for continued improvement in this area at the 6 month follow up.

This example of a successful adaptation of an empirically supported programme, such as Triple P, to suit a particular population, raises interest in its potential for other ‘high risk’ populations.

Teen Triple P. Triple P has been modified for use with the parents of adolescents – Teen Triple P – and a report (Ralph & Sanders, 2004) of a trial of this programme with the parents of adolescents making the transition to high school indicates significant improvements in terms of parental adjustment (measured using the Depression, Anxiety, and Stress Scales (DASS)), aspects of parenting style, parents’ beliefs about qualities relating to their own effectiveness and also reductions in conflict between parents and their adolescent children.

A recent evaluation of Teen Triple P found that the majority of families involved in the research achieved positive change by completing this parent management training programme (Weatherall, 2010). Weatherall used a within-participant design to study the effectiveness of Teen Triple P with 4 families who were referred by community agencies. Although the number of participants in this study is small, results are strengthened by the triangulation of direct behavioural measures, observations of parent and adolescent interaction and the relationship between several self-report measures. The study noted that parents increased their use of Triple P strategies, young people showed an increase in prosocial behaviour, as measured by the Strengths and Difficulties Questionnaire, and that families generally experienced reduced conflict after completing the intervention.

A further development for using Triple P with families of adolescents has been the introduction of a self-administered version of the programme. A randomized trial of Self-

Directed Teen Triple P compared with a wait-list control group showed that providing written material and some telephone support to parents may be an effective early intervention for adolescents demonstrating some emotional or behavioural problems (Stallman & Ralph, 2007). Further research is planned to investigate the sustainability of these effects and to compare the outcomes with those of other forms of Teen Triple P.

Adolescent Transitions Programme. The Adolescent Transitions Programme (ATP) is a multi-component, psychoeducational programme for the prevention of substance abuse and other problem behaviours in adolescence (Andrews & Dishion, 1995). The programme is comprised of separate but coordinated interventions which are offered to parents and to the young people themselves. Like Triple P, the Adolescent Transitions Programme is intended largely as a preventative measure designed to reduce the risk of adolescent experimentation.

The Adolescent Transitions Programme is interesting in two particular respects. Firstly, it is designed to be delivered in school settings, and secondly the programme's intention is to actively engage both the parent and the young person in the intervention. Parents are offered places in a group parent management training course. This course is the Oregon version of parent management training developed by Patterson, Chamberlain and Reid, and which shares many common features with Triple P. Young people are invited to participate in a separate group, facilitated by a peer counsellor, where they develop skills for setting realistic behaviour change goals and developing the skills to achieve them.

Literature evaluating the programme aligns it with Bronfenbrenner's ecological model (Andrews & Dishion, 1995). The fact that it connects multiple contexts – namely home (via parental involvement), school and peer group (by the use of 'peer counsellors' as well as group teaching methods) – certainly appears consistent with the current belief that interventions are more likely to be successful, or produce more enduring changes, when they

are applied across a variety of settings. The fact that ATP relies on school engagement is also a potential limitation, however, given that schools are not generally equipped to support parent education programmes.

Research has shown ATP to be effective in reducing problem behaviour, substance abuse, parent-child conflict, delinquency and depressive symptoms (Andrews & Dishion, 1995; Connell & Dishion, 2008). Recent research describes the possibility of tailoring ATP specifically for the families of young people with depression (Connell & Dishion, 2008). This is a particularly interesting development given that teenagers with behaviour problems often have co-morbid conditions such as depression, ADHD, substance abuse problems and so on.

Interventions for Adolescent Offenders

As noted above, research into the development of anti-social behaviour has established that it falls into two main categories: early onset and adolescent onset. Furthermore, the nature and severity of the problem behaviour both occur along a continuum. The following programmes are examples of interventions that have been developed specifically to address the needs of young people with clinical levels of behavioural problems and associated co-morbid issues. A review of interventions for youth offenders (Kurtz, 2002) concludes that cognitive-behavioural and multi-modal approaches are more effective than punitive, educational, vocational and undirected counselling approaches. Furthermore, interventions that identify and address causal factors associated with offending behaviour have been found to be more effective than those which do not.

Some of the reasons for this are simply that many of the young people who become involved in offending have grown up in families or environments with many problems, and did not learn the values and skills for living successfully within communities (McLaren,

2000). These include social skills, problem solving ability, basic literacy and numeracy skills, and values related to respect for the wellbeing of others.

Multisystemic Therapy. Multisystemic Therapy (MST) derives from a social-ecological framework, and gives consideration to the various contexts that contribute to the onset and development of conduct problems (Harpell & Andrews, 2006). Hence assessments and interventions involve not only the young person concerned, but also family members and other agencies or systems who are involved in influencing their behaviour and supporting them to make changes (Henggeler & Lee, 2003). MST maintains a positive focus on strengths, interventions are tailored to the developmental and psychosocial needs of each individual and his or her family (Kashani, Jones, Bumby & Thomas, 1999) and are designed to promote generalization and long-term maintenance of therapeutic change (Harpell & Andrews, 2006). A review of outcomes from MST interventions found that MST demonstrated larger effects on measures of family relations than on measures of individual adjustment or peer relations, and notes that this corroborates the findings of earlier research identifying that improvements in family relations are predictive of decreases in individual problems and delinquent peer relations (Curtis, Ronan & Borduin, 2004).

The course of MST intervention is intensive - averaging around 20 to 30 sessions over a 4 to 6 month period, and while individualized, procedures are documented in a treatment manual (Henggeler & Schaeffer, 2010; Kashani et al., 1999). The programme is delivered by specifically trained staff who are supervised on a weekly basis by a doctoral level clinician (Church, 2003). It is likely that the high level of involvement by therapists contributes to MST having a relatively high completion rate of 86% compared with an average of about 50% across a range of child and family treatments (Nock & Ferriter, 2005). Interestingly, a New Zealand study of MST implementation notes the high rate of therapist and supervisor

attrition, and the potential impact of this turnover on effectiveness. The researchers suggest several possible reasons for this, all of which relate to the demands of the work in terms of time and intensity (Curtis, Ronan, Heiblum & Crellin, 2009). Another limitation in the same study was the number of parents who did not complete all of the assessment measures – a point which will be explored further in considering implementation issues with ‘high risk’ client groups.

Research evaluating the effectiveness of MST compared with other treatment options for youth with antisocial behaviour, particularly offending, consistently finds it to be the “treatment programme of choice” for this group (Curtis et al., 2009). Outcome measures that have been used include measures of family functioning, overall adolescent behaviour and recidivism (Curtis, Ronan & Borduin, 2004; Harpell & Andrews, 2006). As well as demonstrating the relative effectiveness of MST, follow-up data from several studies indicates that the effects of MST are sustained over time (Harpell & Andrews, 2006).

An interesting point raised by Harpell and Andrews (2006) is the importance of providing a clear definition of what is involved in the programmes to which MST is being compared. The researchers point out that, “In many ways, MST is nothing more than a systematized format for ensuring that responsible, therapeutic practice based on empirically substantiated research targets multiple facets of an adolescent’s life” (p.94). This raises the question of whether a package of well coordinated interventions for an adolescent and their family could be similarly effective.

The intensive clinical input, and the expertise of those involved with providing MST, make it an expensive intervention. However, it still compares favourably to both the cost of residential treatment or incarceration, and the cost of no treatment and the higher rate of offending which results from no treatment (Kashani et al., 1999).

Multidimensional Treatment Foster Care. Multidimensional Treatment Foster Care (MTFC) initially arose from the Oregon group's concern about the fact that many treatments for youth with serious behaviour problems, and particularly those involved with the justice system, involve the placement of young offenders in groups or residential settings with other young offenders (Chamberlain, 2003). The concern arises from the evidence that involvement with an antisocial peer group is one of the major factors contributing to young people engaging in criminal or other antisocial activity.

MTFC is a form of foster care in which children and youth are placed with trained foster parents. The model developed from the belief that addressing the problem behaviour of young people is more likely to be achieved by trained and well supported foster parents who are not already enmeshed in a history of high rates of negative interaction and fighting (Church, 2003). The model has been successfully trialled with diverse populations of young people with complex and challenging problems, but particular attention has been paid to its potential as an alternative to incarceration for young offenders (Chamberlain & Smith, 2003).

Children or young people are typically placed in the MTFC setting for 6 to 9 months (Chamberlain & Smith, 2003). Foster parents receive training beforehand and then participate in weekly group meetings and can access telephone support at all times. A structured, individualized programme is developed for each child, and this is monitored and adjusted in consultation with the foster parent's clinical supervisor (Church, 2003).

In 85% of cases young people are returned to their family or relative's homes following MTFC (Chamberlain & Smith, 2003). On this basis, the young person's family are engaged in the programme throughout the intervention, with parents being kept informed of the young person's progress and challenges, as well as being taught the same strategies as are being used in the foster home. Sustainable outcomes from MTFC have been shown to relate to the

parents' successful implementation of these processes following the young person's return to the family home (Chamberlain & Smith, 2003).

MTFC has been shown to be more effective than group care at reducing criminal offending by young people (Eddy, Whaley & Chamberlain, 2004). Furthermore, research outcomes indicate that young people in MTFC abscond less often than those in group care, and are more likely to complete the programme than those in group care (Chamberlain, 2003). In practical terms, as for MST described above, the cost of the intensive, individualized programme remains considerably less than the expense involved in providing the residential facility required for group care (Eddy, Whaley & Chamberlain, 2004).

Functional Family Therapy. Functional Family Therapy (FFT) is another intervention that has been developed for young people with conduct problems. Research began in the late 1960s in response to growth in the "rate and severity of juvenile delinquency, violence and drug abuse" and the lack of suitable interventions available for "at-risk adolescents and their families" (Sexton & Alexander, 2000, p.2).

FFT begins by identifying strengths and encouraging family members to develop a sense of their own ability to improve their situations. The initial phase of the intervention centres around the therapist's engagement with family members and their attempt to get the family motivated to set goals and commit to participating in the programme. Once engaged the family works together with the therapist first on achieving goals related to behaviour change and then toward 'generalising' these changes to other contexts. On average the programme involves "8 to 12 sessions for mild cases, and up to 30 hours of direct service (e.g. clinical sessions, telephone calls and meetings involving community resources) for more difficult cases" (Sexton & Alexander, 2000, p. 2).

FFT has most often been used as an intervention programme, but is also considered to be an effective preventative measure for at-risk young people (Sexton & Alexander, 2000). Like MST and MTFC, FFT recognizes the importance of an intervention that addresses the multiple contexts and systems that influence a young person's behaviour and choices. FFT is particularly aimed at young people aged 11 to 18 but treatment can include younger siblings as well.

Research evaluating FFT has shown it can be used effectively across a range of settings – home, clinic or school based – and with diverse cultural groups (Robbins, Alexander & Turner, 2000; Sexton & Alexander, 2000). A review of research into treatments for youth violence points out that FFT has been shown to improve family functioning and achieve reductions in aggressive behaviour and criminal offending but that there is no empirical evidence for its effectiveness in reducing more serious, violent or chronic offending or antisocial behaviour (Kashani, et al., 1999).

Implementation of Parent Training Programmes

The effectiveness of manualised treatment programmes such as Triple P, MST and FFT depends upon the fidelity with which they are implemented by practitioners (Fixsen, Naoom, Blase, Friedman & Wallace, 2005). The treatment manuals with their rigorous specifications describing the way in which programmes such as Triple P and MST are to be delivered, and who can be involved in providing these treatments to families, are testimony to this.

There are, of course, multiple factors that influence implementation fidelity. These include characteristics of (a) the implementation system, (b) characteristics of the implementer (e.g. the facilitator or therapist) and their relationship to participants, and (c) the setting in which the programme is implemented (e.g. type of organization and level of support) (Chen, 1998; Domitrovich & Greenberg, 2000). In a study of programme integrity,

Dane and Schneider (1998) distinguished between *strategies* that promote integrity (e.g. a manual, provider training, supervision of staff) and *procedures* that verify integrity (e.g. monitoring adherence to the intervention, the amount of service delivered, participant responsiveness).

As well as considering the integrity of the programme itself, it is important to consider factors relating to the participants. The effectiveness of any parenting intervention depends on its precise delivery, but also on the consistency with which the parents implement the components they are taught - a concept that has been referred to as treatment adherence (Allen & Warzak, 2000). Allen and Warzak propose a functional assessment of parental adherence to the recommendations made by the professional, along similar lines to the behavioural analysis that might be undertaken to determine contingencies that are influencing children's behaviour.

Along similar lines, Scott and Dadds (2009) advocate using various theoretical frameworks to understand why standard, manualised treatments may be less successful for families with particularly challenging or complex circumstances. Several efficacious behavioural family interventions, including Triple P, are derived from Social Learning Theory. Behaviour analysis principles offer a foundation for assessing and conceptualizing family interactions and children's antisocial behaviour. Attachment theory, structural systems theory, cognitive attributions theory and shared empowerment/motivational interviewing provide additional scope and flexibility (Scott & Dadds, 2009). For example, attachment theory may provide insights on why parental attention may not be rewarding, and attribution theory can help to identify parental beliefs about their children that are obstructing change.

Research has shown that some of the challenges for parents seeking assistance with managing their children's behaviour arise from the need for them to take responsibility for activating the change, to be confident in their own ability to parent effectively, and the need to

recognise the extent to which the behaviour is problematic or antisocial (Morrissey-Kane & Prinz, 1999). The way in which parents interpret their own role in shaping their children's behaviour influences the likelihood of them asking for help and, furthermore, the success of their engagement in treatment. Research has found that, of the parents who initiate treatment for family or behavioural issues, up to 60% withdraw prematurely, citing costs, scheduling conflicts and so on. Examples of this can be seen in previous research where parents have withdrawn from, or not completed, interventions for a variety of reasons (e.g. Stevenson, 2003; Weatherall, 2010). A further challenge to those attempting to reduce these high attrition rates is the likelihood that the reasons given by parents may be masking more substantial barriers (Morrissey-Kane & Prinz, 1999).

A study using Pathways Triple P with parents whose children were in the custody of CYFS reported a high attrition rate, and indications that parents had difficulty accepting responsibility for their current circumstances (Stevenson, 2003).

Assemany and McIntosh (2002) reviewed the literature on parent training programmes with the aim of identifying negative treatment outcomes from these interventions. The researchers note with concern that research has focused on positive outcomes, giving little consideration to when or why the interventions are not successful. They identify three classes of negative treatment outcomes of behavioural parent training programmes. These are: (1) high rates of premature family drop-out, (2) failure of parents to engage and truly participate in treatment throughout the process, and (3) failure of the parent and child to maintain positive changes. Rather than undermining the significant positive findings from these programmes, it is suggested that reporting and publication of negative results would aid in identifying particular conditions in which the treatment is not effective, or less effective. Furthermore the publication of such data could contribute to the development of the

programmes by informing strategies and procedures which increase retention and implementation effectiveness.

Aims of the Present Research

Parent management training has proved successful in halting and reversing antisocial development in children. The Triple P programmes are amongst the most widely used (and effective) parent management training programmes, and research has supported their adaptation and development for use with diverse populations. The development of Teen Triple P is of particular interest to the present investigation.

While the Triple P programmes for younger children have been repeatedly evaluated and reviewed, there has so far been relatively little research into the effectiveness of Group Teen Triple P. The research currently under way at the University of Auckland will compare the relative effectiveness of Group Teen Triple P and the less intensive Teen Triple P Seminar Series. A randomized controlled trial of Teen Triple P has also been planned in Brisbane, Australia.

As part of a contractual agreement between Presbyterian Support Upper South Island (PSUSI) and Child, Youth and Family Services (CYFS), a group based parent management training was proposed for parents whose teenagers had been identified as young offenders. After consideration of programme content it was agreed that it would be preferable to use a well-tested intervention for this inaugural group. Hence, a decision was made to provide Group Teen Triple P – a well-researched, evidence-based and manualised parent management training programme – for this specific, and high risk group of families. The circumstances of the investigator, as an employee of PSUSI, allowed her to study the implementation of this intervention programme.

The aim of the present investigation was to evaluate the implementation of providing Group Teen Triple P to parents of young people who have engaged in offending. The following questions were examined:

1. Can the parents of young offenders be retained in a parent management training programme such as Group Teen Triple P?
2. Do the parents of young offenders require adaptations to the manualised version of Group Teen Triple P?
3. What are the effects of completing the Group Teen Triple P programme on the parents sense of competency, the family relationships and the young people's behaviour?
4. What are the main reasons that parents of young offenders give for not completing the programme?
5. How helpful do the parents of young offenders find this particular parent management training programme?

Chapter 2 Method

A contractual agreement between Presbyterian Support Upper South Island (PSUSI) and the Sydenham CYFS Youth Justice team formed the basis for offering a group parenting intervention. Under the existing agreement, CYFS Youth Justice social workers were referring the parents of young people who were involved with their service to PSUSI for counselling. PSUSI had agreed to respond to referrals within 3 days – a typical response being that the referral had been allocated to an appropriate staff member and that attempts had been made to contact the parent to offer an initial appointment. It was considered important that contact be established promptly after parents had consented to the CYFS Youth Justice social worker making the referral.

Participants

Participants in the present research were the parents of young people, aged 13-16 years, who had been recently involved with the Child Youth and Family (CYF) Youth Justice service, and had been referred to the Group Teen Triple P programme (which was named 'Parenting Tools for Our Times').

CYFS Youth Justice have found that the young people who are their clients fall into three broad categories. The first category includes youth who have engaged in only one or two episodes of offending, whose family relationships are still mostly intact and whose parents are looking for support. The second includes youth who have engaged in several episodes of offending which commenced during adolescence, and which has caused some disruption to family relationships with the result that parents are seeking to improve their skills in managing this behaviour. The third group are youth with a life

course persistent pattern of offending whose family relationships have been severely disrupted.

It was intended that the Group Teen Triple P programme selected for evaluation would not be offered to families where offending had been life course persistent but only to families in the first two categories. In practice, the intake process for group participants was not sufficiently rigorous to ensure that those referred met these criteria.

Referrals for the parent group were accepted only from the Family Works team at Presbyterian Support (for existing clients who had been referred under a contract with CYFS Youth Justice) or from the Sydenham CYFS Youth Justice team. Prior to accepting referrals for the parenting group, the two facilitators met with each of the teams and explained the content of the programme. This explanation made it clear that the programme was to be offered to the parents of young people who had recent involvement with CYFS Youth Justice but who did not have a life course persistent history of offending.

The intake process for referrals was managed by Presbyterian Support. Parents who were referred to the programme were contacted by telephone and asked:

- Whether they were aware of the referral.
- Whether they had been given an information flyer about the parenting programme, including information about venue, time and dates.
- Whether they were interested and planned to attend the group.
- Whether they anticipated any problems in getting to the group, such as problems with childcare or transport.

There was no further screening, during this part of the process, as to whether the families referred met the criteria for entry to the programme.

Parents from eight families were referred to the group, and attended some or all of the baseline sessions. Two parents withdrew from the parenting group prior to starting the Group

Teen Triple P content, and therefore did not take part in the research. Six families were recruited for the present study. Their demographic characteristics are summarized in Table 1.

Table 1: Characteristics of the research participants.

Family	Parent(s) attending group	Relationship status of parent	Gender of young person	Age of young person	Young person's living arrangements
A	Biological father	Single	Female	15 years	At home
B	Biological mother	Single	Male	14 years	In CYF custody
C	Biological mother	Single	Male	16 years	At home
D	Biological mother	De facto relationship	Female	16 years	In CYF custody
E	Biological mother	Single	Male	15 years	At home
F	Biological mother and step father	Married	Male	14 years	At home

Family A. Family A was a single, unemployed father whose 15 year-old daughter had been involved with CYFS Youth Justice primarily for stealing offences, including shoplifting and burglary, which had been occurring since she was about 9 years old.

Family B. Family B consisted of a single unemployed mother with two teenage boys. The son who was of primary concern to this project had an extensive history of involvement with CYFS Care and Protection as well as Youth Justice services. Mother B reported that her son's offending included alcohol and drug use as well as breaking and entering, vandalism and offences toward other people. He had experienced difficulties in the education system from a relatively young age. At the time of the Triple P programme he was in the custody of CYFS.

Family C. Family C was a single mother, working full-time in a professional job, with a 15 year-old son and two younger siblings. The nature of her teenager's offending centred around the use of alcohol and drugs.

Family D. Family D was a mother and stepfather with a 16 year-old daughter. Only the biological mother attended the parenting group. Mother D was working full-time in an administrative role.

Mother D reported that she had enjoyed a close relationship with her daughter prior to the fairly sudden and recent onset of her antisocial behaviour. According to Mother D her daughter's problematic behaviour involved absconding and violence, which had led to her living away from the family at the time of the group. The mother suspected that involvement with a problematic peer group and possibly the use of alcohol or drugs had contributed to the development of these problems.

Family E. Family E was a single mother, working full-time in a semi-skilled position. Mother E's 15 year-old son had been involved with CYFS Youth Justice over the previous 5 months in relation to offending which included stealing, alcohol and drug use and violent behaviour. Two younger siblings were also living in the household. At the time of the post-intervention interview Mother E reported that her daughter had recently found out that she was pregnant.

Family F. Family F were a reconstituted family. Mother F had two sons from a previous relationship, and the younger of these, aged 14, had recently been involved with CYFS Youth Justice primarily related to stealing offences such as shoplifting. Mother F's eldest son, aged 16, was also living in the family home. This couple also have three primary school aged children living at home.

Mother F attended the parenting group with her husband who was stepfather to the teenager relevant to this research. One parent worked part-time in a retail position and the other full-time in a semi-skilled trade.

The young person from this family also participated in the research and completed questionnaires and interviews for the post-intervention and follow-up rounds of data collection.

There were two other people who attended some of the baseline group sessions but who withdrew from the group before any data collection was undertaken. One withdrew due to stress-related health issues and the other because she felt she had completed similar material at other parenting courses.

Setting

The Group Teen Triple P parenting sessions were held at the premises of Presbyterian Support Upper South Island (PSUSI), in Bealey Avenue, Christchurch. This venue has a spacious meeting room with an adjoining kitchen, audio-visual equipment and other necessary facilities. There is on-site car parking, and bus-routes which pass nearby.

Some of the interviews with parents were carried out in an office at Presbyterian Support USI, some parents found it more convenient to be interviewed in their own homes, and one parent chose to meet the researcher at a coffee shop close to her workplace. The only young person who participated in the research agreed to meet the researcher at a fast food restaurant on both occasions. All of these venues were chosen according to the participant's preference and convenience.

Approvals and Informed Consent

One of the group facilitators and the researcher were both accredited for Level 4 Standard Triple P but not to administer the Group Teen version. With a fairly short timeframe prior to the commencement of the group, and limited training opportunities in New Zealand for Triple P, permission was obtained from Dr Matt Sanders and Dr Alan Ralph, who have developed and researched Triple P, for the facilitators and the researcher to implement the programme for the purposes of this research project. Dr Sanders agreed to the programme being used with the proviso that clinical supervision be provided by a Triple P trainer in order to ensure the fidelity of the programme. This was provided by an accredited Group Teen Triple P trainer and facilitator, on a weekly basis, throughout the implementation of the Group Teen Triple P programme.

Secondly, approval was sought and gained from the University of Canterbury's Human Ethics Committee. The letter approving the research is reproduced in Appendix 1.

Next, an application was made to the CYFS Research Access Committee seeking approval to interview those teenage children who were clients of CYFS Youth Justice, for the purpose of this research. The committee clarified that, in the case of the young people who were still living with their parents, the parents were able to give consent themselves to the young person being interviewed for this evaluation. The committee's main concern was that the young people not experience any negative effects as a result of completing the questionnaires or participating in the interviews.

The University of Canterbury Human Ethics Committee approval was obtained during the time of the Introduction sessions. During the third and final Introduction session, participants were informed of the researcher's proposal to evaluate the effectiveness of the Group Teen Triple P programme, and they were invited to participate in this research.

The researcher arranged to meet with each of the parents individually. At this first appointment, the nature and purpose of the research were explained, and participants were given a written explanation of what was involved in taking part in the research, the accessibility of the thesis on completion, and assurances that their confidentiality would be safeguarded throughout the process. Participants were also informed of the availability of additional support, on an individual basis, if they required it as a result of issues arising during the group or from participation in the evaluation research. If they were agreeable to taking part, the parents were asked to sign a consent form to confirm this.

By the time of the second interview the CYFS Research Access Committee had given approval for the young people, whose parents were attending the group, to be interviewed for the research. (Permission was not sought to interview young people who were in CYFS care or custody at the time of the research, as it was considered that there would be less opportunity for the parents to utilise the strategies being learned.) So, at these interviews the parents whose teenagers were currently living with them were asked for their consent for the researcher to contact the young people. All four parents gave this consent but only one young person agreed to being interviewed.

Measurement Procedure

The intervention was evaluated using measures of the parents' sense of competency, the quality of the relationship between the parents and their adolescent children, the behaviour of the young people, and the satisfaction of the participants with the intervention. Each of these variables was assessed on three occasions – prior to the Triple P intervention, at the end of the programme and then after a maintenance period of approximately 3 months.

The parents' sense of competency was assessed using the Depression Anxiety Stress Scale and the Parenting Beliefs Scale.

The Depression Anxiety Stress Scale (DASS) developed by Lovibond and Lovibond (1995) is a manualised 21-item questionnaire which assesses symptoms of depression, anxiety and stress in adults. The scale is reported to have high reliability for depression, anxiety and stress, and good discriminant and concurrent validity. Participants rate themselves on a scale from 0-3 for each of 21 items, each of which pertains to one of the three conditions being measured. The results are then coded and scored against severity ratings, which have been determined by the authors of the DASS. It was predicted that, if this intervention has a positive effect on the parents' sense of competency, then their scores on the DASS would be lower when the post-intervention measures were taken.

The second measure of parental sense of competence is the Parenting Beliefs Scale (PBS) developed by Ralph & Sanders (2004). The PBS is a 22-item questionnaire which uses a 6-point Likert scale to measure parents' self-reports of personal agency, self-efficacy, self-management and self-sufficiency. This scale has been used in earlier research evaluating the effectiveness of Group Teen Triple P (Ralph & Sanders, 2004).

The second dependent variable, the impact of the intervention on the relationship between the young person and their parent, was assessed using the Conflict Behaviour Questionnaire (Robin & Foster, 1989). The Conflict Behaviour Questionnaire exists in two versions, a long form and a short form. It can be completed both by parents and adolescents. In a previous evaluation of a Group Teen Triple P programme, Ralph and Sanders selected the shorter version of the Conflict Behaviour Questionnaire, the CBQ20, on the basis that "the longer measure appears to have adequate validity and reliability, and the shorter form correlates .96 with scores from the longer version" (Ralph & Sanders, 2004, p. 4). On this basis, the shorter version of this scale was chosen for this evaluation.

The third variable, changes in the behaviour of the young people over the course of the evaluation, was assessed using the Child Behaviour Checklist (CBCL) (Achenbach, 1991).

The CBCL was chosen because of its sensitivity and the availability of Youth Self Report forms for the young people to complete. Both the Parent Report and the Youth Self Report Forms were to be completed at each of the three measurement points. However, due to time delays in obtaining approval to include the young people in the research, and apparent reluctance by the young people to complete the tasks involved, only one young person completed the questionnaires and interviews required. The CBCL data was interpreted in order to determine (a) whether there were improvements in disruptive and other challenging behaviours, and (b) whether the parents and young people's own assessments of their behaviour were congruent with each other.

As well as completing these questionnaires, either independently or at an interview, participants took part in a semi-structured interview at each of the evaluation points. The interviews involved a guided discussion. There were three main topics of discussion. Firstly, the nature and quality of communication between family members, including rate and severity of conflict. Secondly, the strategies used by parents to manage their children's behaviour, including whether there are specific techniques or ideas they have learned from the group and utilized at home and examples of this. Thirdly, the perception that the parents have of their own competency in managing challenging situations, and the teenagers' perceptions of this. In particular whether either parents or teenagers notice any changes in this in the course of the Triple P programme.

If there were time limitations on the meetings, or if circumstances made it difficult to complete all of the questionnaires, priority was given to completing the interview face-to-face and the questionnaires were left with the participants, along with a post-paid envelope for their return.

Design

The research design for this evaluation was a within-participant design involving the members of six families. Data was collected prior to the intervention, post-intervention and then at a three-month follow-up to measure maintenance.

Intervention Procedures

The intervention followed the *Facilitators Manual for Group Teen Triple P* (Sanders & Ralph, 2002). The parents who attended the programme each received a copy of the *Teen Triple P Group Workbook* (Ralph & Sanders, 2002). The DVD, which included case examples, was used during group sessions as prescribed in the Facilitator's Manual. All of these resources were purchased by Presbyterian Support USI from Triple P New Zealand.

The 'Parenting Tools for our Times' group was held on Wednesday evenings from 7.00pm to 9.00pm. There was no charge to parents for attending the programme. The group sessions, including the Introduction sessions, took place over 9 weeks commencing on 28th April 2010. The first of the Group Teen Triple P sessions was held on the 19th May 2010.

The group was jointly facilitated by a social worker from the CYFS Sydenham Youth Justice Team and a child and family psychologist employed by Family Works, PSUSI.

The first three group sessions were considered an Introduction phase and the evaluation research does not include these. Initial data collection took place in the week prior to the fourth group session, which was the first session of the manualised Group Teen Triple P. The Introduction sessions covered the following matters.

Session 1 included the opportunity for facilitators and participants to introduce themselves. The content of the programme was outlined. There was discussion about the importance of having realistic expectations about improvement or positive change rather than

achieving ‘ideals’. This included a model describing the process of change and emphasizing the idea of ‘readiness’ for making change.

Session 2 contrasted ‘systems-based’ and ‘linear’ thinking – encouraging participants to consider the context in which teenagers’ behaviour is occurring, and avoiding a focus on blame. This session described ‘Spheres of Influence’ – a model which represents a continuum from where an individual has total control (over one’s own behaviour) to having influence (over aspects of a teenager’s behaviour by using contingencies) to no control (over external influences).

Session 3 was designed to provide information to participants that would enable them to have greater success when interacting with professionals and processes which are part of the Police, CYFS or the Youth Justice system. A Police Youth Aid officer spoke about how to achieve the best responses from Police, and the group facilitator from CYFS Youth Justice outlined their intervention options and criteria for involvement.

Sessions 4 to 9 followed the order of the programme for Group Teen Triple P according to the Facilitator’s Manual, with one exception: the provision of one additional group session for the dual purposes of (a) allowing more time for this group of parents to plan and practice routines for managing challenging behaviour, and (b) to maintain the parents engagement in the group (in comparison with having telephone contact only for three weeks as outlined in the *Facilitator’s Manual for Group Teen Triple P*). This variation was discussed and agreed Table 2.

Sessions 5 to 7 of Group Teen Triple P are telephone contacts with the parents participating in the group which are intended to allow participants the opportunity to clarify any of the material presented in previous sessions, and to “tailor the programme to your (sic) family’s needs” (Sanders & Ralph, 2002, 158) by reviewing goals set by the parents and discussing their use of the positive parenting strategies they have learned.

These phone sessions were carried out by the researcher, who telephoned the participants each week in between the group meetings after the second session of Group Teen Triple P material.

The final interviews and questionnaires were scheduled to take place in mid-September, but were delayed following the Canterbury earthquake on 4th September 2010, and instead appointments were made with participants during October 2010.

Table 2: Group Teen Triple P Session Content.

Session	Content	Duration
Session 1	<p>What is Positive Parenting? Introducing key concepts of the programme, which are: Ensuring a safe, engaging environment, creating a positive learning environment, using assertive discipline, having realistic expectations and parental self-care. Factors influencing teenagers' behaviour with specific focus on family and wider social interactions.</p> <p>Making goals for change by focussing on specific skills parents could encourage in their teenage children.</p> <p>Keeping track of problem behaviour by using tools such as diaries or tick sheets to record incidents.</p>	2 hours
Session 2	<p>Review and recap of last session.</p> <p>Encouraging appropriate behaviour by taking opportunities to praise or give time and attention to teenagers.</p> <p>Developing a positive relationship with your teenager.</p> <p>Teaching new skills and behaviours by using behaviour contracts and rewards.</p> <p>Introducing family meetings as an opportunity for communication, negotiating or setting rules.</p>	2 hours
Session 3	<p>Review and recap of last session.</p> <p>Managing problem behaviour using family rules, directed discussion, clear calm requests and logical consequences.</p> <p>Acknowledging teenagers' emotions by talking and listening.</p> <p>Developing parenting routines as a way of preparing for situations that are likely to be difficult.</p> <p>Using behaviour contracts, family rules and meetings.</p>	2 hours
Session 4	<p>Review and recap of previous session.</p> <p>Identifying possible high-risk situations for teenagers.</p> <p>Strategies for dealing with risky situations or behaviour including: imposed prevention, risk reduction, rewarding appropriate behaviour.</p>	2 hours
Session 4 Continued	<p>Review and recap of previous session</p> <p>Developing and practicing routines for managing risky situations – role plays and discussion.</p>	2 hours
Session 8	<p>Review and recap of previous sessions.</p> <p>Questions, discussion, reflection on any aspects of the programme.</p> <p>Certificates for participation.</p> <p>Congratulations and celebrations including food.</p>	2 hours

Chapter 3 Results

This section presents the results obtained on each of the measures completed by each of the participating parents. However, it is important to note that four of the six participants withdrew out of the Group Teen Triple P programme prior to completing it. Also included in this section therefore are details regarding the reasons which participating parents gave for not completing the programme that they had originally agreed to complete.

The results fall into three categories. Category One includes those participants who did not complete the Triple P programme and only took part in the baseline data collection. Category Two are participants who did not complete the Triple P programme but who were available and took part in all three stages of data collection. Category Three consists of those participants who completed the parenting intervention as well as all three rounds of questionnaires and interviews.

Category 1: Family A

Father A, the single father of a 15 year-old daughter, missed some of the Introductory sessions but attended three Group Teen Triple P sessions. This father completed only the baseline questionnaires and interview and could not be contacted after he stopped coming to the group sessions.

Father A scored 13 out of 20 on the Conflict Behaviour Questionnaire (CBQ), against a mean score of 10.5 for fathers from distressed families completing this questionnaire regarding their adolescent children. So, Father A's responses indicated an elevated level of conflict in his relationship with his daughter.

The Depression Anxiety Stress Scale (DASS) produces three index scores each of which has a maximum score of 42. Father A's scores were 16 for depression, 12 for anxiety and 24 for stress. All fell within the moderate clinical range.

According to the Child Behaviour Checklist (CBCL) completed by Father A, his daughter's Total Problems and Externalising scores were both in the clinical range above the 90th percentile for girls aged 12-18. Her Internalising score was in the borderline clinical range. Her scores on the Attention Problems and Rule-Breaking behaviour were in the clinical range above the 97th percentile, and that for Aggressive Behaviour was in the borderline clinical range. On the DSM-oriented scales her score on the Conduct Problems scale was in the clinical range and scores for Attention Deficit/Hyperactivity problems and Oppositional Defiant problems were in the borderline clinical range. Overall, Father A reported significantly more problems than are typically reported by parents of girls aged 12-18.

Father A's overall score on the Parenting Beliefs Scale was 81.

Father A stated that he initially tries to address disagreements with his daughter by talking, but if that doesn't work "I lay down the law". Father A described having a history of using physical punishment for both of his children, but about two years previously had resolved not to hit his daughter. Father A demonstrated an awareness of some positive strategies for managing challenging situations, such as calling on a family friend to mediate conflict, and removing privileges (e.g. removing her mobile phone for a day) as a consequence for non-compliance.

Category 1: Family D

Mother D, the mother of a 16-year-old daughter, attended all baseline sessions and four of the Group Teen Triple P as well as telephone sessions. Mother D made appropriate contributions to discussions and engaged with the facilitators as well as some of the other participants. It was notable that after the group sessions Mother D took some time to update

one of the facilitators about her attempts to utilise the new strategies she was learning in her particular circumstances, and appeared to feel some satisfaction with this.

Mother D was not able to complete the penultimate session for health reasons. She was unable to be contacted after that point and therefore did not participate further in the research.

Mother D maintained contact with her daughter by telephone and text message, and during Sessions 2 and 3 reported that she had been sending texts conveying her affection while not responding to negative messages received from her daughter.

Mother D scored 14 out of 20 on the CBQ, against a mean score of 12.4 for mothers from distressed families completing the questionnaire regarding their adolescent children. So, Mother D's responses indicated an elevated level of conflict in her relationship with her daughter.

Mother D's scores on the DASS subscales were 2 for depression, 4 for anxiety and 4 for stress. All fell within the normal range.

According to the CBCL completed by Mother D, her daughter's Total Problems and Externalising scores were both in the clinical range above the 90th percentile for girls aged 12-18. Her Internalising score was in the borderline clinical range. Her scores on the Rule-Breaking behaviour and Aggressive behaviour were in the clinical range above the 97th percentile, and that for Somatic Complaints was in the borderline clinical range. On the DSM-oriented scales her scores on the Somatic Problems, Oppositional Defiant problems and Conduct Problems were in the clinical range and that for Attention Deficit/Hyperactivity problems was in the borderline clinical range. Overall, Mother D has reported significantly more problems than are typically reported by parents of girls aged 12-18.

Mother D's overall score on the baseline Parenting Beliefs Scale was 77 which is significantly higher than the average scores of parents who completed the questionnaire when

used by Ralph and Sanders (2003) with parents of children making the transition to high school.

Category 2: Family B

Mother B, the single parent of a 14 year-old son, attended all of the Introductory sessions and the first of the Group Teen Triple P sessions but decided not to complete the course. This parent completed all three rounds of data collection.

The following table summarises the questionnaire responses for Mother B.

Table 3: Summary of Questionnaire Results for Mother B.

	Pre-intervention	Post-intervention	Maintenance
CBQ	16	5	0
DASS			
Depression	30	28	8
Anxiety	6	6	4
Stress	18	16	10
PBS	85	82	72

As can be seen from Table 3 Mother B's initial CBQ score was reasonably elevated, whereas her later scores are representative of a well functioning family. One possible explanation for this shift is that Mother B was experiencing less conflict with her son as decisions regarding his future were resolved during the course of the present research.

A similar pattern was observed with respect to Mother B's scores on the DASS subscales. Clearly, the first two scores on the depression scale would be of most concern, as they fell into the severe clinical range. The fact that her follow-up score fell into the normal range is remarkable. These results are consistent with Mother B's report that she has had longstanding issues with depression.

The CBCL completed by Mother B at baseline placed her son's problems in the clinical range, above the 90th percentile for boys aged 12-18, across all problem scales i.e.

Internalising, Externalising and Total problems. His scores on the Anxious/Depressed, Somatic Complaints, Thought Problems, Rule-Breaking behaviour and Aggressive behaviour were in the clinical range above the 97th percentile, and those for Withdrawn/Depressed and Attention Problems were in the borderline clinical range. On the DSM-oriented scales his scores on the Affective Problems, Anxiety Problems, Somatic Problems and Conduct Problems were in the clinical range and those for Attention Deficit/Hyperactivity and Oppositional Defiant problems were in the borderline clinical range. Overall, Mother B has reported significantly more problems than are typically reported by parents of boys aged 12-18.

The overall frequency of reported problem behaviours was very similar on the questionnaire completed at the post-intervention phase. During interviews Mother B reported that her son and his brother had been involved in risky behaviour since they were seven and eight years old. At the maintenance point, Mother B's responses on the CBCL placed her son's behaviour within the normal range across all scales.

Mother B's overall scores on the PBS were 85, 82 and 72, indicating a slight downward shift in scores over the timeframe of the research.

At the first interview, Mother B provided information about her history, including having left a violent relationship when her two sons were pre-schoolers. Mother B stated that she had expected to receive support from her family but found that others struggled with her sons' behaviour. During interviews Mother B consistently described a loving relationship with her sons. She stated that she feels guilty about the experiences they had as young children, and continues to feel protective of them and to advocate on their behalf.

In discussing parenting strategies for challenging situations, Mother B stated that she attempted to ignore inappropriate language or less severe difficult behaviour. She gave the example that her sons became verbally abusive and swore at her or called her names if she

refused to give them money when they asked for it. Mother B reported calling on the Police or CYFS for support to manage when her sons’ behaviour became “out of control” and felt she would continue to do this. Mother B reported that a large proportion of the conflict that happens at home is between her two sons. This has escalated to physical violence at times and on Mother B described feeling afraid for her own safety on some of these occasions.

Mother B was hopeful of a good outcome for her son following the high level of intervention being offered to him at the time of the research interviews. She felt that he was building an understanding of the consequences of his behaviour.

Category 2: Family C

Mother C, a single parent of a 16 year-old son, attended the Introductory sessions and then the first two sessions of Group Teen Triple P. She made the decision not to continue coming to the programme following a crisis related to her son’s behaviour which had potentially endangered other family members. Mother C felt unable to continue to give adequate attention to the parenting programme or to trying new strategies. Mother C expressed interest in taking part in an individual Triple P programme at a later time and did complete all three rounds of data collection for the present study.

Mother C’s questionnaire results are summarised in Table 4.

Table 4: Summary of Questionnaire Results for Mother C.

	Pre-intervention	Post-intervention	Maintenance
CBQ	12	13	Not completed
DASS			
Depression	4	2	Not completed
Anxiety	2	0	“
Stress	8	4	“
PBS	66	69	Not completed

Mother C described having tried a variety of strategies to manage challenging behaviour in her teenage son. At home the children have household tasks they are required to complete

in order to earn pocket money. There is a curfew of 7.00pm but more recently this has become part of her son's bail conditions and is, therefore, followed up by the Police if they discover it has been breached.

Mother C described herself as being "less reactive" now than in the past. She stated that she used to be "very persistent about tracking him down and trying to prevent him from getting involved" in problem situations. An example of this was using physical restraint to prevent him leaving the house when friends came to collect him, or going to a party to retrieve him. As her son has grown and his defiance has escalated she has stopped doing this. Mother C reported that she also used to shout or "roar" at her son when she was arguing with him. Initially this would cause him to "pull back", but now he has "learned to roar himself".

Mother C reported offering incentives to her son to encourage him to comply with conditions that were put in place either by her or by the Police. For example, she was assisting with transport providing it was before his curfew, and if she was contacted by the Police during the night she did not respond until the morning when she knew her son would be sober and calm.

Mother C has contacted the Police for support with parenting her teenage son. She has pressed charges for damage to their household property and there is a bail condition in place prohibiting verbal abuse.

Mother C scored 12 out of 20 on the Conflict Behaviour Questionnaire at the baseline assessment and 13 at the post-intervention measure. She did not complete this questionnaire at the maintenance point. The mean score on the CBQ is 12.4 for mothers from distressed families completing the questionnaire for their adolescent children. So, Mother C's baseline score indicate an elevated level of conflict in her relationship with her son.

On the Depression Anxiety Stress Scale all of her scores fell within the normal range.

The CBCL completed by Mother C at baseline placed her son's Total Problems and Externalising scores both in the clinical range above the 90th percentile for boys aged 12-18. His Internalising score was in the borderline clinical range. His scores on the Withdrawn/Depressed, Rule-Breaking behaviour and Aggressive Behaviour syndromes were in the clinical range. His score for Social Problems were in the borderline clinical range. On the DSM-oriented scales his scores on the Oppositional Defiant Problems and Conduct Problems scale were in the clinical range and scores for Affective Problems and Attention Deficit/Hyperactivity problems were in the borderline clinical range. Overall, Mother C reported significantly more problems than are typically reported by parents of boys aged 12-18. The CBCL completed at post-intervention showed a similar pattern of results with few changes. The only exceptions were his Internalising score, Withdrawn/Depressed score, Attention Deficit/Hyperactivity score and Oppositional Defiant Problems score which had moved into the normal range.

On the CBCL completed at the maintenance assessment this trend toward reduced behaviour problems continued. Total Problems and Externalising Problem scores were still in the clinical range. Rule Breaking behaviour remained in the clinical range and Aggressive Behaviour in the borderline clinical range, but the severity of these was markedly reduced in comparison to the first and second measurements. On the DSM-oriented scales only the Conduct Problems score was in the clinical range and Affective Problems in the borderline clinical range with other scores all in the normal range.

By the time of the maintenance phase of data collection, and following an escalation in this young man's behaviour, he had been assessed and diagnosed with Conduct Disorder, Social Phobia, Anxiety Disorder and Substance Dependence. Mother C described having a sense of relief at receiving this information but then frustration at the lack of actual intervention following them. At the time of the maintenance interview Mother C stated that

she was continuing to advocate on her son's behalf but also challenging him about being able to choose to behave appropriately.

Mother C's overall scores on the Parenting Beliefs Scale were 66 at baseline and 69 at the post-intervention phase. Mother C did not complete the PBS at the maintenance point. These scores are similar to the means obtained at the same data collection points in Ralph and Sanders (2003) research described earlier.

At the time of the post-intervention measures, Mother C's son was in CYFS custody. This followed charges involving alcohol and drugs and violence. On his release from custody he was ordered to an alcohol and drug rehabilitation programme and Mother C reported that he seemed frustrated by his "powerlessness" with respect to this process.

At the maintenance interview many references were made to the impact of the Canterbury earthquake, just over one month previously, on the family's relationships and functioning. Mother C reported that her son's behaviour, and their relationship, had improved after he returned home from his custodial sentence. She attributed this to him appreciating aspects of his lifestyle at home. Mother C stated that following the earthquake her son remained calm and assisted with practical tasks such as fetching water and attaching a tarpaulin to the roof.

By the time of the final interview Mother C reported that she was assisting her son with making plans for his future. He was involved in an activity-based programme for youth and was preparing to enrol in a course for the following year. Mother C had told her son he could continue living at home as long as he is occupied during the day. Mother C was also receiving support from a friend who was helping by providing support with supervision and parenting.

One of Mother C's younger sons had recently been in trouble at school, and Mother C reported that her older son had been supportive in helping her to manage this situation.

Category 3: Family E

Mother E, the single mother of a 15 year-old son, attended all but one of the Group Teen Triple P sessions and participated in all three rounds of data collection. Mother E’s questionnaire results are summarised in Table 5.

Table 5: Summary of Questionnaire Results for Mother E.

	Pre-intervention	Post-intervention	Maintenance
CBQ	10	13	6
DASS			
Depression	6	2	2
Anxiety	4	6	8
Stress	16	14	18
PBS	70	56	69

Mother E’s scores on the CBQ were 10 at baseline, 13 at post-intervention and 6 at maintenance. As can be seen from Table 5, Mother E’s scores on the DASS changed little as a result of the intervention.

At the baseline interviews Mother E described “trying to get the kids to stay calm and keeping calm myself” as one of the main strategies she used to cope with difficult situations. Over recent months, precipitated by her son’s involvement with Youth Justice, she had been working with a social worker and giving more thought to the motivation for certain behaviour in her children, and trying to be more consistent with following through on consequences for behaviour. At the time of this interview Mother E’s son was involved with an activity-based programme for at-risk youth. Mother E was encouraging her son to keep his commitments to this programme and to completing his hours of community service.

Throughout the intervention and evaluation it was evident that Mother E identified particularly closely with messages regarding staying calm and seeking opportunities for positive interaction with her children. During the group meetings and telephone sessions

Mother E described her efforts to maintain communication with her children. For example, choosing to have an important conversation over a mealtime when everyone is most relaxed and enjoying food. She also talked about looking for opportunities to praise her children and accepting times when they are less receptive to this sort of comment or encouragement.

Mother E found that noticing the good things in her children had a positive effect for her own mood and sense of wellbeing, as well as the fact that the children seemed to respond by being more helpful.

One of the challenges that Mother E discussed in group sessions and interviews was managing the balance between “protecting” her teenage children and allowing them to take increased responsibility for themselves. This related to messages within the Triple P content about encouraging children to participate in family decision-making and learning skills for adulthood. Mother E made her son responsible for complying with his community service requirements and praised him when he did so. She found it more difficult to take a role in enforcing his curfew and felt she would be unlikely to inform the Police of breaches.

According to the CBCL completed by Mother E at baseline, her son’s Total Problems, Internalising Problems and Externalising Problems were all in the clinical range as were the scores for Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Thought Problems, Rule-Breaking Behaviour and Aggressive Behaviour. On the DSM-oriented scales, his scores for Affective Problems, Anxiety problems, Oppositional Problems and Conduct Problems were in the clinical range. These results indicate that Mother E reported more problems than are typically reported by parents of boys aged 12 to 18.

The pattern of results was similar on the CBCL completed post-intervention, with some improvements in behaviour indicated by the fact that scores for Withdrawn/Depressed and Thought Problems syndromes had shifted from the clinical range to the borderline clinical

range, and that for Thought Problems from the clinical range to the normal range. All other scores were relatively stable.

At maintenance there was considerably more improvement with only Rule-Breaking behaviour falling in the clinical range and Anxious/Depressed, Thought Problems and Aggressive Behaviour in the borderline clinical range. On the DSM-oriented scales the score for Conduct Problems was in the clinical range and scores for Anxiety Problems and Oppositional Defiant problems were in the borderline clinical range.

Mother E's scores on the PBS varied somewhat across the measurements taken, but do not represent a consistent trend or any effect from the intervention.

By the time of the maintenance interview, Mother E reported that her son's behaviour had settled, that he was soon to complete the requirements of his sentence, and that they had made plans for him to stay with family in Australia where he would be involved in physical work on a farm.

The family had been unsettled by the Canterbury earthquake in the previous month and this may have contributed to Mother E's older son taking increased responsibility for himself and at home. Mother E described her son as "a good support" over this time. At this interview Mother E reported that she was still using the same strategies of seeking appropriate times to communicate about important things, seeking opportunities to praise her children, and staying calm. She acknowledged that she didn't always manage this, but that the situation was definitely improved, and that all of her children had responded to rules and boundaries regarding behaviour and family roles.

Category 3: Family F

Mother and Stepfather F, who were parenting a 14 year-old son, attended all but one of the group sessions and completed the questionnaires on all three occasions. Only Mother F

took part in interviews as her husband felt unable to complete these due to work and other commitments. Teenager F also agreed to take part in the research and completed interviews and questionnaires at post-intervention and maintenance.

Throughout the time of the group intervention and the research Mother and Stepfather F described feeling frustrated and exhausted by their efforts to manage the behaviour of the two older boys, and especially the 14 year-old. Mother F reported that she and her son had experienced increased levels of conflict over the previous two years, although CYFS Youth Justice had only become involved in recent months.

At the baseline interview Mother F reported feeling unable to influence her older sons' behaviour. She described trying various consequences for non-compliant behaviour including taking her son's mobile phone and "grounding" but has found it difficult to enforce these. Mother F reported that her husband threatens the older boys with physical punishment and sometimes does hit them, however this usually leads to conflict between the married couple. In these situations Mother F described feeling forced to take sides, and usually supports her children.

Coping with the effects of their teenage son's challenging behaviour, alongside other life stressors, was impacting on this couple's relationship.

The family's scores on the CBQ are shown in the table below:

Table 6: Family F Conflict Behaviour Questionnaire results.

	Baseline	Post-intervention	Maintenance
Mother F	13	18	18
Step-father F	17	5	9
Son F	Not completed	Mother: 9 Father: 17	Mother: 9 Father: 9

All scores, except for that by Step-father F at the post-intervention phase, fall near or above the means for distressed families according to the normative data. This indicates a

consensus from the family members involved that they have a higher than average rate of conflict. It is interesting to consider these results alongside some of the feedback given by Mother and Son F during interviews. At the post-intervention interview Mother F reported that she had been trying to remain calm in her interactions with her son, but was finding this difficult due to stress, tiredness and frustration with his continued offending and challenging behaviour. At the post-intervention Son F reported having noticed that while his mother still got upset and angry, she no longer lost her temper. Both Mother and Son F reported that most of their conflict occurred in relation to Son F's involvement in offending or breaches in bail conditions, such as not being home before the time of his curfew.

At both the post-intervention and maintenance interviews Son F stated that he had noticed improvements in his relationship with both parents, but especially his step-father. According to Son F his step-father had taken opportunities to spend time with the children, and Son F had appreciated doing something fun together. Son F also said he had enjoyed having his parents talk with him and try to reach agreement about household rules. According to Son F, spending time together and feeling included in decision-making motivated him to improve his own behaviour toward his parents.

Both Mother and Step-father F completed CBCL forms at each of the three data collection points. Son F also completed the Youth Self Report (YSR) form of the CBCL at post-intervention and at maintenance. In order to be able to compare or contrast the ratings by each family member, the results of these are simplified into a series of tables below.

Table 7: Family F CBCL and YSR Responses at Baseline, Post Intervention and Maintenance.

<i>(a) Baseline Scores</i>						
	Problem Scales		Syndrome Scales		DSM Scales	
	Clinical	Borderline	Clinical	Borderline	Clinical	Borderline
Mother F	Total Externalising		Rule breaking Aggressive	Thought prob.	Opp Def Conduct	
Step-father F	Total Internalising Externalising		Social prob. Thought prob. Rule breaking Aggressive	Anxious/Dep Withdrawn/Dep Attention prob.	Affective ADH Opp Def Conduct	
<i>(b) Post Intervention Scores</i>						
	Problem Scales		Syndrome Scales		DSM Scales	
	Clinical	Borderline	Clinical	Borderline	Clinical	Borderline
Mother F	Externalising	Total	Rule breaking	Aggressive	Conduct	Opp Def
Step-father F	Total Internalising Externalising		Rule breaking Aggressive	Somatic Social prob. Thought prob. Attention prob.	Affective ADH Conduct	Somatic Opp Def
Son F	Externalising		Rule breaking		Conduct	
<i>(c) Maintenance Scores</i>						
	Problem Scales		Syndrome Scales		DSM Scales	
	Clinical	Borderline	Clinical	Borderline	Clinical	Borderline
Mother F	Externalising		Rule breaking		Conduct	
Step-father F	Total Internalising Externalising		Rule breaking Aggressive Social prob.	Somatic Thought prob. Attention prob.	Affective ADH Conduct	Somatic Opp Def
Son F	Externalising			Rule breaking	Conduct	

Key: CBCL = Child Behaviour Checklist. YSR = Youth Self Report CBCL.

Each of the family members who completed these questionnaires were quite consistent in their responses across the three data collection points. Mother and Son F's ratings were very similar. Son F's responses regarding his own behaviour suggest that he was less concerned about his antisocial behaviour than were his parents.

Step-father F's ratings identified more areas of concern than did the ratings by Mother F and suggest that he was particularly concerned about his relationship and communication with his step-son.

Mother and Step-father F's scores on the DASS are shown in Table 8.

Table 8: Family F Depression Anxiety Stress Scales results.

		Baseline	Post-intervention	Maintenance
Mother F	Depression	2	0	2
	Anxiety	0	0	0
	Stress	2	0	4
Stepfather F	Depression	24	32	34
	Anxiety	4	0	10
	Stress	18	22	26

There was a large difference between the Mother and Stepfather's scores on the DASS at all time periods. Mother F's comments during interviews indicated a feeling of exhaustion and of 'giving up' with regard to some of the challenges related to her son's offending and other stressors faced by the family. Given Mother F's visible distress during the interviews it appears that that she has chosen not to respond accurately to the questionnaires.

Stepfather F's responses on the questionnaires indicated high levels of depression and stress. His scores appear realistic in view of what is known about the family's situation, as well as what Stepfather F's CBCL scores indicate about his perception of the severity of his son's antisocial behaviour.

Mother and Stepfather F's scores on the PBS are shown in Table 9.

Table 9: Family F Parenting Beliefs Scale results.

	Baseline	Post-intervention	Maintenance
Mother F	93	77	89
Step-father F	80	85	69

All of these scores are well above the mean scores for families involved in the previous research that utilised this questionnaire, and indicate a higher than average level of dysfunctional beliefs regarding parenting.

Chapter 4 Discussion

The aim of the present investigation was to evaluate the implementation of a Group Teen Triple P programme provided to parents of young people who have recently engaged in criminal offending. This aim was only partly met as only two of the eight families referred to the agency actually completed the course and all three sets of assessment measures. Overall the results indicate that Group Teen Triple P had limited effectiveness when provided to this group of parents. Of the two families who did complete the Group Teen Triple P course, one parent reported a reduction in conflict with her teenage son by the time the third measure was taken, but the parents of the other family reported little change in their son's behaviour, although their questionnaire responses did identify fewer areas of concern. The teenager of this second family also reported reduced levels of conflict and increased opportunities for quality time with his stepfather and siblings.

A further four families started the course and took part in the research, and two more enrolled in the group but withdrew prior to the commencement of the Group Teen Triple P course. Of the four parents who began the Triple P programme, but did not complete it, Father A attended three sessions and completed the baseline interview and questionnaires, but then did not return and could not be contacted. Mother D attended four of the Group Teen Triple P sessions but withdrew from the group and research due to health problems. Mother B attended the baseline sessions and the first of the Group Teen Triple P sessions but withdrew because she felt the material was already familiar and did not easily apply to her circumstances. Mother B did complete all research questionnaires and interviews. Mother C attended the baseline sessions and the first two Group Teen Triple P sessions but then withdrew due to a crisis with her teenage son's behaviour. Mother C also participated fully in the research.

The present study has demonstrated that the effectiveness of a behavioural family intervention provided to parents of young people who have been involved with the youth justice system is dependant not only on the quality of the intervention itself but also on variables related to the implementation of that intervention. An unintended but nevertheless important finding is the high level of attrition of participants from the parent training intervention. This is a key feature of the results, and suggests a need to explore the question of why this occurred.

Previous Research on Attrition During Parent Management Training Programmes

Research into the implementation of parent training programmes is extensive. In the present study, the rate of attrition or ‘drop out’ of participants became a major consideration. Perhaps this should have been expected in view of earlier research which has established that up to 60% of parents withdraw prematurely from family treatments (Morrissey-Kane & Prinz, 1999). Furthermore, some groups of parents are more difficult to engage in parent training. This includes parents with few educational qualifications, parents with low incomes, parents from minority groups, single parents, very young parents, parents who engage in high rates of negative behaviour toward their children, and those who consider the intervention to have limited relevance to their situation (Assemany & McIntosh, 2002; Kazdin, Holland & Crowley, 1997; Reyno & McGrath, 2006).

The establishment of good rapport and a trusting relationship between the clinician or facilitator and parents is an important determinant of success in any parent training intervention (Allen & Warzak, 2000). In describing the foundations of the Triple P programmes, Sanders et al. (2003) state that “clinical skills such as rapport building, effective interviewing and communication skills, session structuring, and the development of empathic, caring relationships are important to all forms of family intervention” (p. 19). Where a

positive working relationship is developed between parents and clinicians, the attrition rate is likely to be greatly reduced (Kazdin et al., 1997).

Morrissey-Kane and Prinz (1999) reviewed research regarding the role of parental attributions in determining the effectiveness of parenting interventions. Their review found that in most situations mothers maintain a positive bias toward their children's behaviour, so that they perceive positive behaviour as stable and negative behaviour as transitional. These attributions in turn contribute to parents having a positive view of the effectiveness of their own parenting responses. Conversely, mothers of children with behaviour problems tend to attribute the cause of this misbehaviour to stable aspects of the child's disposition, thereby minimising their own responsibility for, or the potential for achieving positive change in, the child's behaviour. One of the challenges then, in providing successful parenting interventions, is whether the programme which is being offered is congruent with parents' beliefs and expectations, or not.

Forehand and Kotchick (2002) suggest that parental perceptions and expectations can be included in the therapy process. This can be achieved firstly, by asking parents to share their ideas on the nature of their child's behaviour and their expectations about what needs to be done to alter it. This provides information about what might need to be addressed before skills training is initiated. Secondly, parents who hold unrealistic expectations regarding children's behaviour can be educated about appropriate developmental expectations. Third, parents who have become overly focussed on negative aspects of their child's behaviour may benefit from therapist modelling of recognition and acknowledgement of strengths and positive qualities. Fourth, therapists can offer explanations of the social learning principles that underlie parent training techniques. Parents who have some understanding of why they are being asked to do certain things and how behaviour management works may not be so frustrated by the demands placed on them or on setbacks they may experience.

Alongside the high attrition rate from parent training interventions is the fact that parents do not adhere to the programme requirements. Allen and Warzak (2000) identify three types of conditions that contribute to the consistency with which recommendations are implemented. These are: (a) insufficient ability to understand and achieve the skills or functions required, (b) interventions which require time, materials or living conditions which are outside the economic resources of the family, and (c) a level of social isolation which prevents the involvement and support of others which are necessary in order to implement the treatment recommendations.

Overarching the variables associated with the therapists who deliver these treatments, and the parents or families who receive them, are the organisational contexts in which they occur. Evidence-based and manualised treatments are not necessarily typical of the services provided by agencies that offer social services to children and young people and their families.

Practitioners may have concerns regarding the changes to their practice that are necessitated by using evidence-based programmes. They may lack confidence that a manualised programme will have the flexibility to address the specific needs of individual clients, or feel unsure of their own effectiveness with a new intervention. Agency support, appropriate training and supervision are required, and it is essential that the clinical staff delivering these programmes are committed to delivering them with a high degree of fidelity in order to achieve favourable outcomes (Fixsen et al., 2005; Sanders & Turner, 2005). Furthermore, organisations are usually reliant on wider systems for resourcing of the services they provide and are thereby reliant on their approval or collaboration in upholding specific treatment methods.

Causes of Attrition or Poor Adherence in the Present Investigation

Several of the factors identified in the preceding section operated to affect the group recruited for the present research. The impact of these variables is discussed in this section.

Therapist failure to meet the requirements of the parents in the group. In the current study the therapists facilitating the group anticipated some of the challenges of engaging these parents. The three Introductory sessions provided prior to the Group Teen Triple P programme were intended to establish a sense of familiarity and cohesion in the group, and to allow time to identify and address any potential practical obstacles to the parents' attendance. In addition it was hoped that continuing the group sessions concurrently with the telephone support would address any uncertainty or isolation that the parents might experience.

There is little doubt that the two facilitators had the clinical skills for working with these parents, and one was already known to participants. The fact that the two facilitators were of different professional backgrounds, and that there was a male and female facilitator, can be considered strengths of this arrangement. It is possible that the facilitators did not take adequate account of the diverse circumstances of the parents in the group, perhaps finding it difficult to address within this particular group.

The aims of the programme run counter to the beliefs or expectations of the parent. Some parents involved in the present study attributed their teenager's antisocial behaviour to stable, dispositional factors, such as their psychiatric diagnoses. They therefore believed that the behaviour management strategies which form the basis of the Triple P programme were unlikely to have a significant impact on their children's behaviour. The parents who held these beliefs were likely to be less hopeful of favourable outcomes, and less motivated with

regard to specifying changes which they would like to make, than parents who attributed their teenager's behaviour to situational or transitional factors (Morrissey-Kane & Prinz, 1999). These possibilities are congruent with the relatively high scores recorded by most parents on the Parenting Beliefs Scale, indicating the presence of dysfunctional beliefs about their own effectiveness in influencing their children's behaviour.

One of the parents who enrolled in the programme but withdrew prior to beginning the Triple P sessions reported that her daughter's psychiatric diagnosis was the reason for her challenging behaviour. Furthermore, the mother stated she had participated in a similar parenting programme in the past, but had not had any success in modifying her daughter's behaviour. Mother B also withdrew prematurely from the group and cited the fact that her son's behaviour was significantly influenced by his mental health diagnoses. Mother B also described feeling guilty about her son having an unstable family situation during his early childhood. It seems likely that these circumstances contributed to Mother B finding it difficult to challenge her son's antisocial behaviour.

The parent does not perceive the programme to be relevant to their needs at this time.

Two of the parents involved in this programme stated that they had previously completed parent training programmes with similar content. One attended only the Introductory sessions and the other some of the Group Teen Triple P sessions as well before discontinuing. In these cases the young people concerned had both had prior involvement with other educational, health and social services due to longstanding problems with antisocial behaviour. These parents described having attended what they considered to be similar parent education programmes in the past, and to have found these to have limited relevance to their own situations.

During the group sessions and research interviews, parents reported finding that some of the material did not easily apply to their own circumstances. Parents whose teenagers had previously been involved with mental health services doubted whether the strategies described would work for them. Like other versions of Triple P, the Group Teen Triple P programme relies on DVD scenarios to illustrate the use of skills and strategies being taught in the group. The situations conveyed in these relate to relatively minor misbehaviours when compared to those that the present families were facing. The group facilitators attempted to overcome this discrepancy by asking the parents for their own examples and discussing these amongst the group. This was successful in achieving participation from the group but some resistance remained with regard to the parents' perception that the programme content was overly simplistic.

For example, it is possible that some of the parents believed that a treatment involving active parent participation is less relevant in the treatment of adolescents who have already begun to depend less on their families as a primary source of support (Nock & Ferriter, 2005).

The family is overwhelmed by events. Allen and Warzak (2000) identify time and material resources as one of the factors contributing to parental adherence to treatment. When Mother C withdrew from the programme she explained that she was facing a crisis situation with regard to her son's behaviour and needed to prioritise the family's immediate needs, including safety, as well as maintaining her employment, over the parenting group. Mother C was a single parent with two younger children as well as a teenage son who was involved in offending. When her eldest child's behaviour placed her younger children at risk she felt compelled to focus on finding a solution that ensured their safety. The family were also reliant on Mother C's income and she therefore placed a high degree of importance on retaining her employment.

Mother C participated fully in the research, and by the time of the maintenance interview was able to report that her son had received a custodial sentence and other treatment in response to his behaviour at the time of her withdrawal from the parenting group. She had also invited a friend to come and stay with her to assist with parenting and supervision, and reported that this arrangement was working well as the children had established a good relationship with this adult. In considering Kazdin et al.'s (1997) observation that single parents are among those less likely to successfully engage in parent training programmes, it makes sense that Mother C found her parenting challenges more manageable when she had the company and assistance of a friend.

The parent only responds to the negative behaviour. In the group sessions as well as the research interviews Mother F reported feeling exhausted by the demands that her son's offending placed on her. Her scores on the DASS questionnaire were very low. It is possible that her feeling of despondency has enabled her to pull back from the situation and therefore to be less emotionally effected by it. This seems unlikely and is incongruent with her tearfulness during interviews. At the time of the post-intervention interview Mother F reported that her son was appearing in court that morning to face new charges, but that she had decided not to support him by attending on this occasion. Mother F struggled to find examples of positive qualities or behaviours in her son and described a sense of having given up on having any effect on his behaviour. Mother F described feeling ashamed of the impact that her son's offending had on other people, and despairing of the fact that she could not trust him or his friends with her own belongings.

This sense of exhaustion and powerlessness was a barrier to trying new parenting strategies or communication styles. Diminished motivation and a feeling of helplessness contributing to a reduced likelihood of attempting to take steps toward positive change.

Mother F described trying to limit her son's access to a mobile phone as a consequence of misbehaviour. She had abandoned this however after her son looked through her belongings in search of the phone. Mother F described finding it increasingly difficult to enforce consequences for behaviour she found unacceptable.

Non-engagement due to failure to meet the needs of parents with mental health problems. In the current study three of the parents who enrolled in the programme subsequently identified themselves as having mental health problems. One parent withdrew from the programme prior to the commencement of Group Teen Triple P and reported that she had been given medical advice to rest due to her fragile mental health. Mother B reported having long-standing problems with depression, although she did not describe this as a current concern. Mother D also withdrew from the programme at a late stage for mental health reasons. Mother C's circumstances present a number of risk factors for possible depression, anxiety or stress, including being a single parent, coping with her teenage son's challenging behaviour and balancing work and family responsibilities. The fact that her questionnaire responses did not highlight any mental health concerns may be due to protective factors such as the skills and knowledge she has from her own professional training and the boundaries she has put in place for coping with her son's behaviour.

It is widely believed that parent training is less effective with parents who have mental health problems, such as depression. Morrissey-Kane and Prinz (1999, p. 193), for example, argue that "failure experiences lead parents to attribute the cause of their children's problems to factors within the child, to believe that the negative behaviour was intentional, and to view such problems as stable (i.e. dispositional) and unchangeable." They further report that depressed mothers often fail to see the improvement in their children, and hence are not reinforced or encouraged by this improvement. Forehand and Kotchick (2002) concur that

parent training is likely to be less effective for parents with severe mental health problems, or other serious family or relationship issues, and they suggest that it may be better to delay parent training until these problems have received sufficient attention.

Preventing Attrition and Maintaining Programme Effectiveness

Consideration of the reasons why parents either withdrew prematurely from the parenting group, or did not implement the strategies and skills they learned from the Group Teen Triple P programme, provide insights into the conditions that have to be met in order for this kind of intervention to work. Triple P, and other evidence-based parent training programmes, have been successfully implemented with diverse populations of parents (de Graaf, et al., 2008), and it stands to reason that the limiting factors identified in the current study would need to be overcome in order to improve the success rate of future implementations. The answer to this does not lie in varying the programme from its manualised form. Evidence-based interventions which are delivered with high levels of fidelity in the real world produce results which are closer to those observed in efficacy trials than interventions delivered with less fidelity (Forgatch, Patterson & DeGarmo, 2005).

Allen and Warzak (2000) suggest that the contingencies influencing parental adherence to the skills and strategies they have learned are as vital to the effectiveness of the intervention as the contingencies influencing the young people's behaviour. They propose a functional analysis of the factors influencing parental adherence to treatment. This process involves consideration of the parent's prior experience, which would take account of intergenerational patterns of behaviour, both positive and coercive, within families. It would also involve other individual factors such as cognitive functioning, practical considerations such as time, materials and financial resources, and the social isolation or connectedness of the family.

When a parent training programme is unsuccessful this is likely to be due to the interplay amongst a number of variables. Adding to the complexity is the fact that the reasons provided by parents for withdrawing from treatment may not accurately reflect the true barriers (Morrissey-Kane & Prinz, 1999). Therefore, in order to continue to build on the knowledge base surrounding effective parenting interventions, it is valuable to identify factors that maximise the potential for success.

Selection of parents who are likely to benefit. In the present study, some of the parents who enrolled in the group did not meet the intended entry criteria. In particular, some of the young people concerned had been exhibiting antisocial behaviours over several years, receiving attention from a range of support services, rather than having begun to do so during adolescence. It is possible that the rate of attrition would have been less, and the level of engagement somewhat greater, if a more rigorous intake process had ensured that the families involved in this intervention had met the stated entry criteria. For example, a screening or selection interview with the parents could have established their interest in participating in the group as well as gathering details regarding the course of the teenagers' offending behaviour.

In the current research it was thought that it would be sufficient to restrict referrers to two teams of comprised of counsellors and social workers, and to educate these practitioners about the entry criteria. This proved not to be the case, which made it more difficult for the group to develop a sense of cohesion from common experience.

Making it as easy as possible to get to meetings. Some of the reasons that parents give for withdrawal from programmes are related to practical issues such as the timing of sessions, childcare arrangements, financial costs or transport. These are issues that should be considered, in partnership with parents, as part of the intake or enrolment process. The group

involved in this study was held on Wednesday evenings during autumn. Parents were praised on arrival for their commitment to coming out in the dark and sometimes in cold weather. The intake process did include checking with parents regarding childcare arrangements for younger children, and also whether they had transport to come to the group. There had been agreement from PSUSI to provide some assistance with either of these if required. The parents who participated in this group did not give these reasons for not attending, and in fact did collaborate amongst themselves to share transport on some occasions.

Forehand and Kotchick (2002) emphasise the value of ensuring that basic needs are adequately addressed, as parent training is more likely to be successful if these practical requirements have been addressed. This consideration would be particularly relevant in dealing with families with limited income, those who are socially isolated, or those who are highly stressed, that is, the families involved in the present research.

Selection of agencies and facilitators that are trusted by parents. The significance of the relationship between clinicians providing a parent training intervention, and the parents who are the recipients of it, has already been noted here, and is well recognised in earlier research (Allen & Warzak, 2000; Sanders et al., 2003).

The facilitators of the group parenting intervention examined here represented two very different agencies and roles. One facilitator was employed by CYFS and the other by PSUSI. One was male and the other female. One was a social worker and the other a child and family psychologist. The CYFS facilitator was previously known to some parents from his role in casework related to Youth Justice Family Group Conferences. Parents appeared to have a positive regard for this facilitator who presented as non-judgmental, warm and knowledgeable about the challenges they were facing. In spite of this, the role of CYFS staff in implementing the principles and procedures of the Children, Young Persons and Their

Families Act could potentially have had a constraining effect on the parents ability to be open and trusting in the group. The PSUSI facilitator was not previously known to participants. She was the most familiar with the programme material and took a lead role in its presentation. Her gentle manner, and attentiveness to individual participants, seemed encouraging to parents. Overall the facilitators' personal qualities and engagement skills appeared conducive to the development of an effective therapeutic relationship (Forehand & Kotchick, 2002).

Spending as much time as is necessary to establish positive working relationships between the group members and between the facilitators and each group member. Nock and Ferriter (2005) reviewed several studies which have examined the effects of various pre-treatment strategies designed to improve engagement and participation in parent training interventions. Research indicates that any contact prior to the commencement of a programme appears to increase the likelihood of attendance at the first session, although not necessarily for subsequent sessions. Providing parents with information about the intervention appears to increase the accuracy of parental expectations regarding treatment, but again has not been found to contribute to increased attendance over the course of the intervention. A pre-treatment interview has also been shown to have a positive, but inconsistent, effect on treatment attendance. Nock and Ferriter conclude that, given the brevity and simplicity of these measures, they could be added to treatment protocols for the benefit they provide to initial engagement.

Use of supportive and facilitative, as opposed to more confronting, forms of communication have also been shown to have a positive effect on attendance and adherence to treatment (Forehand & Kotchick, 2002; Nock & Ferriter, 2005).

In planning the present group the facilitators made the decision to provide some additional sessions prior to commencing Group Teen Triple P. These were intended to ensure that all of the parents taking part in the group had similar knowledge of the systems and pathways that the youth justice system operates within. It was hoped that through these sessions parents would obtain practical information and also begin to build a sense of common ground and cohesion with other participants. However, this was not sufficient, as the attrition of participants demonstrates.

Taking the time to address attitudes and beliefs that will interfere with parent management training. The fact that parents of children with behaviour problems are more likely to attribute their behaviour to stable, dispositional factors has already been explored. In addition it has been shown that parents who attribute their children's behaviour to external causes beyond their control are more likely to withdraw prematurely from parent training programmes than those who believe their child's behaviour is a function of dispositions within the child (Morrissey-Kane & Prinz, 1999).

Some of the parents involved in the present study described feeling powerless to influence their teenagers' behaviour. They reported that the contingencies they could implement were ineffective, and in some cases the parents were so exhausted by issues relating to the offending that they felt unable to address less severe behaviour occurring in the family home. When interviewed about strategies they used to manage challenging situations or conflict, some parents reported that they would contact the Police or CYFS. While this would be an appropriate course of action when faced with risky or threatening situations, it is also an indicator of the parents reduced sense of control over, as well as responsibility for, their teenage children's behaviour.

In order for parents to feel motivated about implementing behaviour management techniques, such as those taught in Triple P, they first need to develop confidence in the effectiveness of their own parenting, and in the potential for their child or children to achieve positive change in their behaviours. Scott and Dadds (2009) suggest that facilitators offer encouragement to parents by reframing their efforts at implementing new strategies as “heroic”. Highlighting examples when parents have been successful helps the parents to establish a sense of self-control and in turn reduces negative attributions about the child. Morrissey-Kane and Prinz conclude (1999, p.190) that modifying parental blaming attributions “is likely to take sustained effort throughout the course of treatment.”

Moving through the training goals at a speed which is right for all the group members. In the manual for Group Teen Triple P, Sessions 5, 6 and 7 are delivered by telephone. During the planning for the group examined for the current study, it was considered that the break in group meetings that was scheduled to take place over these sessions presented a greater risk of parents disengaging than if the group continued to meet. It was also reasoned that some of the Triple P content would take longer to work through with this client group, and that the additional group sessions would allow increased time for teaching, practicing and discussing the skills involved.

The telephone sessions were implemented by the researcher following Session 4 of the Triple P material. These phone calls appear to have been useful in terms building a rapport with the participant, contributing to their motivation to remain involved.

In spite of these measures to increase the opportunities, and thereby the likelihood, that parents would understand and adhere to the programme, parents were reluctant to engage with several key aspects including goal setting, role plays and maintaining consistent contingencies around the teenagers’ behaviour. The reasons for this probably relate to a number of variables

that have been discussed in this section. A further consideration is that parents had not understood the strategies sufficiently to be able to implement them. Allen and Warzak (2000, p. 381) note the possibility that, “even after a clinician has reduced an intervention into the smallest, manageable steps, the task is still too complex for a particular parent. In such cases, however, it would be difficult to argue that the clinician had selected an appropriate intervention.”

In a group setting it may be difficult for parents to acknowledge that they are having difficulty understanding the material being presented. It is the responsibility of the facilitator to be aware of this potential, and hence able to provide appropriate additional training when required. In the current study parents were given opportunities to revise programme content during the telephone contacts and at the beginning of each group session. However there was no direct assessment of whether cognitive ability or skill comprehension was an obstacle to adherence in the present investigation.

Providing sufficient positive reinforcement for attending, engaging, and doing the practice exercises. Allen and Warzak (2000) explored the social reinforcement that can be put in place to motivate parental compliance with treatment procedures, and discuss the fact that this is most likely to be effective when a good rapport is achieved between the parent and the clinician. In the context of a group intervention, the cohesiveness between group members has potential to add a further dimension to this. In view of the high risk of attrition, and the use of resources involved in this, full consideration should be given to establishing conditions that parents find reinforcing.

The nature of reinforcement in parent training, and ethical issues surrounding this, has been considered in previous research. Rewards can be offered for attendance and for progress. The possibility of paying a small “parenting salary” upon completion of assigned

tasks may increase treatment compliance and reduce attrition, particularly for lower income families (Forehand & Kotchick, 2002).

Conclusions.

The conclusions that can be drawn from this research are limited due to the small number of participants, namely six families, and the fact that only a proportion of these, two families, actually completed the Group Teen Triple P intervention. Perhaps the most interesting results pertain to the implementation of the treatment and the surprisingly high rate of attrition of participants from the group.

Examination of the findings from this research has been considered in the context of earlier research regarding factors contributing to attendance and adherence to parent management training programmes. An overview of some of this research identified variables related to the successful implementation of parenting interventions. These include the organisational context of their delivery, the characteristics of the parents involved, and the relationships between participants and the clinicians who provide or facilitate the parent training programme.

Use of evidence-based interventions may be unfamiliar practice to some clinicians, and to the organisations they are part of. There is a risk of poor engagement with parents if practitioners deliver these interventions according to manualised directions without also considering the multitude of other factors that influence their success. While it is important to maintain the fidelity and integrity of evidence-based treatments, their effectiveness will be optimised if they are delivered in situations where participants are appropriately selected and well prepared for the treatment requirements, and where practitioners do not lose sight of the significance of their engagement skills and personal qualities in establishing a therapeutic relationship.

There is no doubt then, that the determinants of parental attendance and adherence to treatment are many and varied, and that “no single characteristic appears to be necessary or sufficient for dropping out...Rather multiple influences accumulate as risk factors to increase the likelihood that families drop out of treatment” (Kazdin et al., 1997, p. 453). The contingencies necessary to motivate parents to attend and to adhere to treatment programmes need to be as powerful as those that are intended to produce positive changes in the behaviour of their children. In order to optimise the likelihood of achieving positive change it is recommended that practitioners give careful consideration to the contextual variables operating within the families they are working with prior to offering this kind of help.

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Appendices

Appendix A Human Ethics Committee Approval

Human Ethics Committee

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Ref: HEC 2010/52

12 May 2010

Victoria Newcombe
Health Sciences Centre
UNIVERSITY OF CANTERBURY

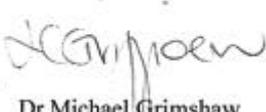
Dear Victoria

The Human Ethics Committee advises that your research proposal "Evaluation of group intervention for parents of youth offenders" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 10 May 2010.

Best wishes for your project.

Yours sincerely


PP Dr Michael Grimshaw
Chair, Human Ethics Committee

Appendix B Participant Information Sheet

Health Sciences Centre

Associate Professor Ray Kirk, Director
Tel: +64 3 366 7001 ext. 3108, Fax: +64 3 364 2490, Email: ray.kirk@canterbury.ac.nz



Programme evaluation for 'Parenting Tools for Our Times' Information Sheet

My name is Victoria Newcombe and I am currently training to be a Child and Family Psychologist. As part of my Master of Science course at the University of Canterbury I need to carry out a research project that involves work with parents and children that helps them to overcome a problem or concern they may have had. I have chosen to evaluate the 'Parenting Tools for Our Times' course.

I am also employed, on a part-time basis, by Presbyterian Support. I am a qualified social worker and work in a management role within the organisation.

This is the first time this group has been offered and it is important to be able to measure whether participating in the group makes any positive difference to you and your families. So, this evaluation will be carried out for the purposes of Child Youth and Family and Presbyterian Support being able to see if the programme has been worthwhile, and the information gathered will also be used for my own university research report.

It is important for you to know that this research has been reviewed and approved by the University of Canterbury Human Ethics Committee.

♦ **What are the aims of this research?**

To learn more about what is effective in helping parents to manage their teenagers' challenging behaviour.

To learn more about what helps parents and teenagers to maintain good communication and relationships.

To learn more about what helps parents to feel more positive about their own skills and abilities.

This project is separate from the Client Satisfaction Surveys asking for your comments about the services provided by Presbyterian Support.

♦ **What will it mean to 'take part' in the project'?**

You will be asked to give your consent to be interviewed on 3 separate occasions – once prior to the start of the group programme, once on completion and once about 2 months after that.

Each interview will take approximately 1 to 1.5 hours and will involve completing some questionnaires as well as some questions and discussion.

You will be contacted to make a time to meet with an interviewer.

You can say where you prefer the meeting to take place, such as at home or at the Presbyterian Support offices.

You will be asked if you are willing to give consent for you teenager to also be interviewed.

You can have a support person with you during the interviews if you prefer.

♦ **Who will be doing the interviewing?**

Interviews will be carried out by me and one of the programme facilitators.

(Appendix B continued)

♦ **What happens if I am uncertain during the interview?**

You can stop taking part in the interview at any time.

You do not have to answer any questions you are not comfortable with.

If more time is needed that will happen only with your agreement.

Assistance can be arranged if any issues come up during the interview that you require help with, or, if you wish to seek additional support for yourself, information about support services can be provided.

♦ **What happens to the information I give during the interview?**

Everything you and your teenage child tells us will be used only for the purpose of the research. You will not be identified in any way when the information is used. The data being collected for the evaluation is reducible to numbers, proportions and patterns and will not include individual case histories. If there is any exception to this type of reporting of data, then specific permission will be sought for this from the participants involved.

Participation in this research is voluntary. You may ask for your data to be withdrawn at any time up to the point when the data analysis has begun, and do not have to give a reason for this. Withdrawal from the research project will not affect any ongoing or future relationships with Presbyterian Support, CYFS, Child Youth and Family Youth Justice or the University of Canterbury.

The information from this evaluation research will be used for the purposes of a Master of Science thesis, which is a public document and accessible online via the University of Canterbury's library. Any information you provide is confidential. The only exception to this is if there is reason to believe that you or someone else is at risk of harm. If this happens I would talk with my supervisor who would help to make a plan to ensure safety.

This information will be used for the purposes of the programme evaluation described above and for the report I write for my university thesis.

♦ **How will I benefit from being part of the project?**

What you tell us will be a valued part of what is learned from this research.

The information you give us will be used to develop and improve services.

You can receive a copy of the research report, or a summary of the outcomes, if you wish.

I hope that this information sheet answers some of the questions you may have about taking part in this evaluation research, but if you have any other concerns, please contact me or one of my university supervisors:

Victoria Newcombe Tel: 363 8229 or victorian@psusi.org.nz

Dr Karyn France Tel: 3642 987 x6610

Dr John Church Tel: 3642 987 x6544

Appendix C Participant Consent Form

Consent Form

I have read the information about the research being conducted to evaluate the 'Parenting Tools for Our Times' group. This evaluation will involve meeting with the researcher for interviews and completion of questionnaires on 3 occasions for about 60-80 minutes each time. I agree to take part.

I understand that the information I provide in questionnaires and interviews will only be used anonymously for research purposes, unless my safety or the safety of others is at risk.

I am aware that the data from this evaluation will be used for Presbyterian Support and Child Youth and Family to make decisions about future programmes, and also for the purposes of a Master of Science in Child and Family Psychology thesis.

I am aware that Presbyterian Support can arrange free professional assistance for me if concerns come up during the research that I require help with.

I am aware that I can stop taking part in the research, and/or request that my information be withdrawn from the evaluation, at any time up until the data has been analysed.

Name.....

Signature.....

Date.....

Contact phone number.....

I would like the interview to take place at

(eg my house/ Presbyterian Support)

(Appendix C continued)

Are you also willing to give permission for your child to be asked to participate in the evaluation?

I give permission for (name of the young person) to take part in the evaluation research for the 'Parenting Tools for Our Times' group.

I understand that this will involve interviews and completion of questionnaires on 3 occasions and that this will take about 60-80 minutes each time.

I understand that the researcher will be asking my child to give their own consent to participate in the research.

Name of parent/caregiver.....

Signature of parent/caregiver.....

Date.....

Appendix D Interview questions

The following is the description of the unstructured interviews, which was included in the application to the University of Canterbury Human Ethic Committee.

“Interviews included discussion relating to:

- the nature and quality of communication between family members, including rate and severity of conflict;
- strategies used by parents to manage their children’s behaviour, including where there are specific techniques or ideas they have learned from the group and utilised at home; and
- the perceptions that the parents have of their own competency in managing challenging situations, and the teenagers perceptions of this. In particular whether either parents or teenagers notice any changes in this in the course of the evaluation research.”

Questions used in interviews were:

- Can you tell me a bit about your relationship with (your teenager)? How well do you think you communicate or get along with each other?
- Can you tell me about a time when you and (your teenager) disagreed about something? How often does this sort of thing happen?
- Can you tell me about what you do to try and manage (your teenager’s) behaviour?
- Have you had the opportunity to try any of the strategies from the group? Tell me more about that.
- How well do you think you are managing (your teenager’s) behaviour? How are you feeling about this?
- Have you noticed any change in this since completing the Triple P parenting group?