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# A REVIEW OF PUBLISHED LITERATURE ON SUPPORTING AND STRENGTHENING CHILD- CAREGIVER RELATIONSHIPS

(PARENTING)

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES



**MAY 2013**

This publication was made possible through the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development under contract number GHH-I-00-07-00059-00, AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I.



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## **AIDS Support and Technical Assistance Resources Project**

AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with BroadReach Healthcare, EnCompass LLC, International Center for Research on Women, MAP International, mothers2mothers, Social & Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

## **Recommended Citation**

Richter, Linda M. and Sara Naicker. 2013. *A Review of Published Literature on Supporting and Strengthening Child-Caregiver Relationships (Parenting)*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

## **Acknowledgments**

Thank you to the reviewers who provided excellent feedback and insight on the first draft of this document: Kate Iorpenda, Senior Advisor: Children and Impact Mitigation, International HIV/AIDS Alliance; Joan Lombardi, Senior Fellow, Bernard van Leer Foundation; Nancy Geyelin Margie, Research Fellow, Office of Planning, Research and Evaluation, Administration for Children and Families, U. S. Department of Health and Human Services; and Nurper Ülküer, Child Development Expert.

Additional thank you to Gretchen Bachman, Senior Technical Advisor, PEPFAR Orphans and Vulnerable Children Technical Working Group Co-Chair, Office of HIV/AIDS, USAID; Janet Shriberg, M&E Technical Advisor, Orphans and Vulnerable Children, Office of HIV/AIDS, USAID; and Marcy Levy, Orphans and Vulnerable Children Advisor, AIDSTAR-One.

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# ACRONYMS

ADHD	attention deficit and hyperactivity disorder
AIDS	acquired immunodeficiency virus
AIDSTAR-One	AIDS Support and Technical Assistance Resources Project
BFI	behavioral family intervention
BPT	Behavioral Parent Training
CBT	Cognitive Behavior Therapy
CCT	conditional cash transfer
CD	conduct disorder
CDC	U.S. Centers for Disease Control and Prevention
CDI	child-directed interaction
CPRT	child-parent relationship therapy
CSDH	Commission on the Social Determinants of Health [World Health Organization]
CSG	Child Support Grant [South Africa]
DSD	Department of Social Development [South Africa]
ECD	early childhood development
GRADE	Grades of Recommendation Assessment, Development and Evaluation
HIV	human immunodeficiency virus
LAMI	low- and middle-income [country]
MAR	mother at risk
NICU	neonatal intensive care unit
PCIT	Parent-Child Interaction Therapy
PDI	parent-directed interaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFP	Protecting Families Program
RCT	randomized control trial
SASSA	South African Social Security Agency
SES	socioeconomic status
STEEP	Steps to Effective and Enjoyable Parenting
STEP	Systematic Training for Effective Parenting

TALC	Teens and Adults Learning to Communicate
UCT	unconditional cash transfer
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
USAID	U.S. Agency for International Development
VIPP	Video-feedback Intervention to Promote Positive Parenting
WHO	World Health Organization



# EXECUTIVE SUMMARY

The remit for this literature review was to undertake a review of published literature from 2000 to 2012 and to summarize empirically based recommendations for supporting and strengthening child-caregiver relationships in the context of AIDS and poverty. The review covers children generally, and takes a strengths-based approach that builds on the resources and capacities of children, caregivers, families, and communities. The review is not limited by geographical scope, but draws on what are considered universal features of children's development and their relationships with caregivers, though specific variables may be influenced by cultural and local context. The review took into account the broad body of research on supporting and strengthening child-caregiver relationships or parenting in order to extract general principles to guide discussions on the implementation of parenting programs in contexts affected by HIV and AIDS and poverty.

Key findings include the following:

- Families comprise the key response to children affected by AIDS and poverty and are a critical platform for sustainable interventions to support and protect affected children.
- Globally, funders, policy makers, and program implementers have accepted that family strengthening is a core component of sustainable and effective responses to protect children affected by AIDS and poverty. While economic assistance is recognized as a key aspect of a family strengthening approach, less is known about effective methods for supporting parenting and caregiving.
- Although very few studies on strengthening parenting have been conducted in settings in which children and families are affected by AIDS and poverty, there are solid grounds for optimism based on positive results from parenting support programs in high-income countries and expertise gained over nearly 100 years of interventions to support parenting.
- Many of the existing evidence-based programs are culture-bound and labor-intensive, and would be difficult and costly to reproduce in low- and middle-income countries. However, it is not known what degree of fidelity to such programs is required to achieve beneficial effects. The research available attests to the wide flexibility of programs within a set of known parameters associated with greater effectiveness.
- There is good reason to assume that the theoretical bases for parenting programs—attachment theory, language acquisition, and social learning, among others—are universal mechanisms despite the fact that they manifest differently under various sociocultural conditions. In addition, the goals of parenting programs in high-income countries—to improve parental facilitation of children's health and development, to reduce parental stress, to improve family well-being, and to manage difficult child behavior—resonate with the known needs of caregivers and children affected by AIDS and poverty, although these also vary according to context.
- Efforts to strengthen parenting are justified by the known impacts of HIV and poverty on children and families. Parents and other caregivers are under stress, children are in danger of

being neglected and critical aspects of their human potential lost, and parent-child and family relationships may suffer as a result of adversities arising from poverty and isolation.

- The studies reviewed together provide good evidence for the value of ongoing parenthood support programs, especially those for young mothers and other caregivers facing particular challenges that put them at high risk for parenting problems. In the context of HIV and poverty in low- and middle-income countries, these at-risk groups are likely to include parents and other caregivers living with HIV, destitute families in high-HIV prevalence areas, aged caregivers, caregivers or children living with a disability, and socially isolated caregivers with little social support.
- Promoting early child development is an enormously promising area, with indications that parenting programs aimed at improving children's development have not received the attention they merit. There is very good reason to expect that programs to promote early language and literacy development are feasible, that they could be used to promote positive relationships between parents and children, and that they will benefit children's language and cognitive development as well as their transition to school. This potential can be greatly enhanced if efforts to promote children's learning are embedded within broader child health partnerships, as occurs in many large-scale programs in high-income countries.
- The effectiveness of parent programs aimed at improving parent-child relationships and better child behavior management are very well supported by evidence from high-income countries. Caregivers of children affected by HIV and poverty report concerns about children's behavior resulting from bereavement, dislocation, disadvantage, and stigmatization. Behavioral problems range from those related to anxiety and depression to acting out, rebelliousness, and aggression. There is a great deal of promise for the design of programs to assist parents and other caregivers, situated within broader efforts to address structural constraints such as poverty, stigma and discrimination, need for child care, and assistance with schooling. Programs to enhance parental sensitivity, to support responsive parenting, and to facilitate parental knowledge and skills are backed by evidence of effectiveness, and may be especially suited for families in which children are born to parents living with HIV. Such families face a number of challenges, including management of parental HIV, infant diagnosis and treatment, challenges to infant growth and development, and specialized infant care if required.
- Evidence from programs to prevent abuse suggests that children and families identified as cases require professional services and intensive intervention. However, efforts to promote greater child and home safety and to eliminate harsh punishment through mass media approaches and training in verbal and behavioral limit setting have been successful. Both safety and child discipline programs are relevant for families living under conditions of high-HIV prevalence and poverty.
- Many lessons have been learned with respect to implementation issues, including parameters of programs that enhance feasibility, acceptability to parents, and effectiveness. These parameters include understanding what parents need and want from a support program; setting clear goals; making local adaptations; using structured messages and attractive and easy-to-read supplemental materials; employing peer trainers, practice, and feedback; involvement of men; inclusion of children where appropriate; ensuring good links and networks with other services; providing material aid when needed; and assistance to families to enroll and continue to participate in parent support programs.

- Social support in the form of encouraging family and peer assistance, and befriending programs has emerged as a key component of successful parent support interventions. This may be included in a variety of delivery methods for parenting support, including outreach, home visiting, and enrollment in group activities.
- Mass media approaches present many possibilities for sharing knowledge about children’s development and knowledge, social norms about discipline, household and child safety, the importance of talking and reading to children, and so on. These can be implemented through a wide variety of mechanisms, including child-to-child approaches, talks in communities and health centers, print, radio, and television. In areas where parent strengthening approaches are being introduced, mass media should be used to prepare for such programs and to reinforce their messages in the broader community. This is the approach taken in Level 1 in the Triple P Parenting Program.
- Parent support programs need to be situated within a broader context of improved structural enablers for parenting. Depending on context, such enablers include protection from human rights violations, protection from stigma and discrimination, economic relief, child care, and assistance with children’s education. The difficulties parents experience as a result of structural factors such as poverty and stigmatization should not be assumed to be addressed by person-centered parenting programs. Experience in several countries indicates that parenting programs are less effective and parents feel alienated and are likely to drop out if parenting interventions do not adequately acknowledge and address the socioeconomic and other challenges experienced by parents.
- As parent programs are developed and implemented to support families and children affected by HIV and poverty, every effort must be made to accumulate experience and an evidence base on which to make decisions to improve effectiveness and to support expansion. Across the evidence reviewed for this paper, the quality of studies declines as they are applied to more marginal families—poorer families, migrants and immigrants, non-Western cultural groups, and families living in low- and middle-income countries. This variability is a major impediment to greater investment in parenting support programs and a significant barrier to iterative programmatic learning and more effective interventions.



# TECHNICAL NOTE

Five appendices are attached to this report: Appendix 1 outlines the methods used; Appendix 2 gives a brief outline of the quality of the available evidence; Appendix 3 contains short summaries of qualitative reviews, overviews, and systematic reviews; Appendix 4 provides short descriptions of identifiable parent support programs and where they have been implemented; and Appendix 5 provides the complete list of papers sourced for the literature review. Papers included in the report's reference list refer to materials relevant to the line of argument developed in the report. These are listed in full only if they do not appear in Appendix 5.

While every effort has been made to achieve a comprehensive review of interventions to strengthen caregiving and parenting with potential for application in low- and middle-income countries affected by poverty and HIV and AIDS, it is very likely that we have missed papers because of the limitations of both electronic and manual search procedures.



# GLOSSARY

For ease of understanding, the following terms are highlighted and defined according to the way they are used in the report.

Caregiving	<i>Caregiving</i> is used interchangeably with <i>parenting</i> , though <i>parenting</i> is the preferred term for long-term care of a child.
Family strengthening	Programs and interventions to support the family and caregiving system, including parenting.
Parenting	The generic category of caregiving a child in a stable, intimate, and caring relationship—not restricted to biological parents.
Parent education	Information and education about children, child development, or other aspects of parenting.
Parent support	A broad range of programs and intervention to support one or more aspects of parenting.
Parent training	Formal training programs based on a curriculum and usually delivered through group sessions.
Parenting interventions	As with parent support—a broad range of programs and intervention to support one or more aspects of parenting.





# INTRODUCTION

In addition to extensive literature on child development, much of which discusses some aspect of parenting or caregiving (Biglan et al. 2012), the literature search for this project identified more than 660 relevant peer-reviewed papers on the topic of parenting support—of more than 2,400 potential publications listed in PsycINFO alone (Lucas 2011). This includes more than 83 systematic reviews and overviews published since 2000.

*...more than 600 relevant peer-reviewed papers on 83 synthetic and systematic reviews on parent support...*

We conducted the literature search in accordance with the best practice review methodology (Cochrane Collaboration 2006), focusing on children and parenting and/or caregiving in general. In addition, we used probe search procedures to identify recent reviews of interventions on particular topics. We summarized the findings on interventions to support and strengthen caregiving and, from the review and additional papers, extracted general principles and lessons learned to support and strengthen child-caregiver relationships and parenting in contexts in which children and families are affected by HIV and AIDS in low- and middle-income countries.

Apart from producing a short, readable, and useful report, the most significant challenge was to link this very large body of knowledge on the value of parent support interventions targeting low-resource settings with what we know and has been documented about the challenges facing caregivers and families of children affected by HIV and AIDS (Richter et al. 2009; Franco et al. 2009). The list of references assembled (see Appendix 4) indicate that almost all the available research has been conducted in the United States, the United Kingdom, Canada, and Australia, with a few papers coming from a handful of other high-income countries like Finland, the Netherlands, and Japan). Within these studies, there is very little reference to cultural diversity or minorities, an issue commented on in several of the systematic reviews. The findings from individual studies, meta-analyses, and other research syntheses are limited in their generalizability to ethnic minorities, even in high-income countries. There are very few studies set in low- and middle-income countries. We identified papers, most of them descriptive studies, and limited to specific aspects of parenting or family life, set in Brazil, the Canary Islands, Chile, Haiti, Iran, Jamaica, Jordan, Lebanon, Pakistan, Puerto Rico, South Korea, Tanzania, Turkey, Uganda, and others. We have tried to make it clear which of the principles extracted and recommendations made are based on direct empirical evidence and which are based on interpretations of potential value and feasibility.



# FAMILIES AND HIV

Very large numbers of children are directly and indirectly affected by the HIV and AIDS epidemic and by the contexts of poverty, inequality, and social instability in which the disease has flourished. Globally, in 2011, children made up 13.2 percent of all new infections, and, some 3.4 million children were living with HIV (UNAIDS 2012b; 2012a). In the same year, 230,000 children died as a result of AIDS-related causes (UNAIDS 2012a), and in 2009, 16.6 million children were estimated to have lost one or both of their parents to AIDS (UNAIDS 2010). Both HIV-infected and HIV-exposed but uninfected children suffer additional mortality and morbidity (Filteau 2009; Isanaka, Duggan, and Fawzi 2009).

Most children (> 80 percent) who have lost a parent to AIDS have a surviving parent, most often their mothers (Richter 2008), and almost all double orphans live with extended family (Richter et al. 2009). But the families and communities of both orphaned and non-orphaned children are challenged by AIDS. In high-burden countries in southern Africa, as many as two-thirds of families are estimated to be affected by an AIDS-related death, caring for an AIDS-sick person, or sharing a household with someone living with HIV (Belsey 2005). In low and concentrated epidemics, the children of people in marginalized groups who are affected by HIV and AIDS are often stigmatized and excluded from services (Franco et al. 2009).

The rapid expansion of treatment is bringing benefits. Parental mortality—that is, the death of a mother, a father, or both—is decreasing (UNAIDS 2010). Sub-Saharan Africa had 1 million fewer AIDS-related deaths in the period from 2001 to 2009. The President’s Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis and Malaria; other local and international donors; and governments have provided resources to mitigate the impact of HIV and AIDS on children, but the reach and scale of these efforts are minimal. It is estimated that only 11 percent of households caring for orphaned and vulnerable children receive any form of support external to the family (UNICEF 2011).

Families were the first to respond to children affected by AIDS, both in the United States and in southern Africa (Frierson, Lippmann, and Johnson 1987; Beer, Rose, and Tout 1988), and they have continued to be the vanguard of care and support for affected children. The same pattern of response has been seen in China, India, Eastern Europe, and other sites of concentrated AIDS epidemics (Bharat 1999; Franco et al. 2009; Li et al. 2008). When parents become ill or die, their spouses, siblings, parents, other family members, and neighbors help with or take on the care of affected children—as kith and kin have always done during times of calamity and misfortune (Rutayuga 1992).

*... families continue to be the vanguard of care and support for affected children ...*

Family and kin are usually the most appropriate source of support for vulnerable people and, in the poorest communities, where there is little or nothing in the way of services provided by government or civil society organizations, they are often the only form of support (Iliffe 1986). This general trend of *mutuality by necessity* does not romanticize families nor gloss over family schisms that can adversely affect children, including when such schisms are occasioned by HIV and AIDS and are exacerbated by stigma and shame, competition for inheritance, and the like (Bahre 2007).

Families are an inherent aspect of human social organization; nevertheless, under social and individual stress, they may not be able to meet children's needs and can become dysfunctional and potentially damaging (Goode 1963). But the idea of "family breakdown" at a societal level is misguided (Mathambo and Gibbs, 2009). Families dissolve and re-form as part of the life and death cycle of change. Even during war, calamitous natural disasters, and genocide, family groups continue to form as the central pillar of social organization for human beings, and the critical foundation for ensuring the current and future well-being of children. Residential group care with paid staff is not a substitute for the family, as is now recognized by scientists who study children as well as by international agreements and conventions (McCreery 2003). Residential group care must, in all cases, be temporary, until suitable family arrangements can be made. This is especially important for young children.

# PARENTING AND HIV

*Parenting* is a functional term for the processes of promoting and supporting the development and socialization of a child. Under most circumstances, children will be parented by their mother and/or their father. However, parenting functions can be independent of biological relationship; thus, for a range of reasons, children are also parented by grandparents, siblings, other family, foster parents, and so on.

In addition to their parents, children in many non-Western cultures are parented by several people, with all of whom they have intimate and secure relationships. This is true in southern Africa, where families regard the siblings of a mother or father as “big mother” or “little father” to a child, depending on birth order (Chirwa 2002; Verhoef 2005). For this reason, the more general term *caregiving* is sometimes used, to include also “parenting” of children by people other than biological parents.

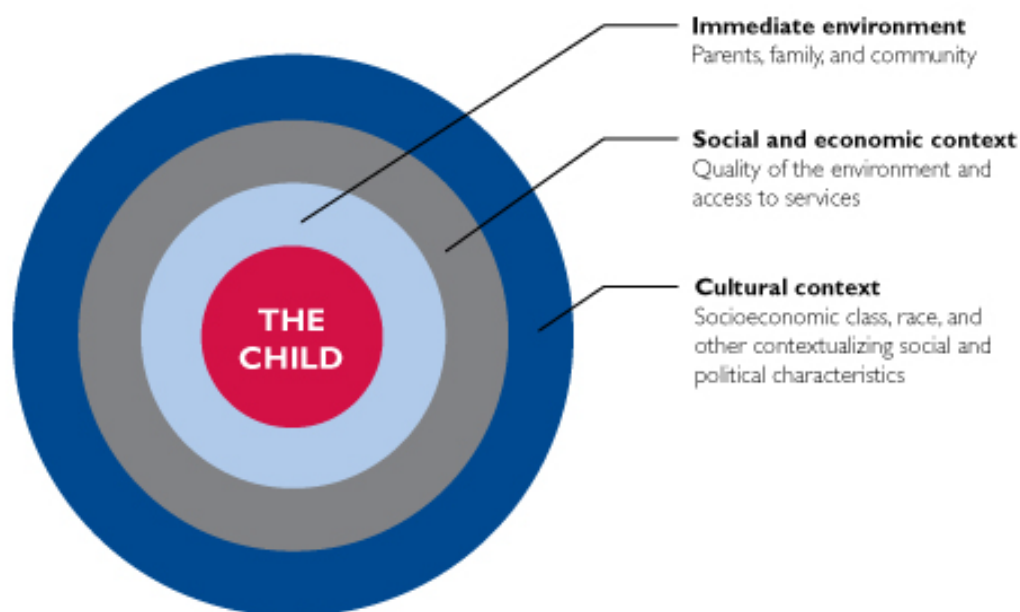
For the earliest period after birth, the vast majority of children will be cared for by their biological mother, especially while the baby is being breastfed. However, infants and young children develop strong emotional attachments to all the people with whom they have regular loving contact, including their father, if he is present, siblings, and other people living in the household (Levitt and Cici-Gokaltun 2011). In turn, these caregivers develop parenting motivations and emotions, which are expressed in their desire to care for and protect the child with affection (Papousek and Papousek 1987). This “intuitive parenting” is evoked when adults take responsibility for the well-being of a child toward whom they are emotionally well-disposed (Dozier and Lindhiem 2006). These positive parental motivations are associated with supportive caregiving (Dix 1991).

The circle of people who constitute “the family” for the child may comprise both biologically related and non-related people, depending on culture and social and individual circumstances (Demo, Allen, and Fine 2000). In the first three years of life, this group of people together forms the most important determinant of the child’s experiences of the world and, for most people, their family remains a fundamental influence on their behavior, values, and achievements for all of their lives. In Bronfenbrenner’s (1986) biopsychosocial ecological model (see ), the child is at the center of parents and family. The household, in turn, is nested among kin and neighborhood. The family interfaces with a variety of services and other institutions, such as schools and clinics, that characterize the social and economic context, and all, together, are situated within a broad cultural and political environment.

*... for most people, their family remains a fundamental influence on their behavior, values, and achievements for all of their lives.*

Parents and close family members comprise the proximal environment for young children. The child’s world is the family—materially, socially, and psychologically—and parents and family also mediate the impact of the broader environment on the young child. Factors such as the quality of the neighborhood, the state of water and sanitation, and ethnic conflict impact the child through the protective capacity and actions of parents and families. For example, if parents keep a child away from dangerous waste or practice hand washing and water boiling, the same environment impacts that child differently compared to one whose parents do not.

**Figure I. Schematic representation of Bronfenbrenner's (1986) biopsychosocial ecological model**



Empirical studies on the impact of HIV and AIDS on children and families are well documented (Foster and Williamson 2000) and indicate both stress and coping (Caldwell et al. 1993; Hosegood et al. 2007). HIV and AIDS potentially drains the capacities of families by reducing income and destabilizing livelihoods and family structure, creating anxiety and grief among adults and children, and increasing dependency and stigmatization, which tear at family and community connectedness (Richter et al. 2009). The epidemic has its worst impacts in contexts characterized by poverty, social instability, discrimination, and exclusion, making it harder for those affected and their families to continue to function in customary and supportive ways (Drimie and Casale 2009). Social exclusion and impoverishment make it harder for caregivers to continue to draw on the emotional and material support of extended families and neighbors, increasing their isolation and further eroding their coping capacity (Bravo et al. 2010).

Affected families and children face a range of stresses associated with disclosure and stigmatization, chronic illness, grief and bereavement, residential instability, potential abuse and maltreatment, and changes of residence and caregivers. The rate of depression among HIV-positive people is high (Bhatia et al. 2011), and a recent report indicates higher-than-expected rates of alcohol use among HIV-positive women (Desmond et al. 2011). Because emotional, human, and financial resources are stretched or depleted, the stresses associated with HIV and AIDS make it more difficult to cope with the challenges confronting all families. Finally, AIDS-associated disability often adds another layer to already-difficult conditions (Rohleder et al. 2009). The combinations of these HIV-specific and HIV-related factors, together with individual and family-level risk and resilience affect parenting, caregiver-child relationships, and family functioning, with secondary effects on children (Murphy et al. 2010; Tomkins and Wyatt 2008).

Despite the known adverse impacts of HIV and AIDS on families, parenting, and child-caregiver relationships, there is a near-complete absence of research on interventions that are effective and

have the potential to be scaled up in both high-prevalence and concentrated epidemic settings. Family reunification and support, mainstays of disaster work (Blake and Stevenson 2009; Vernberg 1999), have not been systematically applied in the HIV and AIDS context and, despite the call for family-centered approaches for children affected by HIV and AIDS, little has been done to expand services beyond small-scale programs (Richter 2010). Efforts to support child-caregiver relationships developed in the United States, for example, by Rotheram-Borus et al. (1997), are sometimes seen to lack feasibility for wide-scale application in resource-poor environments.

It is for these reasons that this review was commissioned—to consider how parental support can be implemented in the context of HIV and AIDS by reviewing what is already known from descriptive and experimental studies conducted in high-income, and where it exists, low- and middle-income countries.





# SUPPORTING PARENTING, STRENGTHENING CAREGIVING

More is published on what adversely affects parenting than on how to support and strengthen caregiver-child relationships. For example, socioeconomic stress is a significant determinant of parenting (Yoshikawa, Aber, and Beardslee 2012), as is parental mental health, especially depression, which is now known to be prevalent among both mothers and fathers of young children (Paulson and Bazemore 2010).

*More is published on what adversely affects parenting than on how to support and strengthen caregiver-child relationships.*

One reason for this bias in our knowledge is that parenting is an embedded process. It is invisible and the requirements for good parenting are tacit. They only become clear when parenting is disturbed in some way. Parenting becomes conspicuous when it seems unnatural, as in the case of new reproductive technologies; when it is deemed inappropriate or risky, as occurs with teen parenting or parenting in poverty; when the parenting bond is broken by separation or death; when parents face challenges as a result of substance abuse or mental health problems; when parenting is made more difficult by disability experienced by the parent or the child; and when parenting is abusive or neglectful. We know that all of these factors damage parenting and, as a result, children's health, development, well-being, achievement, and adjustment are put at risk.

It is difficult to define parent support because it encompasses so many aspects of social and family support, including being financially secure; enjoying social inclusion and acceptance; having the capacity to live with one's children; and access to services to safeguard children's health and give them opportunities to learn, which provide families with a safety net when they are in trouble. For many parents, it also means commitment, sharing, and assistance from a partner and a wider family network.

In most high-income countries, parent support corresponds to a considerable degree with *parent training programs*. Parent training, in turn, includes a wide variety of approaches largely directed toward one or more of three general goals:

1. **To enable parents to better promote and facilitate their child's health, development, and achievement.** This is particularly salient when the knowledge and skill to parent effectively is not fully formed or when parents lack confidence (e.g., as in first-time parenting, teen parenting, or foster parenting) or when parenting is compromised by specific challenges (e.g., disability experienced by the parent or the child, poor mental or physical health, poverty, immigration, parental imprisonment, substance use, interpersonal violence, or parental death or desertion).

2. To **help adults to parent children with less stress, fewer problems, more satisfaction with parenting and family life**, and to foster or preserve parental mental health and the couple relationship and, in general, improve family well-being.
3. To **help parents to manage *difficult* child behavior**. Difficult behavior refers to aggression and oppositional behavior, tantrums, poor peer relationships, non-compliance to parental instructions, and the like.

Of course, many parent training programs go beyond these general goals and are highly specific to particular challenges, such as preventing (Barlow et al. 2007) or treating (Barlow et al. 2006) child abuse and neglect, assisting parents of children with chronic illnesses (Barlow and Ellard 2004), improving children's linguistic preparedness for school (Boyce et al. 2010), and promoting fathers' engagement with children (Cowan et al. 2009).

It is clear that each of these general goals of parenting programs arise in a specific historical, cultural, and social context that is, to a greater or lesser degree, specific to high-income Western countries, and may be more or less applicable in non-Western contexts. For example, parenting is not a solo activity in many traditional societies. Child care is frequently shared because of cultural beliefs that children belong to families and clans rather than to one or two individual parents. This results in what has been called "socially distributed nurturance" (Weisner 1997). It may also be shared by necessity within families and kin because of work and livelihood commitments in the absence or unaffordability of child care (Heyman 2006). As a consequence, information (or misinformation) and skill (or lack of it) may be shared within a caregiving network of related women. To some degree this can help to mitigate lack of preparation and confidence for parenting, help to compensate for some forms of compromised parenting, and lessen the strain on the couple and family relationships. But it is also possible that such shared parenting may serve to sustain harmful practices, such as beatings and humiliation meted out to children, and their group endorsement may make them more resistant to change by an informed parent.

Further, the nature of what is regarded as "difficult" behavior by children differs across cultures. The structure of traditional societies and families is hierarchical, and children have a particular place and specified role in the hierarchy. Children acquire "social responsibility" within an interdependent society that entails respect for elders, compliance, and obedience (Super et al. 2011). Respect and obedience by children significantly reduces caregiver-child conflict, as seen also in the United States. Higher levels of respect and obedience have been found among children in Latino and African-American as compared to European American families and child compliance (Dixon, Graber, and Brooks-Gunn 2008). Cultural differences modify the interpretation and context of what is seen to be "difficult" behavior by Western cultures.

This does not mean that research conducted in the West is not relevant to societies in the South that are heavily impacted by HIV and AIDS. Many low- and middle-income countries are urbanizing rapidly and traditional structures and practices are breaking down, exposing families to many of the parenting stresses long experienced in the West. Moreover, HIV and AIDS are themselves changing families and the requirements of childcare and parenting, as indicated earlier. The challenges of poverty, substance abuse, disability, death and more affect families in many of the same ways no matter where they occur. And there is some evidence that conduct disorders and negative peer relations that manifest in early childhood have common pathways to poor adolescent and adult adjustment (Simonoff et al. 2004).

A great deal of research has been conducted on parenting support in high-income countries, some of it of very good quality. This research has resulted in robust evidence that has been brought

together in synthetic reviews, overviews, and meta-analyses. There is much to learn from these studies that can guide the development of programs to support parenting in low- and middle-income countries in ways that benefit children affected by HIV and AIDS. In turn, though, as such programs are developed, they themselves will have to be subjected to rigorous evaluation, as well as comparisons with alternative interventions to benefit children. Such research is essential in resource-constrained settings, where policy makers have to reach decisions about which children's services to support to achieve a given outcome at a specified cost. Such decisions always entail social value as much as social-scientific judgments (Stevens, Roberts, and Shiell 2010).

*A great deal of research has been conducted on parenting support in high-income countries, some of it of very good quality. This research has resulted in robust evidence that has been brought together in synthetic reviews, overviews and meta-analyses. There is much to learn from these studies that can guide the development of programs to support parenting in low- and middle-income countries in ways that benefit children affected by HIV and AIDS.*



# THEORETICAL ORIENTATIONS IN PARENT SUPPORT

Regardless of their particular theoretical origins, most parenting support programs operate within a transactional model of parent-child relations (Sameroff 2009). That is, they assume that parental beliefs and actions affect children; reciprocally, children's beliefs and actions affect parents. These transactional processes are capable of producing virtuous and vicious cycles of interaction that become embedded with short- and long-term positive or negative outcomes for children, parents, and the family.

Parenting support programs aim to change parental beliefs and actions with the goal of changing child behavior which, in turn, is likely to lead to changes in parental well-being, including improved couple and family relationships. Improvements in parental well-being and the quality of caregiver-child and couple relationships and family life are likely to nurture better communication, more parental attention for positive child behaviors, and increases in child adaptive behaviors. Better parent-child relationships are also more conducive to teaching and learning, as well as parental guidance about risk behaviors and negative peer influences.

*Parenting support programs aim to change parental beliefs and actions with the goal of changing child behavior which, in turn, is likely to lead to changes in parental well-being including the couple and family relationships.*

Parent support programs are loosely grounded in four distinct theoretical orientations. They are loosely grounded in the sense that parent support programs are theoretically informed, but by and large, empirically and practically determined by the particular purposes of the program. Many programs incorporate elements of all four theoretical approaches in multidimensional interventions:

1. Adlerian psychology assumes that human beings aspire to develop and achieve through their interconnectedness with others. By this view, parents can help children to achieve their psychological and behavioral goals through the use of logical and natural consequences to child behavior, mutual respect, and encouragement (Adler 1935). Popkin (1993) added aspects of communication theory to the basic approach of developing "empathy training" for parents. That is, **parents are helped to understand their child's behavior in terms of the child's purposes and to guide the child to achieve their adaptive goals.** The most widely implemented parent training program based on Adlerian psychology is Systematic Training for Effective Parenting (STEP) (Dinkmeyer and Dinkmeyer 1979).
2. Attachment theory based on the work of Bowlby (1969) and others **stresses the importance of secure attachments to consistent, sensitive, and responsive caregivers in the first two years of life.** Parent support programs that promote secure attachment focus on making parents aware of their young children's communicative signals and appropriate caregiver responses to them. Attachment programs have successfully

incorporated individual videotaped feedback into parenting support. Examples of such approaches are the Circles of Support (Marvin et al. 2002) and the Steps to Effective and Enjoyable Parenting (STEEP) (Erickson and Egeland 2004) programs.

3. Social learning theory, based on the work of Bandura (1977), postulates that **children learn in social contexts, from observing the behavior of others**, particularly parents. Programs based on this approach help parents to understand the effect of their behavior on children and how to change their own behavior, also by using group and video feedback. Well-known programs based on these principles include Project Teens and Adults Learning to Communicate (TALC) (Rotheram-Borus et al. 2001) and Video-feedback Intervention to Promote Positive Parenting (VIPP) (Lawrence et al. 2012).
4. Cognitive behavioral therapies, based on the work of Beck et al.(1979), aim to **change the way parents interpret and respond to children's behavior**. For example, parents commonly assume that difficult children have motives to “test the limits,” “wind them up,” or “get them back.” These interpretations arouse emotions in parents which lead to behaviors that frequently escalate rather than resolve interactional difficulties. Cognitive approaches help parents to identify distorted thinking and adopt rational interpretations of a child's behavior. Examples of programs that incorporate cognitive behavioral principles are the Incredible Years Parenting Programme (Webster-Stratton 1992) and the Protecting Families Programs (PFP) (Boyd, Diamond, and Bourjolly 2006).

A number of commentators on parent support interventions have drawn attention to the programs' lack of attention to context (Nelson, Laurendeau, and Chamberland 2001), systemic thinking, and structural interventions. Many programs include mothers only, rather than mothers and fathers, and very few take into account other potentially influential members of the family, such as grandparents, older siblings, and aunts and uncles—with the unintended consequence that these members feel excluded and may undermine positive changes (Mockford and Barlow 2004). There is also generally very little attention given to cultural factors or parenting styles (Sanders and Woolley 2005), the wider systems of which families are a part, or poverty, discrimination, and other social and structural causes of inadequate parenting and/or poor child outcomes (Lucas 2011; Nelson, Laurendeau, and Chamberland 2001).

# CHARACTERISTICS OF PARENT SUPPORT INTERVENTIONS

Parenting interventions in their current form originated in the 1920s. There are several different types of parent interventions—for example, mass media, family-school-community coalitions, group programs, home visiting, and intensive parent-child guidance and therapy. Some programs, such as Triple P, include many or all of these types of intervention. The proliferation and diversity of parenting interventions are illustrated by the fact that in 2010, 140 different parent programs were registered in one database in the United Kingdom (Lucas 2011). Short descriptions of programs included in the review, illustrating different types of approaches, are provided in Appendix 3.

Interventions may directly target parental behavior (e.g., trying to change parents' thoughts and actions, teaching parents how to encourage a child's schoolwork), or they may be indirect, helping parents by giving them social support, assisting them with employment, or in other ways reducing stresses that interfere with effective parenting or are associated with punitive childrearing (Sweet and Appelbaum 2004).

Almost all parenting interventions have been developed, implemented, and evaluated in urban settings in the United States, the United Kingdom, Australia, and Canada (McNaughton 2004). It is estimated that about half of all programs are conducted in community settings and the other half are divided equally between facilities such as clinics and day centers. Many parent interventions are conducted by professional nurses, psychologists, and/or social workers, some by trained non-professionals and peers (Thomas et al. 1999; Bunting 2004; Sweet and Appelbaum 2004), and a small proportion are self-help programs with varying degrees of facilitator or therapist support (O'Brien and Daley 2011; Sorge, Moore, and Topiak 2009).

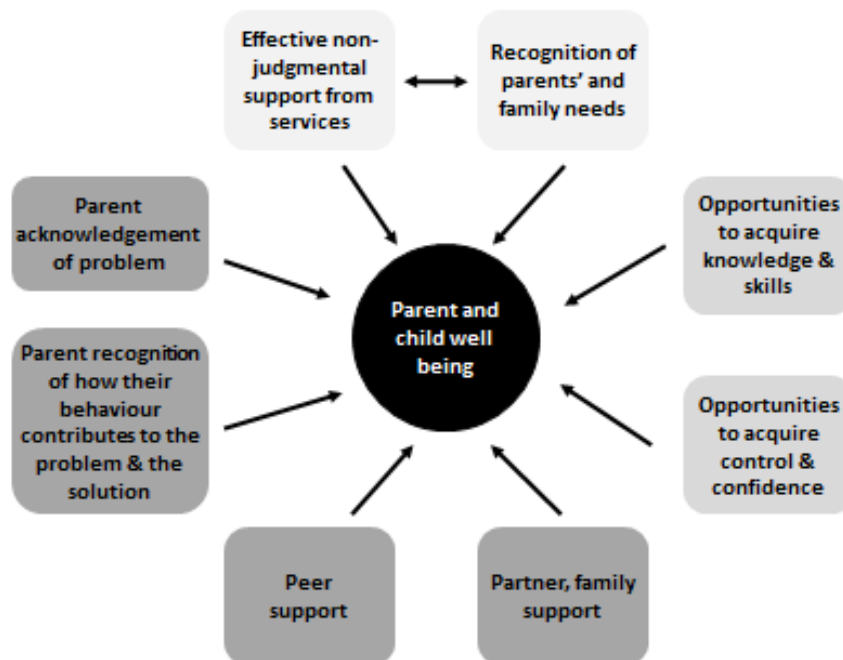
Many programs target low-income parents, on the basis of the threats to parenting due to socioeconomic stresses. About half include parents considered to be at risk of poor parenting, child abuse, or neglect (Thomas et al. 1999; Bunting 2004). The majority are directed at parents of children younger than five years of age, and tend to focus on behavior problems. Fewer than half of all programs include fathers.

*Parenting interventions have a wide range of objectives, but social support is reported by both parent participants and professionals to be highly valued.*

Parenting interventions have a wide range of objectives, but social support is reported by both parent participants and professionals to be highly valued (Thomas et al. 1999). Social support takes the form of access to goods and services (Ayón 2011), information, and guidance (Mbenkenga et al. 2011), and an opportunity to make friends, share troubles, and counter social isolation (Letourneau, Stewart, and Barnfather 2004; Smith-Fawzi et al. 2012). Social support provided by partners, families, peers, and professionals have positive effects on a wide range of parenting aspects, including self-perception, coping, and mental health (Gardner and Deatrck 2006). In a model proposed by Kane, Wood, and Barlow (2007), social support is core to the mechanisms by which

parenting interventions advance parent and child well-being. An adapted version of the model, developed from a synthesis of qualitative research, is shown in Figure 2.

**Figure 2. Social Support in Parent and Child Well-Being (adapted from Kane, Wood, and Barlow 2007)**



In addition to social support, almost all parent support programs include the following elements, among others (Taylor and Biglan 1998):

- **Information** on children’s age and stage developmental capacities, gender differences, and temperament, and other expressions of individuality to counter unrealistic expectations of appropriate child behavior.
- **Promotion of positive parenting strategies** and effective discipline.
- Emphasis on the **importance of listening to children** and giving verbal explanations and directives in order to create channels for communication that displace coercive and other harsh disciplinary practices.
- **Explanation of pro-sociality**, such as cooperative behavior with peers, compliance to parental requests, and verbal problem solving in preference to physical aggression.
- Understanding of the parents’ perspective and **responding to parental needs, and promoting self-efficacy, self-esteem, and self-confidence in parents.**

These goals are attained by a variety of methods that may set out in a formal manual or are more spontaneous or responsive to individual or group needs. Didactic teaching, demonstration and



illustration, modeling, and group or videotape feedback are used, in conjunction with teaching aids, notebooks, diaries, homework assignments, and the like. Sessions may include both children and parents or combine parallel and joint sessions, and programs may run from a few days to several years.

Home visiting is a mechanism used in many parent support programs. In some, home visiting is the core method for conveying information, support, and linkages to at-risk parents and families, such as in the U.S. Nurse-Family Partnership devised by Olds et al. 1997; in others, it is one method within a multi-modal approach, such as in Fast Track (Greenberg, Domitrovich, and Bumbarger 2001), Head Start, and Healthy Families America (LeCroy and Krysik 2011) in the United States, and Philani Plus in South Africa (Rotheram-Borus et al. 2011). It has been noted that few, if any, programs articulate a theory about the mechanisms of home visiting and, like other parenting interventions, the frequency of home visits vary widely, from weekly to every two to three months. McNaughton (2004) lists 19 different interventions in home-visiting programs. These include anticipatory guidance, assessment, breastfeeding promotion, counseling, developing the nurse-family relationship, encouraging the use of child preventive health services, enhancing parental self-esteem, establishing trust, focusing on the mother's concerns, provision of health and child development information, health and social services, listening, mobilizing social support for parenting, problem solving, promoting child development, referral, screening, and the provision of social support. Sweet and Appelbaum (2004) estimate that there are thousands of home-visiting programs in the United States, of widely differing kinds. Home-visiting programs range from those that are tightly constructed and implemented with maximum fidelity to the original design (such as the Nurse-Family Partnership of Olds et al. [1997]) to those that encourage local adaptation of the purposes and methods of home visits and other intervention components, such as Sure Start in the United Kingdom (Melhuish and Hall 2007) and Communities for Change in Australia (Edwards et al. 2011).

In sum, parenting support interventions, including home visiting, have been designed in many variations tailored to the specific needs of the target population, the issues addressed, and the resources available. While the diversity of parent support programs is a strength, not all have been found to be effective. Unfortunately, as will become clear further on in the report, the knowledge base is not yet sufficient to indicate which delivery mechanisms in which programs are most effective for different target groups with unique characteristics.



# EFFECTIVENESS OF PARENTING SUPPORT

Overviews of parenting support programs and interventions, such as this one, can be organized in different ways. For example, they can be organized by mode of the intervention, such as center-based, home visiting, individual counseling at services such as clinics, groups sessions at clinics, and so on, as was done by Walker (2011) in her review of interventions to promote equity through early child development programs. Or an overview can be organized by the title of the parent program, such as Incredible Years (Webster-Stratton 1992), Strengthening Families (Kumpfer, DeMarsh, and Child 1989), Triple P-Positive Parenting Program (Sanders 1999), or Systematic Training for Effective Parenting (STEP) (Robinson, Robinson, and Dunn 2003).

However, there are problems with both these ways of organizing the available evidence. First, modes are not programs, nor do they have specific purposes. As pointed out earlier, home visiting may be a feature of many different programs and may be used to accomplish a very wide range of goals. In many programs, home visiting is used to follow up with especially vulnerable families who are not reached by community-based programs. Moreover, mode of delivery may not be relevant to the efficacy of the program; for example, no differences in effect have been found for Triple P programs whether delivered individually, in groups or through self-help (de Graaf et al. 2008).

The problem with organizing material by the title of the program is that the best-known programs are all behavioral family interventions (BFI) based on social learning principles to reduce family risk factors associated with child behavior problems (de Graaf et al. 2008). That is, they are parenting programs that have been developed to reduce child non-compliance, aggression, oppositional behavior, tantrums, and acting-out behavior. These are not necessarily the key concerns of all parents seeking support.

In the following section, we provide very short overviews of the evidence in five categories of parent support interventions, organized by the central purpose of each program. These purposes are:

- Preparing for parenthood
- Promoting early child growth, development, learning, language, and education
- Child behavior management
- Family relations and child protection, and
- Parental well-being.

## Parents want:

- To be involved
- To be provided with information
- To learn practical skills
- Social support from family
- Their confidence to be built
- To meet people in the same circumstances as themselves
- To be referred to the services they need.

We also summarize some implementation issues remarked on in the literature. Although we did not undertake unique searches for papers on specific categories within these topics, we identified a large number of relevant individual studies, as listed in Appendix 5. The conclusions we draw are based on overviews, comprehensive reviews, and meta-analyses (see Appendix 3). Between 2000 and 2012, with two important papers a year before (1999) and a year after (2013), we identified 83 overviews, qualitative reviews, and systematic reviews.

The descriptions that follow are built up progressively, so that evidence presented in an earlier section, for example, on home visiting, is not repeated in a subsequent section.

## **PREPARATION FOR PARENTHOOD**

These programs include intervention that helps prepare for parenthood and its progression through various phases of childhood, including both first-time parents and parents facing new challenges. Groups included are teen parents, first-time parents, prospective parents, foster parents, parents facing challenging circumstances, such as those occasioned by a preterm baby or a child with a chronic illness or disability, drug-using parents, parents living with a disability or mental illness, and programs that aim to increase father engagement.

The available literature is clear that these groups **of parents feel assisted and reassured by interventions that involve them in the care of their child** (Brett et al. 2011), **provide them with the information they need and practical skills for dealing with the problems they experience** (Coren et al. 2010), aid them in making the transition to home care (Matson, Mahan, and LoVullo 2009), **facilitate increased social support from family** and significant others (Letourneau, Stewart, and Barnfather 2004), **help build their confidence** as parents, **connect them with peers** with whom they can share experiences (Kane, Wood, and Barlow 2007; Mercer and Walker 2006), **and link them to the types of services they need.**

All types of parents benefit from accurate factual information, using a range of media, though the gains are greatest for high-risk groups (Moran, Ghate, and van der Merwe 2004; Shaw et al. 2006). **Parent information and education programs are more effective when they focus on concrete issues**, such as health care, home safety, child development, harsh physical punishment, monitoring and protection, and substance use. Mass media can be used to emphasize the importance of parents in children's lives, children's normative ages and stages, social norms about discipline, household and child safety, the importance of talking and reading to young children, and so on (Daro 1994; Daro and Gelles 1992; Kishchuk et al. 1995). The preference for concrete information and examples applies also to skill building, which has optimal uptake when it is **practical and includes "take home and try" tips** (Moran, Ghate, and van der Merwe 2004). Programs that attempt to change parental attitudes without providing parents with specific child management and parent-child interactions skills, and opportunities to practice them, are less successful. Other broad-based approaches, especially those that involve social support, such as "befriending" programs, and outreach to isolated parents, are especially valuable (Moran, Ghate, and van der Merwe 2004).

The most extensive and substantial research has been published on teen parenting, particularly in the United States. Parent support programs have been found to help teen mothers to feel more confident, be more responsive to their babies, and enhance the quality of their interaction with their children (Barlow et al. 2011; Coren, Barlow, and Stewart-Brown 2003; Riesch et al. 2010), as well as to improve clinic attendance, immunization rates, and child growth (Akinbami, Cheng, and Kornfeld 2001).

The most robust evidence for achieving improved parenting, children's outcomes, and use of services comes from nurse home-visiting interventions for high-risk mothers that employ professional staff (McNaughton 2004). Among other benefits, studies have found that such programs enable teen mothers to continue their education (Sweet and Appelbaum 2004). Gardner and Deatrck (2006) also found positive effects for home-visiting programs that sensitize mothers to infant cues and teach specific skills such as infant massage.

In general, mothers prefer face-to-face contact to video instruction in preparing them for parenthood or the challenges of parenthood (Mercer and Walker 2006), but there are also encouraging results from programs that provide telephone support to women during pregnancy and postpartum as an adjunct to other services (Dennis and Kingston 2008).

In their review, Gagnon and Sandall (2007) determined that studies on antenatal education for the general population were too variable to support any conclusions about benefits. However, a review of support interventions for new parents found that programs beginning during the antenatal period and continuing during the postnatal period were associated with a significant positive effect on all assessed outcomes: parenting, parental stress, health-promoting behavior of parents, cognitive and social and motor development of the child, child mental health, parental mental health, and couple adjustment (Pinquart and Teubert 2010). Evidence supports the implementation of a wide range of interventions in the perinatal and postnatal period, with beneficial impacts on parents and the parent-infant relationship (Barlow et al. 2010). Education after birth, including sleep enhancement, increases mothers' knowledge and has been found to have benefits for infant sleeping with the added effects on parental and couple well-being (Bryanton and Beck 2010).

*... programs beginning antenatally and continuing postnatally, were associated with significant positive effect on all assessed outcomes.*

There appears to be too little methodologically acceptable evidence on parenting support programs for parents with mental illness (Craig 2004), parents of children with chronic illness (Anderson and Davis 2011), and for programs to assist parents with children with disabilities in low- and middle-income countries (Einfield et al. 2012).

There are also very few studies of interventions to improve father engagement. However, promising findings have been reported for programs that encourage men to interact with their child, sensitize men to infant cues, and teach them specific skills involved in baby care (Magill-Evans et al. 2006).

*... promising findings have been reported for programs that encourage men to interact with their child ... and teach them specific skills involved in baby care.*

In conclusion, while universal services should be used to identify high-risk groups, many parent support programs are better targeted with greater intensity and resources to high-risk groups than to the population at large (Barlow et al. 2010). Free-floating interventions, for example, those that are mounted at clinics, with erratic membership and little active facilitation, have not shown positive results (Gardner and Deatrck 2006).

# PROMOTING CHILDREN'S GROWTH, DEVELOPMENT, LEARNING, LANGUAGE, AND EDUCATION

This category includes parent support interventions to promote child growth, learning and development, language and literacy, and school performance. However, we found only a handful of overviews and systematic reviews on these topics.

In an overview of potentially feasible and effective strategies to strengthen families in the context of HIV and AIDS, Chandan and Richter (2009) argued that intervention programs that enhance caregiving and link caregivers with support and services play a pivotal role in strengthening families for the benefit of children. In addition to structural interventions, including social security transfers for the neediest families, they recommended two strategies given their demonstrated benefits in other settings: 1) home visiting for first-time, low-income pregnant mothers and their young children and 2) early childhood development programmes for low-income children and families.

Engle et al. (2011) reviewed parenting interventions in low- and middle-income countries, including unpublished reports, which aimed to increase responsiveness to infants, encourage learning, and promote positive discipline, among other outcomes. They found substantial positive effects on child development in all of the 11 effectiveness studies they reviewed, nine of which also found benefits for cognitive and socio-emotional development, and two of which encouraged parent knowledge, home stimulation, and learning activities with children. The authors concluded that the “most effective programmes were those with systematic training methods for the workers, a structured and evidence-based curriculum, and opportunities for parental practice with feedback” (p. 1341).

However, neither economic interventions in the United States (Lucas et al. 2008) nor home-visiting programs in the United States, Ireland, Bermuda, and Jamaica (Miller, Mauguire, and MacDonald 2012) have been found by systematic review methods to be effective strategies for supporting the development of preschool children of socially disadvantaged parents. In both reviews, though, significant programmatic and/or methodological weaknesses were identified that cast doubt on any definitive conclusions.

In the case of economic interventions, all nine studies reviewed (eight in the United States) involved welfare reform, in which cash payments were tied to work or other requirements. The payments were very small (an average of U.S.\$11.50 a week) and could not have been expected to be associated with marked improvements at the family, parent, or child level. In addition, all involved some enforcement of low-status work that may have increased rather than decreased parental stress and adversely affected parent-child engagement. Despite these constraints, the interventions were associated with non-significant benefits for child health and child emotional state, as well as language and cognitive performance, and educational achievement.

Miller and Eakin's (2012) review on home support for socioeconomically disadvantaged parents in high-income countries, in which parents were trained to provide a more nurturing and stimulating environment for their young children, found no effects on children's cognitive development. There were insufficient data to perform meta-analyses on other outcomes (children's socio-emotional and physical development, parenting behavior, and the quality of the home environment), but no consistent pattern of findings was shown in any of the constituent studies. The reviewers concluded that poor reporting of the studies, particularly with respect to randomization and attrition, limit the extent to which reliable conclusions about the effectiveness of such programs can be drawn.

A review of child health partnerships involving multiple stakeholders from both government and civil society showed positive results for child development as well as for parenting and service utilization (e.g., immunization) (Jayaratne, Kelaher, and Dunt 2010). Examples include Sure Start and Every Child Matters in the United Kingdom, First 5 California and Early Head Start in the United States, Healthy Child Manitoba and Toronto First Duty in Canada, and Families First, Best Start and Every Chance for Every Child in Australia. These partnerships provide a range of services whose relevance is locally determined, from financial assistance to breastfeeding support to child care and facilitation of early learning. In fact, in most of the consortia, although generally led or coordinated by health services, children's early learning is a core goal. Many programs use peer family advisors or mentors, who are reported to have credibility, and are able to engender trust and counter parents' isolation and self-blame.

Passive parent support approaches, such as sending books home without parent outreach and engagement, have not been shown to be effective (Moran, Ghate, and van der Merwe 2004). However, a systematic review of the impact of parent support interventions on education (Nye, Schwartz, and Turner 2006) concluded that parental involvement in schooling resulted in significant overall positive effects on children's academic achievement, raising children's average performance to be considerably above that of children in the control group. The largest effects occurred in programs in which parents offered some form of incentive for their child's performance. The impacts on reading have been more extensively studied than those on mathematics or other school subjects.

Reese, Sparks, and Leyva (2010) conducted a systematic review of parent interventions to promote preschool children's language and emergent literacy. The interventions were of three types—shared book reading, parent-child conversations and storytelling, and parent assistance for children's writing. Shared book reading improved children's expressive and, in some cases, their receptive vocabulary, and telling stories about personally experienced events was found to be a promising supplement to book reading. Parents of low socioeconomic status, who are generally presumed to be unmotivated and too stressed for high levels of parent-child engagement, were able to implement the program, with positive impacts on their children's language and literacy development. The reviewers conclude that parents are an undertapped resource for children's early learning. Telling stories and making books have been incorporated into Head Start, especially for migrant families (Boyce et al. 2010), and Moran, Ghate, and van der Merwe (2004) also classify these strategies as promising parent programs for improving children's literacy.

### **Child behavior management**

Programs that target better child behavior management, and conduct problems specifically, are the most extensively studied of all parent support interventions. It has been known for some time that structured parent group programs are effective interventions to improve parenting and better manage the behavior problems of preschool children (Thomas et al. 1999; Bunting 2004). Systematic reviews have consistently reported positive results (Barlow and Parsons 2005; Barlow et al. 2010), some of which endure through childhood, reducing delinquency in adolescence and other antisocial behaviors in adulthood (Piquero et al. 2008; Sandler et al. 2011). Importantly, behavioral and cognitive, group-based parenting programs have also been shown to lead to significant reductions in harsh parenting practices, according to both self-reports and independent assessments (Furlong et al. 2012).

The most widely implemented parent-child relationship and behavior management programs are The Incredible Years (Webster-Stratton 1992), Triple P Positive Parenting (Sanders 1999), and

Parent-Child Interaction Therapy (Budd et al. 2011). No differences in effectiveness have been found between different types of programs; for example, between behaviorally and non-behaviorally oriented approaches (Gavita and Joyce 2008; Lundahl, Risser, and Lovejo 2006), or between Triple P and Parent-Child Interaction Therapy (Thomas and Zimmer-Gembeck 2007). Self-help programs also lead to similar outcomes to those achieved with more intensive professional inputs (de Graaf et al. 2008; O'Brien and Daley 2011). Some doubt has been cast on evidence of the effectiveness of even the best-known programs (Wilson, Havighurst, and Harley 2012). At this stage, it is unclear which interventions are likely to be of more benefit to which families, although group approaches seem to be more successful than individual programs. An exception is cases where parents and/or children have specific needs. Parents generally prefer an interactive style of facilitation to didactic teaching (Moran, Ghate, and van der Merwe 2004).

Moderators of success include low socioeconomic status and single parenthood, with family adversity significantly undermining positive changes in parental attitudes and behavior problems (Lundahl, Risser, and Lovejo 2006). Parents whose children have severe behavior problems also benefit less, and such families probably need to be enrolled in individual supplemental services at the same time as group programs (Moran, Ghate, and van der Merwe 2004). These findings highlight the importance of addressing stresses in parents' lives, including socioeconomic disadvantage, as well as assisting families to access other needed services, as an essential aspect of parenting support interventions.

More limited success has been achieved in addressing adolescent conduct problems (Woolfenden et al. 2001). Intensive approaches, such as cognitive behavior therapy, have been found to be as effective as behavioral parent training, though both are more effective when combined with broad systemic approaches that include parents, young people, schools, and other relevant community structures (McCart et al. 2006; O'Connell, Boat, and Warner 2009). In the same way, active parental engagement has been found to be an important feature of school-based and community programs to prevent tobacco, drug, and alcohol abuse among young people. In this context, parent engagement is more successful if it is holistic, including also the parent-child relationship and conflict management rather than focusing exclusively on substance use (Petrie et al. 2007).

With respect to specific problems, parent training in contingency management (e.g., specifying behaviors to be changed, reinforcing desirable behavior and ignoring undesirable behavior, using "time out") has been found to be effective with parents of children with attention deficit and hyperactivity disorder (ADHD). Parental confidence and self-esteem increased, parental stress was reported to be reduced, as were ADHD symptoms and child non-compliance (Kohut and Andrews 2004).

A systematic review of six randomized controlled trials of interventions to help foster parents manage the difficult behavior of children in the context of the U.S. child welfare system showed little evidence of improvement in psychological functioning among looked-after children, that of foster parents or carers, and in foster agency outcomes. The reviewers conclude that, in order for foster care programs to be effective, programs addressing parent support needs must be complemented by a wide range of other services and interventions (Turner, MacDonald, and Dennis 2007).

### **Family relations and child protection**

Under this heading are included parenting interventions that promote attachment, the parent-child relationship, parent-couple relationships, household safety, and the prevention of non-accidental



injuries, child neglect, and abuse. In this section, we will not repeat pertinent comments about home visiting, parental confidence and effectiveness, behavior management, and parent-child relations, topics we have covered above.

Attachment between mother and child can be promoted, and sensitivity to infant cues and responsiveness to infant learning and communication improved, through videotaped feedback and guided facilitation, though these methods are often training- and labor-intensive (Zeanah et al. 2011). Target groups usually include clinic-referred parents (e.g., depressed mothers) and at-risk infants (e.g., adopted children, very-low-birth-weight babies). Positive outcomes are associated with professional as opposed to non-professional staff, children at risk rather than parents at risk, and sensitivity-enhancing interventions versus broad goals of improving attachment or mother-infant interaction (Bakermans-Kranenburg, Van Ijzendoorn, and Juffer 2005).

Improving parental knowledge of child development through greater awareness of infant sensory, cognitive, and motor capacities has been shown to increase parental sensitivity and responsiveness to infant signals. One of the most commonly used mechanisms for achieving this is the Brazelton Neonatal Behavioral Assessment Scale (Beeghly et al. 1995). Infant responses to the scale are demonstrated to parents in order to increase their awareness and responsiveness to the infant and enhance feelings of nurturance.

A meta-analysis of studies in the United States to examine the safety, permanency, and well-being of children in kinship versus institutional care (Winokur, Holtan, and Valentine 2009), is of particular relevance to children affected by HIV and poverty in low- and middle-income countries. This is because of the inclination of some foreign donor organizations to promote institutional care of children who have lost parents. Kinship foster care in the United States enables children to live with persons they know and trust and is believed to reinforce children's sense of identity, which comes from shared family history and culture (Winokur, Holtan, and Valentine 2009). The data from Winokur and colleagues' review indicate that children in kinship foster care have better behavioral development, mental health, and placement stability than children in non-kin foster care. In the United States, as in poor AIDS-affected countries, controversies abound regarding the unequal financial support, training, services, oversight, and certification received by kin as opposed to non-kin caregivers. Despite the methodological weaknesses of the studies included, the review provides an important stimulus to the debates.

Interventions to prevent unintentional injuries, especially the possession and use of safety equipment and practices, usually include information provided in the media, parent education, and home visiting. A meta-analysis of nine randomized controlled trials found that intervention families had a significantly lower risk of child injury. They had fewer home hazards and a home environment more conducive to child safety. Parents also expressed an increased conviction about the importance of protecting young children (Kendrick et al. 2007; Kendrick et al. 2008), a finding also of relevance to children in poor countries, whose environments are frequently hazardous as a result of open fires, proximity to the road and waste deposits, unclean water, poisonous household fuels such as paraffin, and the like.

A review of prevention of child maltreatment identified parent education and home visiting as among the most promising interventions (Mikton and Butchart 2009). Programs that have been shown to effectively prevent child abuse and neglect target high-risk families, start at birth, and deliver intensive services of long duration that are implemented by well-trained professional staff (Geeraert et al. 2004; Macmillan 2000; Nelson et al. 2001). A trial of Triple P in 18 randomized U.S. counties demonstrated a significant prevention effect on child maltreatment as indexed by

substantiated child maltreatment cases, child out-of-home placements, and child maltreatment injuries (Prinz et al. 2009). There is currently no evidence that educational programs alone prevent child abuse (Macmillan 2000). It has been argued that a significant limitation of current child abuse programs is that they do not adequately address poverty, which is a major risk factor for child maltreatment (MacLeod and Nelson 2000; Nelson, Laurendeau, and Chamberland 2001).

### **Parental well-being**

A meta-analysis by Barlow, Coren, and Stewart-Brown (2003) and a more recent update (Barlow, Coren, and Stewart-Brown 2009) found 20 studies of the effects of parent support programs on maternal psychosocial health with sufficient data to calculate an average effect size. This is one of the largest meta-analyses we found in the field of parent support programs. The review found statistically significant differences favoring the intervention group on maternal depression, anxiety and stress, self-esteem, and marital adjustment.

In a 2012 meta-analysis, Barlow et al. (2012) identified 48 eligible studies involving 4,937 participants with outcomes related to parental psychosocial health. Overall, participants in the parenting interventions (which were of three types: behavioral, cognitive, and multi-modal) showed statistically significant short-term improvements in depression, anxiety, stress, anger, guilt, self-confidence, and satisfaction with their spousal relationship. Only stress and confidence remained significantly better at one-year follow-up. There were only limited data on fathers, but men in programs showed statistically significant short-term improvements in stress. The data gave the reviewers confidence to suggest that, together with evidence about the importance of paternal psychosocial functioning on the well-being of children, parenting programs should make every attempt to include fathers; either through encouraging father involvement in already-established programs (e.g., by holding classes on weekends) or by tailoring a paternal support component into the program.

Overall, good results for parental well-being have been found as a consequence of participating in parent support programs. However, no such enthusiasm can be established for the effects of parent support programs on mothers with mental illness who have young children (Craig 2004). While mentally ill parents share with others the common problems of parenting, they also experience a number of issues due specifically to their mental illness. These require more individualized and intensive intervention than is available in standard parent support programs.

# ADAPTATION AND IMPLEMENTATION

Many of the best-known programs developed in high-income countries are culture-bound, especially from the perspective of their predominant focus on “problematic” child behavior: non-compliance, opposition, aggression, and so on. They are also labor-intensive and, even if they were completely suited to the context of AIDS and poverty—and it is our view that they are not—they would be costly and difficult to reproduce in low- and middle-income countries (Shaw et al. 2006).

Parent support programs of various kinds have been adapted to diverse cultural groups in the United States, the United Kingdom, Australia, and Canada (e.g., Brotman et al. 2011; Hall et al. 2007; Kumpfer et al. 2008; 2012; Mares and Robinson 2012; Reid, Webster-Stratton, and Beauchaine 2001; Sanders, Turner, and Markie-Dadds 2002; Webster-Stratton 2009), as well as in low- and middle-income countries (Baker-Henningham 2011; Beardslee et al. 2011; Kagitcibasi, Sunar, and Bekman 2001). In addition, several reviews attest to the success of various forms of parent support in enhancing a range of child and family outcomes in low- and middle-income countries (Engle et al. 2007; Engle et al. 2011; Eshel et al. 2006; Knerr, Garnder, and Cluver 2013).

The major issue for adaptation, as identified by Castro, Barrera, and Martinez (2004) is implementing evidence-based interventions with fidelity (top-down) but adapting them to be responsive to the resource constraints and cultural needs of a local community (bottom-up). Backer’s (2001; cited in Castro, Barrera, and Martinez 2004) program adaptation guidelines follow a logic model that aims to preserve the core components of an effective program, while making changes to facilitate the program’s effectiveness within the local environment. The guidelines involve assessing the fidelity/adaptation issues, identifying the program’s theory of change, assessing community concerns, determining the needed resources and available training, involving the community, and monitoring fidelity/adaptation issues. The most important elements of adaptation usually involve modifying the program content and making changes to program delivery and, as Castro and colleagues note, attention must be given to maintaining the deep versus surface structure of programs that contribute to their success.

Many parent support programs contain common elements (see Figures 2), and outcome studies identify general approaches rather than either specific content or specific modes of program delivery that are necessary to success. For this reason, it would seem that programs could be designed to support parents in low- and middle-income countries affected by HIV with a fair degree of latitude, depending on the goals of the program.

The general approaches that have been identified as important in local adaptation are the following (Moran, Ghate, and van der Merwe 2004):

- Ensuring that programs respond to parents’ needs by asking parents what information, advice, and support they would find useful. This can be done by working with parents before they join a program, ensuring the program addresses their concerns, using trusted local staff where possible, ensuring that staff are well trained, that they don’t talk down to parents, that interactive rather than didactic styles of working are used, and ensuring that parent feedback is incorporated and that services are changed as a consequence of feedback.

- Assisting parents to stay in the program by hosting programs close to where parents live, providing or paying for transport, ensuring child care, and sharing meals. These have all been found to increase parent participation and retention, as has providing relevant incentives for uptake and continued engagement such as certification. If the program aims to reach the most vulnerable families, non-attenders and dropouts must be pursued and efforts made to re-engage these parents.
- Being sensitive to parental sociocultural context, including poverty, unemployment, culture, and ethnicity. Parent programs that incorporate specific assistance for parents facing socioeconomic difficulties have better retention rates, are valued more by parents, and have better outcomes than programs that address only parent, child, or parent-child issues. It is thus especially important for parenting programs to link with other services and sources of assistance to which parents with particular needs can be referred and linked.
- Providing structured programs and programs with attractive and appropriate supporting materials. Materials include leaflets, simple books, photographs, and videotapes, and are most appreciated when they incorporate parents' own lives and situations, without being oversimplified or patronizing (Moran, Ghate, and van der Merwe 2004).
- Contextualizing programmatic messages and approaches within different cultural perspectives on parenting, many examples of which are found in the United States in programs for African-American and Latino-American families (e.g., Farber 2009; Gross et al. 2009; Katz et al. 2011; Scott et al. 2010; Sheely and Bratton 2010) and among Aboriginal (Lee et al. 2010), West African, and other ethnic groups in Australia (Renzaho and Vignjevic 2011). Recruitment into parent programs, content of programs, and style of presentation may need adjustment to encourage fathers to participate, as demonstrated by Alio et al. (2011), Cowan, Cowan, and Knox (2010), Cullen et al. (2011), Fletcher, Freeman, and Matthey (2011), and Magill-Evans et al. (2006).
- Maintaining longer-running programs, which are generally more effective, but this is in terms of months compared to weeks, rather than years, in comparison to months (Letourneau et al. 2004).

A summary of some of Moran et al.'s (2004) key messages for “what works” in practice is shown in Table 1.

**Table 1. A Selection of Key Messages for Effective Parenting Programs**

Early interventions report better and more durable outcomes.	Later interventions are better than none, and may be especially useful for parents under stress.
Interventions that have clear goals, are based on theory, have an articulated theory of change, and work toward measurable outcomes are more effective.	General programs, without clear goals and anticipated outcomes, are less effective.
Universal programs aimed at primary prevention among high-risk families have more positive outcomes.	Targeted interventions are needed for families with special needs in addition to universal prevention strategies.
Universal approaches are best implemented through structured group programs.	Individual sessions are best suited to parents and/or children with severe problems and for parents who are less likely to access group programs (e.g., home visiting for teen mothers).
Multicomponent interventions can address parental concerns more adequately.	These can be provided by the same or different agencies or service providers but must coordinate with each other to meet parent's needs.
Behavioral programs that focus on specific parenting skills and practical, take-home tips are more effective.	General directives are not useful for parents, and may be experienced as patronizing. This is one of the reasons why peer mentors seem to be appreciated.
Interventions that work in parallel (though not necessarily at the same time) with parents, families, and children are more effective.	Sessions for children, parents, and families together can be provided by the same or different agencies or service providers but must coordinate with each other to meet the needs of families.

The Triple P Positive Parenting Program uses five levels of intervention that provide a useful model for how parent support might be delivered in low- and middle-income settings. Each of these levels needs to be adapted to the purpose of the parent support program, whether to prepare for parenthood or particular challenges of parenthood, promote early child development and learning, advise parents on how to manage children's difficult behavior, increase child protection, and/or improve parental and family well-being. Not all these elements can be merged into a single program, as they vary in relevance by child age as well as by parent and family circumstance.

At Level 1, universal, media-based information campaigns can be mounted that affirm the importance of parents to children's health, well-being and, educational achievement; alerts parents to children's age- and stage-based competencies and needs; raises awareness of safety issues for children and the adverse effects of harsh punishment; and encourages parents to speak and read to their children. At Level 2, more targeted information and education campaigns can be directed to parents with shared concerns, such as a particular age group or stage, disclosure of HIV to children, developmental delay, improving children's success at school, and so on. At Level 3, a brief group-parent training or support program can be convened if parents express the need or desire for such support. At Level 4, an ongoing support group directed to a particular issue can be organized, provided it is responsive to expressed need; and Level 5 interventions may involve referral to available social welfare services. Interest in these various levels of parent support will need to be tested in communities as well as practical aspects of implementation such as training of local community workers, duration of programs, and support materials.



# STRUCTURAL ENABLERS FOR PARENTING

There are many reasons why children who experience social exclusion, deprivation, and hardship have poor psychological, health, and educational outcomes. Compromised caregiving is likely to be a contributor to these effects. But the causes of compromised caregiving and poor child outcomes are multiple, often reinforcing each other at the personal, sociocultural, and political levels, as made clear in the final report of the World Health Organization's Commission on the Social Determinants of Health (CSDH 2008).

There is a strong policy focus on parenting in Australia (Bayer et al. 2007), Canada (Gfellner et al. 2008), the United Kingdom<sup>1</sup> (Bunting 2004; Lewis 2011), the United States<sup>2</sup> (Weaver 2012), Norway (Ogden et al. 2005), and the Organisation for Economic Co-operation and Development (Adema et al. 2012; Rodrigo et al. 2010). At the same time, though, there is concern that the expansion of parenting programs should not be at the expense of a simultaneous effort to address inequality, discrimination, poverty, exploitative work conditions, lack of access to services, and other structural drivers of both poor human development and poor parenting (Abelda 2011; MacLeod and Nelson 2000).

Critics have argued that it is convenient to construct parents as both the primary problem and the solution (in the form of training to “fix” parenting) to issues such as poor school performance, behavior problems, school dropout, youth crime, and substance use (Lucas 2011). A similar line of thinking has been followed in low- and middle-income countries highly impacted by HIV and AIDS. There is a tendency to see the difficulties experienced by children and the threats to their longer-term prospects as principally caused by parental illness, death, and family dissolution—at the expense of addressing underlying structural sources of suffering for parents and children, such as long-standing and widespread poverty, lack of services, and corruption (Richter 2008).

Poverty is the major threat to the well-being of children and families, in both low- and high-income countries (Yoshikawa et al. 2012). At-risk families need not only person-centered intervention such as parenting support, but also policies and services that secure their human rights, basic income, employment, housing, education, health, transport, and childcare, to enable them to provide for their children's subsistence (Febbraro 1994). These basic provisions can also reduce the stresses that can diminish and distort parenting capacities, affect parental mental health, and trigger neglectful, harsh, and even abusive parental behavior. In this respect, lessons can be learned from several European countries (e.g., France, Germany, and Sweden) that have been able to reduce family poverty levels, with gains for parents and children, through family policies such as cash benefits, tax concessions, and child support (Peters et al. 2001).

In response to this imperative, four structural approaches are important as foundational or parallel interventions to parenting programs in low- and middle-income countries heavily impacted by HIV

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<sup>1</sup> For example, Every Child Matters; Sure Start; National Services Framework for Children, Young People and Maternity Services; Choosing Health (Kane et al. 2007; Lucas 2011).

<sup>2</sup> For example, Head Start and Early Head Start (Jones Harden et al. 2012).

and AIDS. These are human rights and protection from discrimination, income strengthening, and, especially cash transfer programs, childcare, and free or assisted education. Each of these is briefly reviewed below.

## **HUMAN RIGHTS AND PROTECTION FROM DISCRIMINATION**

In countries that tolerate discrimination against groups of people based on color, ethnicity, language, religion, sexual preference, sexual practice, drug use, and so on, affected parents find it very difficult to fulfill their parenting roles. They may be forced to live apart from their children, as is the case with many migrant workers; their children may suffer socioeconomic disadvantages because of the difficulties they encounter in trying to find work or housing; their children may be discriminated against and denied services or access to education, and they may be afraid that their children will be forcibly removed from their care and placed in an institution or a foster home (Beard et al. 2010; Rhodes et al. 2010).

Supportive interventions include self-help and solidarity, education and empowerment, care, decriminalization and legal representation, safety and protection, and community-based child protection networks (Rekart 2006).

## **CASH TRANSFERS**

Families affected by HIV and AIDS get poorer as a result of loss of income and livelihood, additional costs associated with care seeking and treatment, increased dependency, asset selling to meet survival needs, and loss of access to support as a result of stigma and discrimination (Richter et al. 2009). A large amount of literature attests to the adverse effects on caregiving and children as a result of these impacts. For these reasons, programs to strengthen parenting should be an adjunct to broader-based efforts to secure the survival and livelihoods of AIDS-affected families, the vast majority of whom strive to do better by their children despite their destitution (Richter 2012). While there are several mechanisms for addressing the economic difficulties facing AIDS-affected families, consensus is developing for the ease and speed of cash transfers to the poorest households in high-HIV prevalence settings.

Adato and Basset (2012) have updated their review of evidence on social protection and cash transfers to strengthen families affected by HIV and AIDS, covering more than 300 documents and evidence on impacts of 10 unconditional cash transfer (UCT) programs in Southern and Eastern Africa and 10 conditional cash transfer (CCT) programs in Latin America. In addition, they consider the relative strengths and weaknesses of cash transfers in comparison to food transfers and nutrition programs, public works, microcredit and livelihood programs, and social services. They concede that the best evidence for cash transfers comes from settings that are not severely AIDS-affected, and therefore the findings have to be generalized, with thought given to the way in which HIV may affect the context. HIV is intertwined with a range of vulnerabilities, the most significant of which is poverty. For this reason, the authors argue, “Social protection is a moral and economic imperative. While preserving basic levels of comfort and human dignity among the sick, social protection interventions may also be the only means of preventing the destitution of entire households, as well as irreversible health, nutrition, and education deprivation among children—with lifelong consequences” (p. xiv).



The evidence from Latin America of cash transfers for child benefits is strong, as it is for family economic strengthening. Good evidence is now also available from several high-HIV prevalence countries (Davis et al. 2012), including through the recent national evaluation of the Child Support Grant (CSG) in South Africa (DSA, SASSA, and UNICEF 2012). Because the CSG is universally available, the researchers compared children with early access to the grant to those with later access. Early access children, especially girls, not only did better at school, but also reported less recent illness and had lower reported risk behaviors during adolescence, including sexual activity, teen pregnancy, and drug and alcohol use.

Cash transfers get much-needed money directly to families more quickly and with fewer overhead costs, if they are unconditional, than other forms of economic strengthening. As Adato and Bassett (2012) point out, microcredit and livelihood activities are only suitable for households that have no labor constraints and have some asset endowments off which to work. In conclusion, they argue that “AIDS-affected families do not comprise a homogenous category; they embody many variations with respect to wealth or poverty, education, household structure, stage of illness progression, dependency ratios, social status and access to assets. This argues for a mix of social protection approaches rather than a single approach. However, pursuing a mix does not conflict with a national strategy of scaling up cash transfers for the most vulnerable families” (p. xvii).

In addition to the known positive impacts of cash transfers on children’s health and education, an intensive study of a program in Tanzania, in which very small cash pensions were paid to destitute elderly caregivers, demonstrates clearly the impact of socioeconomic relief on the quality of parenting and its beneficial effects on children (Hofmann et al. 2008). Both grandparent carers and children in this mixed-methods study attested to feeling loving and being loved when they were able to provide and access some of the most basic necessities—soap to wash with, kerosene with which to cook food and to provide light, predictable meals, and foodstuffs in addition to a staple carbohydrate.

In sum, we cannot strengthen parenting without supporting parents to be able to provide for life essentials for themselves and their children. Social grants, cash transfers, livelihood schemes, public works, micro lending, health insurance, and other mechanisms help to give basic social protection to the poorest families. This is the first step toward strengthening parenting.

## **CHILD CARE**

Many families in low- and middle-income countries need childcare. In *Forgotten Families* Heymann (2006), provides a startling picture of the extent of the gap in 180 countries. “There has been a dramatic transformation in the workforce worldwide, with hundreds of millions of people leaving the home or farm to join the formal [and informal<sup>3</sup>] labour force; the majority of both men and women are in the labor force in nearly every region in the world; more than 930 million children under fifteen are being raised in households in which all of the adults work” (p. xi).

In most low- and middle-income countries, formal childcare is expensive and largely urban-based—beyond the reach of the families who most need it. Informal childcare is less expensive, but also unregulated and sometimes unsafe. Parents who lose income or pay because of caregiving responsibilities are forced to leave children alone at home or take them along to their work environment. This may be an open fire by the side of a busy road where food is prepared for truck

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<sup>3</sup> “And informal” added.

drivers, or a polluted rubbish dump where a parent scrounges for food or objects that can be bartered or sold. In the Heymann study (2006), which involved analyses of data from 55,000 people in five regions of the world, 36 percent of families had left a child alone at home, 39 percent left a sick child at home alone or sent a sick child to school, 27 percent left the child in the care of another (paid or unpaid) child, and 23 percent took a child with them to unsafe work conditions.

AIDS-affected families especially need help with childcare, as the pressures on income, livelihood, and the care for sick household members mount, and less-able individuals (adolescents and the elderly) are obliged to take on the major responsibility for the care of children. Under these circumstances, young children are in danger of receiving less attention than they need, with adverse consequences for their health and psychological development (Heymann et al. 2007).

Community childcare programs, spaces, or centers, run by local women who are trained to provide kind, safe, and hygienic childcare, with sufficient support to prepare one or more nutritious meals for children, can be of enormous relief to families with high burdens of care in the family, including care for young children. As indicated earlier, childcare programs that promote parent-child interaction and offer educational and language stimulation have been shown, also in low- and middle-income countries, to have positive benefits for children's cognitive development, health, and education (Engle et al. 2011).

Programs that aim to strengthen parenting must support childcare. This helps parents to continue working, and to conduct livelihood and care activities in the home relieved of the anxiety of looking after young children. A wide variety of options for childcare support are available and can be tailored to local circumstances. Childcare programs also provide a ready platform for other efforts to strengthen parenting.

## **FREE OR ASSISTED EDUCATION**

Besides food, the second-highest expenditure item for poor families is education, and this remains the case even in the face of free education policies at the national level. Districts, schools, and individual teachers levy a range of unofficial fees, schools demand that parents buy books and that children wear specific uniforms, and households must meet the costs of transport to and from school. These constitute major impediments for poor families (Kadzamira and Rose 2003). The educational vulnerability of children affected by HIV and AIDS, parental anxiety related to enrolling and sending children to school, and children's desire to attend school form a common refrain in studies examining the impacts of poverty and HIV on children and families (Boutayeb 2009).

The Global Monitoring Report of Education for All indicates that more than 100 million children, the vast majority from developing countries, are not in school. It is estimated that only about 65 percent of children are in primary school in Africa, and only 20 percent of children in sub-Saharan Africa are in secondary school (Boutayeb 2009; Lewin 2009). Of course, access is not the complete picture, and what children in school learn is also important. However, there are indications that efforts to strengthen parenting include involving parents in children's education, and conversely, that assisting parents to access education for their children may increase parental investment in children (Jansen 2004; Therdikildsen 1998).

Programs that enable free or assisted education for children affected by AIDS, through any number of mechanisms—including advocacy at the national and local-government levels, block grants to schools, uniform and fee programs—are likely to reduce parental and family stress and facilitate a more positive environment for parenting.

# CONCLUSIONS

Families, parents, and children affected by HIV and AIDS are very likely to benefit from parent support, though it is questionable whether there can be a uniform package delivered effectively using a standardized approach. The deep structure comprising effective elements of parent support has been identified as follows:

- Support programs that respond to parents' expressed needs
- Group sessions, with outreach through home visits to marginalized and at-risk families
- Social support and reassurance from professionals, or trained para-professionals and peer mentors
- Opportunities to meet with others in the same position or facing the same challenges, who empathize and provide encouragement
- Authoritative, simple information on topics requested by parents
- Attractive materials for guidance
- Concrete advice and direction
- The chance to practice new approaches at home and report back
- Referral to and assistance in accessing related services
- Assistance with material needs, whether economic, housing, employment or discrimination, and help to overcome structural barriers to effective parenting.

These elements need to be assembled in different ways for parents with varying needs and circumstances and with children of different ages. Pregnant women newly diagnosed with HIV are a readily apparent group that is likely to appreciate parenting support and benefit from it, as suggested by Mothers to Mothers-to-Be (McCull 2012) and other peer mentor approaches. New mothers are especially appreciative of parent support, especially when they face additional challenges brought on by their circumstances or health, or the health of their baby. Families who take in children of kin who are ill or recently deceased are another discernible group, as are older caregivers looking after grandchildren and sibling caregivers.

Communities affected by AIDS and poverty are likely to have a variety of needs related to children and the challenges of parenting, including disclosure of their own or others' HIV to children, speaking and reassuring children about illness and death, counseling against stigmatization and discrimination, supporting children undergoing difficult experiences when parents are ill or die, and helping children stay in school.

This review provides a resource of approaches and principles from which new programs for parents of children affected by HIV and AIDS can be developed. However, such programs need to be based on a thorough understanding of what parents would find useful, need to have meaningful parent participation, and need to address material and other challenges that parents face in meeting the needs of their children in the context of AIDS and poverty.



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# APPENDIX I

## METHODS OF THE REVIEW

The literature on the topic of parent support is extensive and complex. For a critical and evaluative account of what has been published on the topic, we adopted the following approach:

1. A literature search was conducted in accordance with best-practice review methodology (The Cochrane Collaboration 2006).
2. The focus of the search was parenting and/or caregiving in general.
3. To supplement standard electronic database search techniques, we used probe search procedures to identify recent reviews of interventions on particular topics, with follow-up of particularly effective or promising interventions for certain specific caregiving challenges.
4. We summarized findings on interventions to support and strengthen caregiving.
5. Lastly, we extracted from the review general principles of interventions to support and strengthen child-caregiver relationships and parenting that can be taken forward in discussions about potential programming and implementation.

### LITERATURE SEARCH

We followed a systematic process for this literature search, using a combination of electronic and manual approaches. Electronic databases efficiently generate large numbers of articles that contain the stipulated keywords, or *search terms*, that are linked to papers published in a variety of journals. The manual component consisted of meticulously sorting through the titles and abstracts generated by the electronic database, deleting irrelevant entries, and tracking down the full texts of the relevant papers, as well as important sources referenced in the selected papers.

The literature search process is illustrated in **Figure 2**, beginning with the selection of relevant electronic databases to search. Electronic databases were selected on the basis that they covered a variety of journals and disciplines relevant to this topic with minimal overlap (see Table 1). For the purposes of academic discipline, the databases were limited to those covering, or at least extending into, the fields of social science and public health. The main databases used were *EbscoHost* and *ProQuest Central*, as these cover the majority of journals and relevant secondary databases. *PubMed* extended the search into the biomedical field, and the *Cochrane* and *Campbell Libraries* included systematic reviews of specific subjects. Secondary databases or search engines included *Academic Search Complete*, *Africa-Wide Information*, *Child Development and Adolescent Studies*, *EconLit*, *ERIC*, *Family & Society Studies Worldwide*, *Health Source*, *Left Index*, *Medline*, *PsychArticles*, *PsychCritique*, and *PsychInfo*. Each of these secondary databases offers access to numerous periodicals and peer-reviewed journals.

The composition of search terms was critical, as it determined the results extracted from the electronic databases. Once compiled, the list of search terms was adjusted to fit the search framework for each database.

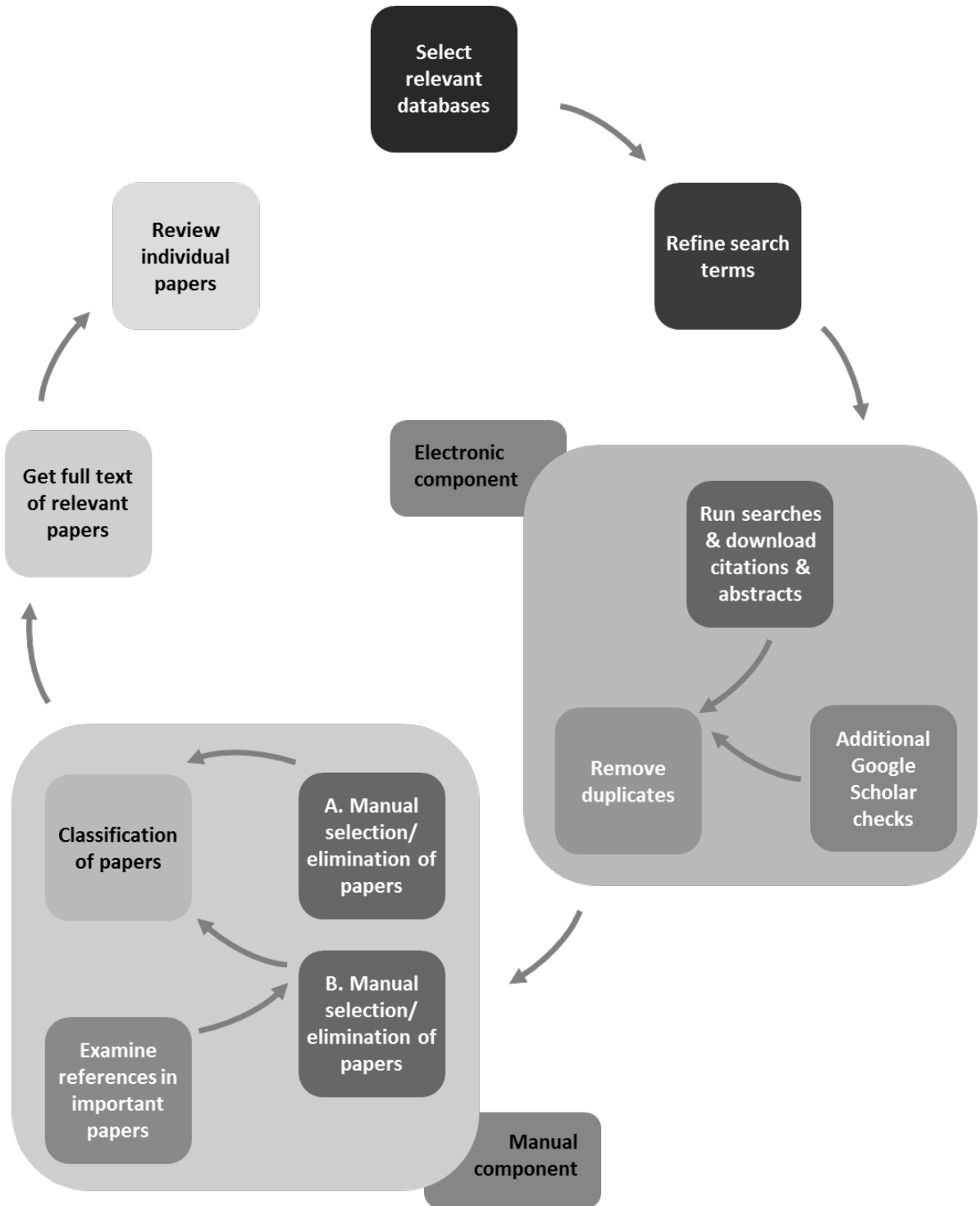
Using the compiled list of terms, we then ran individual searches in each database. Result citations and abstracts were downloaded into the *EndNote* reference management program. These results were downloaded sequentially, beginning with the database yielding the most relevant results, e.g. *EbscoHost*. Results from the other databases were then downloaded and imported into the *EndNote* library, which removed exact duplicates and stored the unique results in a new file. Ultimately, the number of results from each database was not necessarily indicative of the number of relevant papers on the topic in the database. While a database like *EbscoHost* is likely to contain more relevant papers than a biomedical database, databases cannot be compared on the basis of relevance or comprehensive hits due to the process of removing duplicates.

The first step of the manual review component entailed examining each title and abstract within the *EndNote* library and eliminating duplicates that *EndNote* did not catch, due to transcription or other errors. At this time, papers that ultimately did not fit the inclusion criteria were also removed. Selected papers were then manually examined and categorized as either *significant papers* or *part of the body of the review*.

In a second search phase, we combed the reference lists of papers in the *body-of-review* set for citations that might have been skipped in the initial electronic search. In a third phase, we used *Google Scholar* and the websites of specific journal publishers to further check for additional titles. Any *new* citations and abstracts found in the second and third phases were then manually reviewed for final inclusion/exclusion and classification, and the relevant papers were added to the *EndNote* library. Full text versions of all selected papers were then sourced and individually reviewed.

This review ultimately only covered papers published between 2000 and 2012. Important papers published before 2000 did inform the review and are included in Appendix 4. This review does not cover unpublished, non-bibliographic or gray literature, as per the agreed terms of the assignment. Publications in other languages are often difficult to access, and English translations may not be available. For this reason, we only included literature published in English. Nevertheless, valuable contributions to the issue of strengthening and supporting the caregiver-child relationship have been made in non-English publications. Whenever possible, relevant foreign-language publications were included, when a translation into English was available or could be made using Google Translator; these publications also informed background considerations for the review.

Figure 2. Diagram Illustrating the Review Procedure



**Table 1. Data Sources**

<p><b>EbscoHost</b></p> <p>EbscoHost is one of the world's largest intermediaries between publishers and libraries and provides access to some 26,008 e-journals acquired through Ebsco using numerous secondary databases and publishers covering a wide variety of disciplines.</p>	<p><b>The Cochrane Library</b></p> <p>The Cochrane Library contains high-quality, independent evidence to inform healthcare decision-making. It includes comprehensive systematic reviews including clinical trials.</p>
<p><b>ProQuest Central</b></p> <p>ProQuest Central is an extensive aggregated full-text database including more than 17,580 journals. Its coverage is international and archives material from 1971 to the present.</p>	<p><b>The Campbell Collaboration</b></p> <p>The Campbell Collaboration is the sibling organization to the Cochrane Collaboration and focuses on social and psychological interventions. It promotes the accessibility of systematic reviews in areas such as education, criminal justice, social policy, and social care.</p>
<p><b>PubMed</b></p> <p>PubMed is a service of the U.S. National Library of Medicine that includes over 17 million international citations, dating back to the 1950s. Although PubMed is primarily a biomedical database, numerous life science journals are included.</p>	<p><b>Google Scholar</b></p> <p>Google Scholar is a search engine designed for broad access to scholarly literature. Searches extend across many disciplines and sources.</p>

## SEARCH TERMS

In order to conduct a comprehensive search, a list of search terms was compiled iteratively. Full titles and abstracts of papers were searched using the search terms.

Table 2 contains the list of the search terms used, with asterisks indicating a truncated search term. As agreed in the terms of reference, the search was restricted to children generally, and did not specifically search for articles on adolescents or youth in particular. Efforts to support and/or strengthen parenting for or by adolescents or caregiver-adolescent relationships were included insofar as they were identified by the generic search term “child\*”.

**Table 2. Search Terms**

babies		attachment		counsel?ing
baby		Care		educat*
child*		caregiving		intervention
infant		famil*		program*
orphan		guardian		stability
toddler		Home		strengthen*
		interaction		support*
		involvement		therapy
		one-parent		train*
		parent*		well?being
		parent-child		
		relations*		
		Single?parent		

\*truncated words, e.g. parent\* will result in hits for *parent*, *parents*, *parental* and *parenting*

? wild cards, e.g. counsel?ing will result in hits for *counseling* and *counselling*

As previously noted, search terms were adapted to the search framework of each database. For example, a search in one database, covering search terms in the abstract (AB) will accept the input:

AB (child OR children OR infant OR orphan OR baby OR babies OR toddler) AND (parent\* OR family OR guardian OR single?parent OR one?parent OR parenthood OR care OR caregiving OR parent-child OR relation\* OR interaction OR attachment OR involvement OR "home structure") AND (support\* OR strengthen\* OR train\* OR educate OR education OR therapy OR intervention OR stability OR counsel#ing OR well?being OR program\* OR programme\*)

However, another database will require search input to be tailored to search within the title and abstract (tiab):

#1 child [tiab] OR children [tiab] OR infant [tiab] OR orphan [tiab] OR baby [tiab] OR babies [tiab] OR toddler [tiab]

#2 parent [tiab] OR parenting [tiab] OR family [tiab] OR guardian [tiab] OR "single parent" [tiab] OR "one parent" [tiab] OR parenthood [tiab] OR care [tiab] OR caregiving [tiab] OR parent-child [tiab] OR relation [tiab] OR relationship [tiab] OR interaction [tiab] OR attachment [tiab] OR involvement [tiab] OR "home structure" [tiab]

#3 support [tiab] OR supporting [tiab] OR strengthen [tiab] OR strengthening [tiab] OR train [tiab] OR training [tiab] OR educate [tiab] OR education [tiab] OR therapy [tiab] OR intervention [tiab] OR stability [tiab] OR counseling [tiab] OR counselling [tiab] OR well-being [tiab] OR "well?being" [tiab] OR program [tiab] OR programme [tiab]

#1 & #2 & #3

# INCLUSION AND EXCLUSION CRITERIA

In the first phase of electronic searching, the time period was left open primarily because much important work on parenting, such as that by Diana Baumrind, was conducted in the 1970s and 1980s. Some of these references were retained as background material. In its final form, the review is limited to the period between 2000 and 2012.

The review is also limited to the assessment of the published literature on supporting and strengthening caregiver-child relationships and parenting in the *English* language.

Certain topics were excluded because they were judged to be unrelated to the overall topic, often because they were too specific or detailed. Preference was given to interventions, approaches, and programmes with some evidence for their efficacy, effectiveness, or feasibility in a population-based approach. Table 3 includes the final inclusion and exclusion criteria for this literature review.

**Table 3. Inclusion and exclusion criteria used to focus search results**

<b>Inclusion</b>
Papers published in scholarly, peer-reviewed journals
Empirical literature on supporting/strengthening caregiver-child relationships
Parenting support and methods for strengthening caregiver-child relationships
Descriptions of interventions
Evaluations of interventions
Factors influencing the success/failure of interventions
Characteristics of the intervention or the target group, participation/attrition, differential benefit, etc.
Commentaries/opinions
Synthetic reviews, overviews, policy discussions, cost-benefit analyses
<b>Exclusion</b>
Technical reports, working/discussion papers, unpublished literature
Papers focused on specific pathologies, rare and uncommon illnesses, disorders or disabilities, such as attention deficit disorder and hyperactivity, autism, etc.
Papers focused on specific populations such as imprisoned parents, foster care in the context of welfare placement, divorce and court mediation in parenting, etc.
Papers in which the focus was child outcomes (for example, a study of preterm babies at 5 years) rather than on interventions to strengthen parenting or parental capabilities, etc.
Descriptions of parenting or care environments in the absence of intervention; for example, child caregivers in AIDS-affected families; parenting by depressed mothers, etc.
Clinical applications, including prevention of mother-to-child transmission , psychiatric treatment, individual psychotherapy, etc.



Table 4 below shows the process of selection and elimination of finds from the initial search to the final set of papers included in and informing the review; 500 papers are included in the review listing. Additional references which are not included in the review listing are cited in the report.

**Table 4. Selection and Elimination of Papers**

<b>Steps in search procedure</b>	<b>Campbell Library</b>	<b>Cochrane Library</b>	<b>EbscoHost</b>	<b>ProQuest</b>	<b>PubMed</b>	<b>Reference Lists</b>	<b>Google Scholar</b>
<i>Initial phase electronic search</i>	143	1,180	281,261	88,979	77,203		
<i>Export citations and removed duplicates within databases</i>	143	1,180	19,674	7,060	10,003		
<i>Results minus duplicates between databases</i>	143	1,180	17,101	5,512	8,748		
<b>TOTAL in Endnote Library</b>	32,684						
<i>First manual sorting through titles and abstracts</i>	14	111	970	65	60		
<b>TOTAL in Endnote Library</b>	1,220						
<i>Second manual sorting through titles and abstracts</i>	11	67	528	44	30		
<b>TOTAL in Endnote Library</b>	680						
<i>Second phase search of reference lists in significant papers</i>	11	67	528	44	30	6	
<i>Third phase search in Google Scholar</i>	11	67	528	44	30	6	7
<b>TOTAL in Endnote Library</b>	693						
<i>Separated by time period</i>	Pre-2000	2000-2012					
	40	653					
<i>Manual sorting through complete text of each paper</i>	Pre-2000	Background papers			Papers in the review		
	47	122			500		
<b>TOTAL in Endnote Library</b>	669						



## APPENDIX 2

# THE QUALITY OF THE EVIDENCE FOR PARENTING SUPPORT

Criteria for assessing the quality of a study include:

### RANDOMIZATION

In order to conclude that an intervention has an effect, it is necessary to take steps to eliminate sampling and selection bias in the distribution of participants to treatment and comparison groups. For example, more motivated parents might sign up for parent training in order to improve their relationships with their children. If beneficial effects are found in the parent training study, it may not be easy to determine if the results are caused by the program or by pre-existing characteristics, such as the parents' motivation for healthy relationships with their children; it is also possible that the results may be attributed to an interaction of both variables.

Such potential bias is addressed by random allocation and blinding. Blinding involves concealing the group assignment—treatment or comparison—from both participants and from the investigators who assess outcomes (Jadad 1996). Acceptable groups for rigorous comparison include a *no-treatment group*, a group eligible for the intervention but on a waiting list, and an *as-usual group* (normal service provision).

In theory, randomization should ensure that confounders (hidden or extraneous variables) are equally distributed between the intervention and the comparison groups. However, small sample sizes may not sufficiently control for confounding factors. This can occur when attributes, such as parental motivation or social class, are unevenly distributed between the intervention and control groups. For this reason, the distribution of known potential confounders must either be compared between the different study groups at the outset, or researchers must adjust for confounders at the analysis stage.

### MEASUREMENT OF INTERVENTION EFFECTS

Many studies rely on parental reporting—parents' own attitudinal, emotional, and behavioural changes and those of their children—as a measure of outcome. Parental report can be biased toward positive or negative outcomes for themselves, their children, and their families. Because of reporting bias, study outcomes should be assessed independently and through the use of standardised instruments (for example, psychological questionnaires and scales). Examples of standardized parent, child, parent-child relationship, and home environment outcome measures used in studies of parenting programs are shown in Table 5 and 6.

**Table 5. Examples Of Parent And Independent Outcome Measures**

<b>Parental knowledge</b>	<b>Parental attitudes &amp; behaviors</b>	<b>Parental self-confidence</b>	<b>Parental wellbeing</b>	<b>Independent ratings</b>
<i>Include knowledge, skills (e.g. supervision, boundary setting, communication), attitudes, behavior (e.g. discipline, affection), wellbeing (e.g. depression, self-esteem)</i>				<b>Measures provided by independent observers or in case records</b>
Parenting Knowledge Test	Parental Attitude Questionnaire	Pharis Self-Confidence in Infant Care	Edinburgh Postnatal Depression Scale	Conner's Teacher Rating Scale
Knowledge of Infant Development Inventory	Behavior management scenarios	Rosenberg Self-Efficacy Scale	Beck Depression Inventory	Case records of injuries
Infant Feeding Questionnaire	Adult-Adolescent Parenting Inventory	Parenting Self-Confidence Scale	Parenting Stress Index	Teacher Assessment of School Behavior

**Table 6. Examples of Child and Home Environment Outcome Measures**

<b>Child development</b>	<b>Child socio-emotional development</b>	<b>Child language</b>	<b>Parent-child relationship</b>	<b>Home environment</b>
<i>Conduct problems, depression/anxiety, sleep difficulties, drug use, school readiness, literacy and numeracy, educational performance</i>			<i>Attachment, warmth, communication, punishment, home safety</i>	
Bayley Scales of Infant Development	Child Behavior Trait Rating	Bzoch-League Receptive-Expressive Emergent Language	Parent Child Early Relational Assessment	Caldwell HOME Scale
Denver Developmental Screening Test	Strengths and Difficulties Questionnaire	Utah Test of Language Development	Videotaped mother-child interaction	Home hazards and safety measures
Griffiths Mental Development Scale	Child Behavior Checklist	Peabody Picture Vocabulary	Maternal Interactive Behavior	Daily activities, shared mealtime, etc.

Measurement challenges are compounded in settings for which measures have not been standardized, including most low- and middle-income countries, where foundational psychometric work on scale development and validation has not yet been completed. Researchers encounter similar problems when attempting to assess the current state of knowledge in a field, such as in a systematic review; the wide range of instruments (as well as scales and sub-scales) used make comparisons difficult, as does the fact that assessments are often made at different time points.

## **SAMPLE SIZES**

In general, sample sizes in effectiveness studies of parent support interventions are too small to test the effects of sub-group differences. Furthermore, very few studies provide details on the sample size calculations or information about the size of the changes that the study measures were powered to detect (Barlow et al., 2011).

## **MISSING DATA**

Attrition from parent support interventions is high; approximately 30–40 percent of recruited participants drop out of programs (Thomas et al., 1999; Barlow et al., 2003; Barlow & Parsons, 2005; Bunting, 2004), largely due to logistical difficulties associated with transport, work schedules, and child care. Programs that address these constraints tend to have better retention.

Missing data is seldom subject to *Intention to Treat* (ITT) analysis. ITT includes all participants in the analysis to counter the potential for bias from loss of participants with particular characteristics. For example, if the most-at-risk families drop out of the intervention, the effects of the program might appear to be more successful than they would have been if more at-risk families had remained in the study.

## **FOLLOW-UP EFFECTS**

Although most evaluations assess outcomes immediately post-intervention, few studies follow participants beyond that point. The few studies that do longer follow-up tend to provide invaluable information on maintenance of effects.

As is seen in the main report, the evidence base for parenting support interventions is regarded as generally average to poor, depending on the specific topic. The majority of individual studies of programs are of methodologically poor quality, with several threats to the validity of the data collected and significant risk of bias. This is illustrated in Appendix 2, in the summary of overviews and systematic reviews, which demonstrates that between only 15 (Lundhal, et al., 2006) and 50 (Coren, et al., 2003) percent of relevant studies are found to be eligible for inclusion in systematic reviews.

Bias in the excluded studies is most likely to be in the direction of Type I error, meaning the acceptance of a positive result which may not be justified. On the other hand, the very stringent criteria for inclusion in randomized control trials may lead to an overall underestimation of the benefits of programs in systematic reviews.



## APPENDIX 3

# SUMMARIES OF OVERVIEWS AND SYSTEMATIC REVIEWS (2000-12)

Review	Description	Findings
<p>Thomas, H., Camiletti, Y., Cava, M., Feldman, L., Underwood, J., &amp; Wade, K. (1999). Effectiveness of parenting groups with professional involvement in improving parent and child outcomes. Ontario, Canada: Public Health Research, Education and Development Program (PHRED). <a href="http://www.ephp.ca/PDF/1999_Professional%20Led%20Parent.pdf">http://www.ephp.ca/PDF/1999_Professional%20Led%20Parent.pdf</a></p>	<p>Inspected 238 articles, shortlisted 31, and reviewed 4 strong and 10 moderate quality studies. Quality criteria included study design, confounders, blinding, measurement, and attrition rate. Only one evaluation of a public health intervention was found.</p>	<ul style="list-style-type: none"> <li>• All interventions, especially group-based behavioral programs, reported positive effects on child or parent behavior and/or parent-child interaction</li> <li>• Benefits were maintained in the six studies with follow-up beyond six months.</li> </ul>
<p>Macleod, J. &amp; Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review. <i>Child Abuse &amp; Neglect</i>, 24, 1127-1149.</p>	<p>Reviewed preventive and reactive programs published or unpublished between 1979 and 1998, targeting children up to 12 years of age, with data sufficient to calculate an effect size. The review identified 56 studies.</p>	<ul style="list-style-type: none"> <li>• Most programs, which aimed to promote family wellness and prevent child maltreatment, were successful, with the highest effect sizes for outcomes measuring family wellness and the lowest effect sizes for outcomes measuring child maltreatment.</li> <li>• Social support/mutual aid programs had the highest effects. Lowest effects were found for home programs with fewer than 12 visits and less than six months duration; effects were greater over time.</li> <li>• Intensive family preservation, high levels of participant involvement, an empowerment/strengths-based approach, and social support appeared to be the most effective components.</li> <li>• The reviewers cautioned that parenting programs are not a cure for poverty. Stresses due to poverty have been linked to child maltreatment and efforts to address poverty should be prioritized.</li> </ul>

Review	Description	Findings
<p>Macmillan, H. L., with the Canadian Task Force on Preventive Health Care. (2000). Preventive healthcare 2000 update: Prevention of child maltreatment. <i>Canadian Medical Association Journal</i>, 163(11), 1451-1458.</p>	<p>In an update of the 1993 report, the author reviewed four new observational studies and several longitudinal studies of screening for risk factors. Of the studies reviewed, two were new home-visiting studies using professionals (Olds, Elmira); three used nonprofessional visitors; and the remaining three focused on comprehensive health services, parent education and support, and combined services and programs to prevent sexual abuse.</p>	<ul style="list-style-type: none"> <li>• This update described screening procedures that are not recommended due to high rates of false positives.</li> <li>• Two randomized controlled trials, both using professional nurses, showed a reduction in the incidence of childhood maltreatment or fewer outcomes related to physical abuse and neglect among first-time disadvantaged mothers and infants who received early and continued home visits throughout the child's infancy.</li> <li>• No effects were reported with paraprofessionals, although the studies were methodologically weak.</li> <li>• None of the other approaches rendered sufficient evidence to justify expansion.</li> </ul>
<p>Akinbami, L. J., Cheng, T. L., &amp; Kornfeld, D. (2001). A review of teen-tot programs: Comprehensive clinical care for young parents and their children. <i>Adolescence</i>, 36(142), 381-393.</p>	<p>Identified 46 papers, of which four met the eligibility criteria. All four programs were conducted in clinics or academic environments in urban areas. As with other programs in the past, those covered in this study reported very high attrition by 18 months.</p>	<ul style="list-style-type: none"> <li>• In general, infant outcomes were favorable: better clinic attendance, growth, and immunization.</li> <li>• Only one program found improved maternal behavior, e.g., in the use of preventive health services or the use of car seatbelts.</li> <li>• Generally, little benefit was demonstrated for child development knowledge and/or parenting skills.</li> <li>• Despite attrition, benefits were retained among the families who were followed for up to 24 months.</li> </ul>
<p>Nelson, G., Laurendeau, M.-C., &amp; Chamberland, C. (2001). A review of programs to promote family wellness and prevent the maltreatment of children. <i>Canadian Journal of Behavioral Science</i>, 33(1), 1-13.</p>	<p>Conducted a broad overview of programs, organized according to Bronfenbrenner's (1986) ecological framework. Made reference to a comprehensive review by Todres and Bunston (1993).</p>	<ul style="list-style-type: none"> <li>• At the time of the study, no evidence existed to show that educational programs prevent child sexual abuse.</li> <li>• Only home visitation programs had been shown to prevent child physical abuse and neglect; multicomponent, community-based programs had been shown to promote family wellness.</li> <li>• Most effective interventions began at birth, last several years, are intensive, and are run by well-trained professional staff.</li> <li>• A significant limitation of most programs reviewed is that they do not adequately address poverty, which is a major risk factor for child maltreatment.</li> </ul>
<p>Woolfenden, S., Williams, K. J., &amp; Peat, J. (2001). Family and parenting</p>	<p>Identified 970 papers, of which eight evaluation trials met the</p>	<ul style="list-style-type: none"> <li>• Provided evidence that maternal mental health can affect child outcomes.</li> </ul>



Review	Description	Findings
<p>interventions in children and adolescents with conduct disorder and delinquency aged 10-17. Cochrane Database of Systematic Reviews. 2001:2. DOI: 10.1002/14651858.CD003015.</p>	<p>inclusion criteria. Seven trials included juvenile delinquents, and one trial included children and parents not yet in contact with the justice system. The review covered a total of 749 children and their families, randomized to a family and parenting intervention or to a control group.</p>	<ul style="list-style-type: none"> <li>• Studies focused on structured prevention programs to strengthen parenting through group-based formats.</li> <li>• Most sessions occurred weekly, and most programs were based on seven to twelve sessions.</li> <li>• Few studies showed positive results on follow-up.</li> <li>• Most studies included mothers only.</li> </ul>
<p>Barlow, J., Coren, E., &amp; Stewart-Brown, S. (2003). Parent-training programs for improving maternal psychosocial health. Cochrane Database of Systematic Reviews. 2003: 4. DOI: 10.1002/14651858.CD002020.pub2.</p>	<p>From 26 identified studies, 20 provided sufficient data to calculate effect sizes for five outcomes: depression, anxiety/stress, self-esteem, social support, and relationship with spouse/marital adjustment.</p>	<ul style="list-style-type: none"> <li>• These meta-analyses showed statistically significant results favoring the intervention group for depression, anxiety/stress, self-esteem, and relationship with spouse/marital adjustment.</li> <li>• There was no evidence for effects on social support.</li> </ul>
<p>Coren, E., Barlow, J., &amp; Stewart-Brown, S. (2003). The effectiveness of individual and group-based parenting programs in improving outcomes for teenage mothers and their children: A systematic review. <i>Journal of Adolescence</i>, 26(1), 79.</p>	<p>Reviewed individual or group-based programs, offered ante- or post-natally to pregnant or parenting teens (age less than 20 years old), using a structured format and focusing on improving parenting attitudes, practices, skills or knowledge. Identified 24 papers, of which 14 were reviewed. The 10 excluded were not parenting programs.</p>	<ul style="list-style-type: none"> <li>• Teenage birth rates are higher among lower socioeconomic groups, partly because more affluent teens may terminate unwanted pregnancies.</li> <li>• There was considerable diversity in programs. Even some video interventions consisting of only one or two sessions produced positive changes in a range of parent and child outcomes. The majority of programs were weekly groups that ran for 12–16 weeks.</li> <li>• The results indicated that parenting programs are effective in improving a range of outcomes—including maternal sensitivity, identity, self-confidence and the infants’ responsiveness to their parents—for both teenage parents and their infants.</li> <li>• It was hypothesized that group processes and peer-group support may play a significant role in producing change.</li> </ul>
<p>Robinson, P., Robinson, M. &amp; Dunn, T. (2003). STEP parenting: A review of the research. <i>Canadian Journal of Counseling</i>, 37, 270-278.</p>	<p>This paper reviewed research on the effectiveness of Systematic Training for Effective Parenting (STEP). This review was in response to a controversy arising from prior publications and aimed to demonstrate the importance of encouraging the use of scientifically-supported programs.</p>	<ul style="list-style-type: none"> <li>• The review concluded that the evidence does not support STEP’s effectiveness.</li> <li>• Evidence for changes in parental attitudes was contradictory, and the authors maintained that such changes were not sufficient to conclude that a parenting program was effective.</li> <li>• While some researchers reported that STEP improved children’s self-esteem,</li> </ul>

Review	Description	Findings
		<p>the authors questioned whether this was a sufficiently robust indicator of psychological health.</p> <ul style="list-style-type: none"> <li>• There was not a substantial body of evidence that showed STEP training improved children's behavior.</li> </ul>
<p>Bunting, L. (2004). Parenting programs: The best available evidence. <i>Child Care in Practice</i>, 10(4), 327-343.</p>	<p>Reviewed three Cochrane Reviews of parenting programs, two systematic reviews on parenting programs listed on the UK National Health System's Database of Abstracts of Reviews of Effectiveness, and other studies identified by following up references from relevant articles.</p>	<ul style="list-style-type: none"> <li>• This review summarized the 14 methodologically strong or moderate studies reviewed by Thomas et al. (1999).</li> </ul>
<p>Craig, E. A. (2004). Parenting programs for women with mental illness who have young children: A review. <i>Australian and New Zealand Journal of Psychiatry</i>, 38(11/12), 923-928.</p>	<p>Provided an overview of the effects of maternal mental illness on children and interventions that have been evaluated.</p>	<ul style="list-style-type: none"> <li>• The review classified parenting programs into generic programs and specific programs for at-risk parents.</li> <li>• Despite existing enthusiasm for the application of parenting programs, there was a lack of empirical data relating to their effectiveness for mothers with mental illness.</li> <li>• Many parenting programs were generic and population-based. However, parents with mental illness experienced both the common problems encountered by all parents and a range of issues due to their mental illness.</li> </ul>
<p>Geeraert, L., Van Den Noortgate, W., Grietens, H., &amp; Onghena, P. (2004). The effects of early prevention programs for families with young children at risk for physical child abuse and neglect: A meta-analysis. <i>Child Maltreatment</i>, 9(3), 277-291.</p>	<p>This meta-analysis synthesized the results of 40 evaluation studies of early prevention programs for families with young children at risk for physical child abuse and neglect. Most of the studies employed non-randomized designs. Both published and unpublished studies were included if they were written between 1975 and 2002 in English, French, German or Dutch. Studies focused on the efficacy of programs for preventing child abuse in families identified as at-risk; programs in which support or services began before the birth of the child or within the first three years; and programs in which the definition of child</p>	<ul style="list-style-type: none"> <li>• This meta-analysis found a significant positive overall effect (similar to the results of other meta-analytic reviews of prevention programs for child abuse and neglect), demonstrating a significant decrease in abusive and neglectful acts.</li> <li>• This review identified significant risk reduction in such factors as parent-child interaction, child functioning, parent functioning, family functioning, and context characteristics.</li> <li>• This review concluded that more research is needed around the relationship between effects and program or target group characteristics.</li> </ul>

Review	Description	Findings
	maltreatment was limited to physical abuse and neglect.	
<p>Kohut, K. S., &amp; Andrews, J. (2004). The efficacy of parent training programs for ADHD children: A fifteen-year review. <i>Developmental Disabilities Bulletin</i>, 32(2), 155-172.</p>	<p>Reviewed studies published in the last 15 years that focused on training programs for parents of school-aged children with ADHD. Specifically tried to compare programs based on contingency management principles with parent training programs that aimed to improve social skills or problem-solving skills among children.</p>	<ul style="list-style-type: none"> <li>• Across all of the contingency management and child training studies, parent training programs resulted in increases in parental confidence in their management abilities and increase their self-esteem.</li> <li>• Parent training programs also helped reduce parents' stress and led to a reduction of both ADHD symptoms and child noncompliance.</li> </ul>
<p>Letourneau, N. L., Stewart, M. J., &amp; Barnfather, A. K. (2004). Adolescent mothers: Support needs, resources, and support-education interventions. <i>Journal of Adolescent Health</i>, 35(6), 509-525.</p>	<p>Reviewed research published between 1982 and 2003 for the purpose of describing the support needs of adolescents, identifying available resources, and reviewing relevant support education intervention studies to provide directions for future research. Identified five post-hoc evaluations of existing programs, ten quasi-experimental intervention studies, and four randomized controlled trials.</p>	<ul style="list-style-type: none"> <li>• Social support is intended to counter the poor socioeconomic conditions of many young mothers that include stress, family instability, and limited educational opportunities.</li> <li>• The available literature suggested that adolescents frequently rely on family members, primarily their mothers followed by their partners, for support. Partner support is correlated with the mother's psychosocial wellbeing and favorable developmental outcomes for the infant.</li> <li>• Many studies reported improvements in maternal knowledge, timing to subsequent pregnancy, return to schooling, knowledge of child development, responsiveness, child adjustment, immunization, etc.</li> <li>• It is important to note, however, that each study was hampered by some type of methodological weakness.</li> <li>• Most interventions focused on education and informational support provided by professionals. Given the influence of their peers, adolescents may benefit more from reciprocal lay support.</li> <li>• No research was identified that examined interventions designed to enhance the natural (e.g., family members' and partners') or adolescents' peer support networks.</li> <li>• Future interventions should examine ways to maintain supportive relationships with parents, partners, and friends and to include them in support-education interventions.</li> </ul>

Review	Description	Findings
<p>McNaughton, D. B. (2004). Nurse home visits to maternal-child clients: A review of intervention research. <i>Public Health Nursing, 21</i>(3), 207-219.</p>	<p>The review examined 13 research studies published between 1980 and 2000 that tested the effectiveness of home-visiting interventions using professional nurses as home visitors.</p>	<ul style="list-style-type: none"> <li>• Participants in most studies were either pregnant or in the postpartum period and demonstrated multiple risk factors, such as teenage parenthood; single parenting; a low income; a lack of social support; drug, tobacco, or alcohol abuse; and more likely to deliver a low-birth-weight baby.</li> <li>• The studies did not consistently apply theory.</li> <li>• Although inconsistent, most studies reported benefits, including maternal and child health, maternal mental health, improved parent-child interaction, home environment, maternal perceptions of infant behavior, reduction in child abuse and injuries, and increased use of health services.</li> </ul>
<p>Moran, P., Ghate, D., &amp; van der Merwe, A. (2004). <i>What works in parenting support? A review of the international evidence.</i> London: UK Department of Education and Skills. Research Report No 574. ISBN 1 84478 308 1.</p>	<p>The aim of this review was to give a systematic overview of the parent support literature for policy makers in the UK, to chart key findings in a standardized form, and to distil overarching messages in a succinct and accessible way. This review covered a wide range of services, combining scientific rigor with practice and policy relevance and accessibility. Programs were sorted into four categories: <i>what works</i>, <i>what is promising</i>, <i>what does not work</i>, and those in which effectiveness is still <i>not known</i>. Both qualitative and quantitative evaluations were included.</p>	<ul style="list-style-type: none"> <li>• While early interventions show the best and most sustainable outcomes for children, late interventions may still help parents deal with parenting under stress.</li> <li>• Interventions with a strong theory base and a clearly articulated model of the predicted mechanism of change work better, as do interventions that have measurable, concrete objectives.</li> <li>• Universal interventions (aimed at primary prevention among whole communities) are needed at the less severe end of the spectrum of common parenting difficulties.</li> <li>• Targeted interventions (aimed at specific populations or individuals deemed to be at risk for parenting difficulties) should be used to tackle more complex types of parenting difficulties.</li> <li>• Interventions that pay attention to implementation factors for 'getting,' 'keeping,' and 'engaging' parents.</li> <li>• Services that allow multiple routes in for families.</li> <li>• Interventions using more than one method of delivery (i.e., multicomponent interventions).</li> <li>• Group work, where the issues involved are suitable to be addressed in a 'public' format, and where parents can benefit from the social support of being with</li> </ul>

Review	Description	Findings
		<p>peers.</p> <ul style="list-style-type: none"> <li>• Individual work, where problems are severe or entrenched or parents are not ready/able to work in a group, often including an element of home visiting as part of a multi component service, providing one-to-one, tailored support.</li> <li>• Interventions that have manualized programs.</li> <li>• Interventions delivered by appropriately trained and skilled staff, backed up by good management and support.</li> <li>• Interventions of longer duration, with follow-up/booster sessions, for problems of greater severity or for higher risk groups of parents.</li> <li>• Short, low level interventions for delivering factual information to parents, increasing knowledge of child development.</li> <li>• Behavioral interventions that focus on specific parenting skills and practical ‘take-home tips’ for changing more complex parenting behaviors and impacting on child behaviors.</li> <li>• ‘Cognitive’ interventions for changing beliefs, attitudes and self-perceptions about parenting.</li> <li>• Interventions that work in parallel (though not necessarily at the same time) with parents, families and children.</li> </ul>
<p>Sweet, M. A., &amp; Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. <i>Child Development</i>, 75(5), 1435-1456.</p>	<p>Analyzed results from 60 home-visit programs within five child and five parent outcome groups.</p>	<ul style="list-style-type: none"> <li>• In general, home visits yielded improved parent attitudes and behavior and improved child functioning. However, programs that targeted the prevention of child abuse and parent stress were less successful.</li> <li>• Mothers in home-visit programs were more likely to go back to school or continue their education. However, there was no statistically significant difference from control groups in employment or level of reliance on public assistance.</li> <li>• Programs that employed professional staff, as compared to nonprofessional or paraprofessional staff, had better outcomes.</li> </ul>

Review	Description	Findings
		<ul style="list-style-type: none"> <li>Other program design features were not consistently related to outcomes; it is still unclear what factors make home-visit programs successful.</li> </ul>
<p>Bakermans-Kranenburg, M. J., Van Ijzendoorn, M. H., &amp; Juffer, F. (2005). Disorganized infant attachment and preventive interventions: A review and meta-analysis. <i>Infant Mental Health Journal</i>, 26(3), 191-216.</p>	<p>The authors reviewed 15 preventive interventions that attempted to improve sensitivity, responsiveness and engagement in order to explore variations in outcomes among studies and conditions associated with greater effectiveness.</p> <p>Disorganized attachments are associated with separation, stress, parental ill-health, poor regulation in premature, drug-exposed and other vulnerable infants and other conditions. It predicts later stress management and problematic behavior.</p>	<ul style="list-style-type: none"> <li>The target groups in the studied interventions included clinically-referred families (e.g., for postpartum depression), at-risk children (e.g., adopted children or very low-birth-weight infants), and at-risk parents (e.g., those living in poverty, single parents, and parents dealing with unstable life circumstances).</li> <li>Intervention outcomes ranged widely from negative to positive effect sizes. Positive outcomes were associated with a later start (after 6 months of child age, as compared to antenatal or within the first 6 months); using professionals versus nonprofessional staff; reaching at-risk children versus at-risk parents; and interventions focused on improving parent sensitivity versus programs with broad goals.</li> </ul>
<p>Barlow, J., &amp; Parsons, J. (2005). Group-based parent-training programs for improving emotional and behavioral adjustment in 0-3 year old children. <i>Cochrane Database of Systematic Reviews</i>. 2005: 2. DOI: 10.4073/csr.2005.2.</p>	<p>The objectives of this review were to establish whether group-based parenting programs are effective in improving the emotional and behavioral adjustment of children less than three years of age, and to assess the role of parenting programs in the primary prevention of emotional and behavioral problems. Only randomized-controlled trials of group-based parenting programs and studies that had used at least one standardized instrument to measure emotional and behavioral adjustment were included. Only five out of 140 studies met the selection criteria.</p>	<ul style="list-style-type: none"> <li>Emotional and behavioral problems (including tantrums, immature and oppositional behaviors, aggression, whining, thumb sucking, soiling, school phobia, etc.) among young children are common (between 7-21%), and frequently predict mental and social problems in adolescence and adulthood.</li> <li>Parenting is an important contributor to the adjustment of young children.</li> <li>Overall, the findings provided support for the use of group-based parenting programs to improve the emotional and behavioral adjustment of children less than 3 years of age.</li> <li>There was insufficient data on follow-up and of the effectiveness of parent training for primary prevention.</li> </ul>
<p>Hoagwood, K. E. (2005). Family-based services in children's mental health: A research review and synthesis. <i>Journal of Child Psychology and Psychiatry</i>, 46(7), 690-713.</p>	<p>Out of 4,000 papers published since 1980, 41 studies met the set methodological criteria. The studies fell into three categories: families as recipients of interventions (e.g., family education classes and support programs); families as co-</p>	<ul style="list-style-type: none"> <li>Few experimental studies supported the conclusion that family-based services improve child and youth clinical outcomes.</li> <li>The majority of the studies reviewed examined interventions designed to help families better meet their</li> </ul>

Review	Description	Findings
	therapists; and studies of the processes of family involvement.	<p>children’s mental health needs. These programs provided education, support, enrollment in services, empowerment, and skills training.</p> <ul style="list-style-type: none"> <li>• The methodologically acceptable studies included in the review demonstrated unequivocal improvements in outcomes, such as retention in services, knowledge about mental health issues, self-efficacy, and improved family interactions.</li> </ul>
Johnson, G., Kent, G., & Leather, J. (2005). Strengthening the parent-child relationship: A review of family interventions and their use in medical settings. <i>Child: Care, Health &amp; Development</i> , 31(1), 25-32.	The review focused on interventions designed to develop the relationship between parent and child. It provided a historical review of the development of three family interventions: filial therapy, Hanf’s operant conditioning procedure for the treatment of handicapped young children and their mothers, and parent training interventions based on social learning theory. This review concluded with suggestions for how these approaches could be useful to health professionals in medical settings.	<ul style="list-style-type: none"> <li>• Psychological interventions aiming to strengthen the bond between parents and children are extensively used in child and family therapy services for stress reduction and childhood behavioral issues.</li> <li>• These interventions are effective, especially when they include parent skills training.</li> </ul>
Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programs for the treatment of physical child abuse and neglect. <i>Cochrane Database of Systematic Reviews</i> . 2006:3. DOI: 10.1002/14651858.CD005463.pub2.	This review focused on studies of short-term (between six and 30 weeks) group and individual parent-training programs. It included only randomized-controlled trials with a control group (waiting list, no treatment, or alternative treatment group), and at least one indicator of abuse, neglect or maltreatment (e.g., placement on the child protection register, maltreatment recorded in medical record, non-organic failure to thrive, or out-of-home placement of the child). Of the 132 studies reviewed, 26 were relevant to the subject, and only seven were included in the review.	<ul style="list-style-type: none"> <li>• Child neglect and abuse are serious public health problems; abuse has a very strong link to subsequent psychopathology.</li> <li>• Maltreating and abusive parents are less positive, supportive and nurturing, and more negative, hostile, and punitive in their relationships with their children. Abusive parents react more negatively to parental challenges, such as a crying infant; frequently have inappropriate expectations of the child; are unaware of the child’s needs; believe in the value of punishment; and may look to the child for the satisfaction of their own emotional needs.</li> <li>• Most studies reported positive results for parent and child behavior and family functioning, but few were statistically significant.</li> <li>• Programs that address issues specific to abuse (for example, excessive parental anger, misattributions to child behavior,</li> </ul>

Review	Description	Findings
		etc.) were more effective than those that did not address abuse issues.
<p>Eshel, N., Daelmans, B., Cabral de Mello, M. &amp; Martines, J. (2006). Responsive parenting: Interventions and outcomes. <i>Bulletin of the World Health Organization</i>, 84, 991-998.</p>	<p>Out of 200 papers and book chapters on responsive care, the authors chose a representative sample of 50, with priority given to randomized controlled trials. Both developed and developing country studies were included.</p>	<ul style="list-style-type: none"> <li>• Responsive care involves observation, interpretation, and action.</li> <li>• Maternal responsiveness is linked to improved child health and development.</li> <li>• The most common interventions to improve responsiveness included home visits alone or a combination of home visits and clinic care. These interventions had a modest effect on responsiveness.</li> </ul>
<p>Gardner, M. R., &amp; Deatrck, J. A. (2006). Understanding interventions and outcomes in mothers of infants. <i>Issues in Comprehensive Pediatric Nursing</i>, 29(1), 25-44.</p>	<p>Examined strategies that nurses and other health care providers can use to facilitate effective mothering during the first two years of life. Reviewed 23 studies conducted between 1994 and 2004 describing interventions designed to strengthen mothering (among non-teenage mothers) of infants less than 24 months old. Classified interventions into five broad categories:</p> <ul style="list-style-type: none"> <li>• individual education and support (e.g., pre- and postpartum orientation toward infant cues and behaviors and skill development)</li> <li>• group programs</li> <li>• mother-infant contact (e.g., Kangaroo care)</li> <li>• home visiting by nurses and non-professionals</li> <li>• multicomponent programs incorporating several strategies.</li> </ul>	<ul style="list-style-type: none"> <li>• Mothering in the first two years is critical to infant health, development, and wellbeing.</li> <li>• There is some evidence for the effectiveness of all five categories: individual education and support; group programs; mother-infant contact; home visiting; and multicomponent programs incorporating several strategies.</li> <li>• However, the strongest evidence suggested that nurse home-visiting interventions in high-social-risk populations and groups with free-floating membership (such as those created on an ad-hoc basis during clinic visits), seem to have less influence on mothering processes.</li> <li>• More evidence is needed on the effectiveness of social support from family and peers, which has a positive influence on perceptions of mothering capabilities, coping, and overall maternal mental health. Social support also facilitates parental coping, decreases parental stress and anxiety, and promotes effective family functioning for parents of chronically ill children.</li> </ul>
<p>Lundahl, B., Risser, H. J., &amp; Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. <i>Clinical Psychology Review</i>, 26(1), 86-104.</p>	<p>Reviewed 63 of 430 studies between 1974 and 2003 that met the following nine criteria:</p> <ul style="list-style-type: none"> <li>• published in an English peer-reviewed journal</li> <li>• reported on non-laboratory-based parent training programs targeting disruptive-child behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• Disruptive child behaviors, including aggression and noncompliance, are the most common problems for which parents seek assistance.</li> <li>• Behavioral and non-behavioral-oriented parent training programs did not differ significantly in their impact on child or parental functioning.</li> <li>• Moderators of effects included: individual programs (more); clinical</li> </ul>



Review	Description	Findings
	<ul style="list-style-type: none"> <li>• group-based</li> <li>• had at least 1 treatment and 1 control group which were drawn from the same population</li> <li>• reported on outcomes in addition to parent satisfaction</li> <li>• included data sufficient for meta-analysis</li> <li>• excluded developmental delay.</li> </ul>	<p>significance of children’s problems (more); single parenting (less); socioeconomic stress (less).</p> <ul style="list-style-type: none"> <li>• Parent training was less effective for single parents, more severe child problems and for economically disadvantaged families. The latter groups benefited significantly more from individually delivered parent training compared to group delivery.</li> <li>• Child age did not affect outcomes.</li> <li>• Improvements were retained for up to one year following behavioral programs, but decreased over time.</li> <li>• Family adversity significantly undermined positive changes in parental behavior.</li> </ul>
<p>Magill-Evans, J., Harrison, M. J., Rempel, G., &amp; Slater, L. (2006). Interventions with fathers of young children: Systematic literature review. <i>Journal of Advanced Nursing</i>, 55(2), 248-264.</p>	<p>Reviewed 14 intervention studies published in English between 1998 and 2003 that met the following criteria: included a control group or used a pre-test and post-test design, measured an aspect of father-child interaction, and analyzed father outcomes separately from mother outcomes. The review identified 12 different interventions.</p>	<ul style="list-style-type: none"> <li>• The majority of the interventions (9/12) targeted fathers of newborns or infants to address sensitivity to infant behavior and to teach such specific skills as infant massage or infant-care skills. One study addressed the social and physical environment for labor and delivery. The remaining three interventions targeted fathers of toddlers or preschool-age children.</li> <li>• Those interventions that showed a significant influence on the father’s behavior with his child were: prenatal education; infant massage; parental observation of infant behavior; and enhanced participation for fathers in a Head Start program including a support group, father-child recreation activities, and discussion groups for fathers of toddlers accompanied by father-child playtime (McBride 1991).</li> <li>• In all interventions, there was an opportunity for fathers to learn how to observe and interpret child behavior.</li> <li>• Although the number of intervention studied was limited, there was evidence that, if interventions involve active participation with or observation of the father’s own child, the intervention may be effective in enhancing the father’s interactions with the child and a positive perception of the child.</li> <li>• There is less information on how interventions influenced child development.</li> </ul>

Review	Description	Findings
<p>McCart, M. R., Priester, P. E., Davies, W. H., &amp; Azen, R. (2006). Differential effectiveness of behavioral parent-training and cognitive-behavioral therapy for antisocial youth: A meta-analysis. <i>Journal of Abnormal Child Psychology</i>, 34(4), 527-543.</p>	<p>Reviewed the results of 30 studies on Behavioral Parent Training (BPT) and 41 studies on Cognitive Behavioral Therapy (CBT) for youth with anti-social problems. Of 426 studies published between 1973 and 2004, 76 (18%) met the inclusion criteria. Of these studies, 73 reported post-treatment outcome data and 17 reported follow-up outcome data. The effectiveness of both approaches was demonstrated in a number of controlled psychotherapy outcome studies.</p>	<ul style="list-style-type: none"> <li>• Parenting styles characterized by coercive parent–child interchanges, inconsistent discipline, and poor parental monitoring place youth at risk for the development of antisocial behavior problems.</li> <li>• BPT typically aims to alter maladaptive parent–child interactions by training parents to use behavioral techniques to reinforce youth’s prosocial behavior and decrease youth’s antisocial behavior.</li> <li>• The mean effect sizes for both BPT and CBT are in the small to medium range, suggesting that both are effective in reducing youth’s antisocial behavior.</li> <li>• A number of convincing studies suggest that broad-based interventions that involve parents, youth, and external systems (e.g., schools) are more effective than either BPT or CBT alone.</li> </ul>
<p>Mercer, R.T., &amp; L.O. Walker. 2006. A review of nursing interventions to foster becoming a mother. <i>Journal of Obstetric, Gynecologic and Neonatal Nursing</i>. 35(5):568-82.</p>	<p>Reviewed nursing interventions that assist women to prepare for their role as mother. The studies were classified into five overlapping categories: instructions for infant caregiving (N = 5), building awareness of and responsiveness to infant interactive capabilities (11), fostering maternal-infant attachment (6), maternal social role preparation (3), and interactive therapeutic nurse-client relationships (3).</p>	<ul style="list-style-type: none"> <li>• Mothers preferred live instructions as opposed to video or audiotaped instructions.</li> <li>• Interventions promoting attachment were largely ineffective.</li> <li>• Interactive nurse-mother relationships were associated with greater maternal competence in high-risk settings.</li> <li>• Intensive and longer-lasting interventions were more effective. Less competent mothers, in particular, did better when engaged in intensive interventions.</li> <li>• Perhaps too much emphasis been placed on teaching how to care for the infant instead of problem solving with the mother to come up with her own solutions. It is important to emphasize the role of family and friends in providing support, physical and emotional care, and guidance.</li> </ul>

Review	Description	Findings
<p>Nye, C., Schwartz, J., &amp; Turner, H. (2006). Approaches to parent involvement for improving the academic performance of elementary school age children. <i>Campbell Systematic Reviews</i>, 2006:4. DOI: 10.4073/csr.2006.4.</p>	<p>The review was limited to randomized controlled trials that included parental involvement. A total of 19 studies met the criteria. The review focused on studies where the parent had a direct interaction with the child in either the delivery or monitoring of the intervention.</p>	<ul style="list-style-type: none"> <li>• Parental involvement resulted in a positive and significant overall effect on children’s achievements.</li> <li>• Children in the combined parental involvement group performed approximately half a standard deviation higher in an academic setting compared to those in the control group.</li> <li>• Many of the studies focused on reading achievements. Mathematical achievements showed only slightly significant changes between control and intervention groups.</li> <li>• The largest average effect was seen in programs where parents provided some kind of reward or incentive for their child’s academic performance. The next largest average effect was seen in programs where parents received education and training on how to improve their child’s general academic performance.</li> <li>• Duration of parental involvement did not appear to be important to outcomes.</li> </ul>
<p>Shaw, E., Levitt, C., Wong, S., Kaczorowski, J., &amp; the McMaster University Postpartum Research Group (2006). Systematic review of the literature on postpartum care: Effectiveness of postpartum support to improve maternal parenting, mental health, quality of life, and physical health. <i>Birth</i>, 33(3), 210-220.</p>	<p>Reviewed 22 postpartum support programs that focused on improving maternal knowledge, attitudes, and skills relating to parenting, maternal mental health, maternal quality of life, and maternal physical health. Used the Jadad et al. (1996) scale, which assigns a numeric score based on randomization, blinding, and description of dropouts, to assess the methodological quality of each study.</p>	<ul style="list-style-type: none"> <li>• Universal postpartum support for low-risk women did not result in statistically significant improvements for any outcomes examined.</li> <li>• Home visits, peer support and educational visits to a pediatrician resulted in statistically significant improvements in maternal-infant parenting skills among low-income primiparous women at high risk for family dysfunction. It remains to be determined whether these improvements will result in a reduced incidence of child abuse or neglect.</li> <li>• Maternal satisfaction was higher with home visitation programs.</li> <li>• In conclusion, there is some evidence that high-risk populations may benefit from postpartum support.</li> </ul>

Review	Description	Findings
<p>Gagnon, A. J., &amp; Sandall, J. (2007). Individual or group antenatal education for childbirth or parenthood, or both. <i>Cochrane Database of Systematic Reviews</i>. 2007:3. DOI: 10.1002/14651858.CD002869.pub2.</p>	<p>This paper reviewed nine randomized controlled trials out of 46 studies, involving 2284 women. Criteria for inclusion required: a controlled trial evaluating structured forms of antenatal education classes provided to individual or groups of future parents; random allocation to treatment and control groups; loss to follow up be insufficient to materially affect the comparison; and data be available in a form suitable for analysis.</p> <ul style="list-style-type: none"> <li>• Antenatal education aims to help prospective parents prepare for childbirth and parenthood.</li> </ul>	<ul style="list-style-type: none"> <li>• Programs can be intensive one-day trainings or be comprised of multiple classes over several weeks. The interventions can be administered individually or through group sessions. Venues include teachers' homes, community centers, hospitals and clinics. Classes or groups can be for pregnant women only or for women and their partners.</li> <li>• Women report that their primary reason for attending childbirth classes is to reduce their anxiety about labor and birth. Men attend classes to satisfy the wishes of their partners and to learn about infant care.</li> <li>• Interventions varied greatly and no consistent outcomes were measured. Since each study tested different outcomes, the usual benefit of meta-analyses, which involves increasing statistical power by combining small studies, could not be achieved.</li> <li>• The effects of general antenatal education for childbirth or parenthood, or both, remain largely unknown.</li> </ul>
<p>Kane, G. A., Wood, V. A., &amp; Barlow, J. (2007). Parenting programs: A systematic review and synthesis of qualitative research. <i>Child: Care, Health &amp; Development</i>, 33(6), 784-793.</p>	<p>This paper critically appraised four of six purposively selected papers (from a pool of 40) and developed an argument on what aspects of training programs are most helpful to parents.</p>	<ul style="list-style-type: none"> <li>• Systematic reviews and meta-analyses of randomized controlled trials indicate that parenting programs can improve many aspects of family life. However, there is a dearth of information concerning what it is that makes parenting programs meaningful and helpful to parents.</li> <li>• The authors conclude that the acquisition of knowledge, skills and understanding, together with feelings of acceptance and support from other parents in the group, enable parents to regain control and feel more able to cope. This leads to a reduction in feelings of guilt and social isolation, increased empathy with their children, and confidence in dealing with child behavior.</li> </ul>
<p>Kendrick, D., Barlow, J., Hampshire, A., Polnay, L., &amp; Stewart-Brown, S. (2007). Parenting interventions for the prevention of unintentional injuries in childhood. <i>Cochrane Database of Systematic Reviews</i>. 2007:4. DOI:</p>	<p>The review included 11 randomized controlled trials, one non-randomized controlled trial, and two controlled before and after studies, which evaluated parenting interventions administered to</p>	<ul style="list-style-type: none"> <li>• Most common interventions were parent education, support services, and home visits.</li> <li>• Based on nine RCTs included in the meta-analysis, intervention families had a significantly lower risk of child injury.</li> <li>• Several studies found fewer home</li> </ul>

Review	Description	Findings
10.1002/14651858.CD006020.pub2.	parents of children aged 18 years and under. Reporting included outcome data on injuries (unintentional or unspecified intent), and possession and use of safety equipment or safety practices. Parenting interventions were defined as those with a specified protocol, manual, or curriculum aimed at changing knowledge, attitudes, or skills covering a range of parenting topics.	<p>hazards, a home environment more conducive to child safety, or a greater number of safety practices in intervention families.</p> <ul style="list-style-type: none"> <li>• Reduction in injuries may have occurred via a range of mechanisms including increasing the ability of parents to manage minor injuries without medical help, improvements in the quality of child care provided, improved home safety, and an increased conviction that children must be protected.</li> </ul>
Petrie, J., Bunn, F., & Byrne, G. (2007). Parenting programs for preventing tobacco, alcohol or drugs misuse in children <18: A systematic review. <i>Health Education Research</i> , 22(2), 177-191.	Forty six reports in 20 studies (from a potential 122) met the inclusion criteria. Studies had to include one of the following objective or self-reported measures: smoking, drinking or drug use by child; intention of child to smoke, drink or take drugs; alcohol and drug use in criminal offending; antisocial behavior, risky sexual behavior, and antecedent behaviors such as truancy, conduct disorders or poor academic performance. Studies took place almost exclusively in the United States.	<ul style="list-style-type: none"> <li>• Recent trends show a growth in heavy drinking with an associated increase of smoking and illegal drug use among children and youth.</li> <li>• Despite some methodological shortcomings, the evidence suggests that parenting programs can be effective in reducing substance misuse in children.</li> <li>• The strongest evidence came from work with preteen and early adolescent children.</li> <li>• Many interventions were brief.</li> <li>• Although the most effective interventions were school-based, active parental involvement was an important feature of successful interventions. Rather than focusing exclusively on substance use, successful interventions used parents to involve adolescents in family activities, maintain good familial bonds, and manage conflict.</li> </ul>

Review	Description	Findings
<p>Robinson, P., Robinson, M., &amp; Dunn, T. (2007). STEP parenting: A review of the research. <i>Canadian Journal of Counseling</i>, 37, 270-278.</p>	<p>This review provided an overview of the controversy surrounding the origins and known effectiveness of <i>Systematic Training for Effective Parenting</i> (STEP). STEP was published in 1976 and based on Dinkelmeyer and McKay's 1973 publication <i>Raising a Responsible Child</i>. STEP teaches "parents to understand and accept their child's behavior, emotion and lifestyle, while applying correct discipline techniques, encouragement, reflective listening, and democratic family structure" (p. 271). The review specifically examined four questions: whether STEP workshops positively changed parental attitudes; whether parental use of STEP resulted in healthier psychosocial development among children; whether STEP produced positive behavior change in children; and whether specific behavior change procedures advocated by STEP have empirical support.</p>	<ul style="list-style-type: none"> <li>• Some studies found that STEP resulted in positive changes in parental attitudes. However, changes in parental attitudes were not consistently reflected in children's behavior. In fact, there was very little evidence to suggest that STEP changed children's behavior. For example, refraining from physical punishment, as advocated by STEP, was generally regarded as positive parenting but was unevenly related to children's self-esteem.</li> </ul>
<p>Thomas, R., &amp; Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of parent-child interaction therapy and Triple P-Positive Parenting Program: A review and meta-analysis. <i>Journal of Abnormal Child Psychology</i>, 35(3), 475-495.</p>	<p>Examined 24, out of a possible 50, studies published between 1980 and 2004 to evaluate and compare the outcomes of two widely disseminated parenting interventions: Parent-Child Interaction Therapy (PCIT) and Triple P -Positive Parenting Program. Inclusion criteria required at least one parent or child behavior problem outcome measure, and empirical data needed for meta-analysis. Participants in all studies included caregivers and 3 to 12 year old children.</p>	<ul style="list-style-type: none"> <li>• Parenting interventions tend to focus on child management.</li> <li>• In general, the analyses revealed positive effects of both Triple P and PCIT, but effects varied depending on intervention length, components, and source of outcome data.</li> <li>• Both interventions reduced parent-reported child behavior problems and parenting problems.</li> <li>• The effect sizes were large when outcomes of child and parent behaviors were assessed with parent-report.</li> <li>• There were no published dissemination or transportability studies from either intervention, meaning there was no current evidence for effectiveness of either Triple P or PCIT in a community setting.</li> </ul>
<p>Turner, W., Macdonald, G., &amp; Dennis, J. A. (2007). Behavioral and cognitive behavioral training</p>	<p>Reviewed six randomized controlled trials, out of a potential pool of 25 studies,</p>	<ul style="list-style-type: none"> <li>• Foster carer training typically refers to an educational or training process designed to provide foster carers with</li> </ul>

Review	Description	Findings
<p>interventions for assisting foster carers in the management of difficult behavior. Cochrane Database of Systematic Reviews. 2007:1. DOI: 10.1002/14651858.CD003760.pub3.</p>	<p>that involved 463 foster carers. Assessed the effectiveness of cognitive-behavioral training interventions in improving looked-after children's behavioral/relationship problems; foster carers' psychological well-being and functioning; foster family functioning; and d) foster agency outcomes.</p>	<p>information and skills designed to help them fulfill their responsibilities.</p> <ul style="list-style-type: none"> <li>• Training is believed to have enhanced caring attitudes and skills, helped foster carers deal more effectively with children's behavior, and decreased foster carer attrition.</li> <li>• Results suggested little evidence of effect on the psychological functioning of looked-after children and foster carers, or on fostering agency outcomes.</li> <li>• The authors concluded that for foster care intervention to be successful, training needs to be supported by other services and interventions.</li> </ul>
<p>Bennett, C., Macdonald, G., Dennis Jane, A., Coren, E., Patterson, J., Astin, M., &amp; Abbott, J. (2008). Home-based support for disadvantaged adult mothers. Cochrane Database of Systematic Reviews. 2008:1. DOI: 10.1002/14651858.CD003759.pub3.</p>	<p>The review was withdrawn in response to feedback relating to its methodological quality. A revision has not yet been published.</p>	<p>Review withdrawn.</p>
<p>de Graaf, I., Speetjens, P., Smit, F., de Wolff, M. &amp; Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting program on parenting: A meta-analysis. <i>Family Relations</i>, 57, 553-566.</p>	<p>This paper reported on two meta-analyses: 1) the effectiveness of Triple P to improve parenting style; and 2) the maintenance of positive changes over time. The review was restricted to Level 4, which can best be described as "Parent Training." Of 25 relevant studies, 19 were reviewed, 18 of which were RCTs. Most of the studies targeted high-risk areas rather than high-risk groups. Sixteen studies were conducted in Australia, and one each in Germany, Hong Kong and Switzerland. Outcomes were measured by self-report, using either the Parenting Scale or the Parenting Sense of Concern Scale.</p>	<ul style="list-style-type: none"> <li>• Triple P is a behavioral family intervention (BFI) which aims to reduce family risk factors associated with child behavior problems by enhancing the skills and confidence of parents to apply child management techniques.</li> <li>• Reported parenting styles improved significantly after participation in Triple P Level 4 programs.</li> <li>• These results were maintained for periods between 3 and 12 months.</li> <li>• Parents reported greater satisfaction with their parenting role and had positive expectations of change.</li> <li>• Positive effects were independent of the form of delivery – individual, group, or self-help.</li> <li>• Positive effects were similar across families with children in the normal and clinical range of behavior problems, and across child gender.</li> </ul>
<p>Dennis, C.L., &amp; Kingston, D. (2008). A systematic review of telephone support for women during pregnancy and the early postpartum period. <i>Journal of Obstetric, Gynecologic and Neonatal Nursing</i>,</p>	<p>This review aimed to assess the effects of telephone-based support on smoking, preterm birth, low birthweight, breastfeeding, and postpartum depression. Studies were</p>	<ul style="list-style-type: none"> <li>• Perinatal support was traditionally delivered face-to-face, but the findings of this review suggested that telephone support (provided by a professional) as an adjunct intervention appeared to be influential in reducing various perinatal</li> </ul>

Review	Description	Findings
37(3), 301-314.	included if they were randomized controlled trials, aimed to reduce the risk of adverse health outcomes for women and their infants and provided telephone support by a layperson or health professional antenatally or during the first 2 months postpartum. Fourteen trials published between 1986 and 2004 were included in the review. All the studies took place in the USA, UK or Canada.	<p>risk factors.</p> <ul style="list-style-type: none"> <li>• The findings suggested that telephone support could prevent smoking relapse, contribute to preventing low birth weight, increase breastfeeding duration and exclusivity, and decrease postpartum depression symptomatology.</li> <li>• The authors concluded that the results were encouraging.</li> </ul>
Gavita, O., & Joyce, M. (2008). A review of the effectiveness of group cognitively enhanced behavioral based parent programs designed for reducing disruptive behavior in children. <i>Journal of Cognitive and Behavioral Psychotherapies</i> , 8(2), 185-199.	This review aimed to examine the effects of various parenting intervention intensity levels in the treatment of children's conduct problems. In particular, the review examined whether adjunct cognitive interventions reduce parental stress and add to the efficacy and durability of standard parenting skills training. Only five of 66 studies conducted between 1970 and 2008 met the inclusion criteria, which took into consideration randomized controlled trials that included at least one group-based parenting program that was enhanced with a cognitive module for reducing parental distress.	<ul style="list-style-type: none"> <li>• The results indicated that cognitively enhanced parenting programs could be highly effective in improving both child disruptive behavior and parental distress. The improvements were maintained at three years follow-up.</li> <li>• For all the studied outcomes, cognitively enhanced programs added only a small effect when compared to standard parenting programs.</li> <li>• The meta-analysis showed no evidence that the cognitively enhanced programs effectively improved parents' sense of self-competence.</li> </ul>
Kaminski Wyatt, J., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. <i>Journal of Abnormal Child Psychology</i> , 36(4), 567-589.	This review used meta-analytic techniques to synthesize the results of 77 evaluations, out of a pool of 576 studies, published between 1990 and 2002 that focused on training programs aimed at improving parenting skills. Examined three commonly held, but rarely tested, assumptions about parent training: 1) that instruction in child development is necessary and sufficient to ensure parental behavioral changes; 2) that manualized programs produce better outcomes than programs without a curriculum;	<ul style="list-style-type: none"> <li>• There was a significant positive overall effect size showing that parent training programs prevent or ameliorate early child behavior problems.</li> <li>• As had been found in other reviews, the mean effect size for parenting outcomes was higher than it was for child outcomes. Furthermore, parent knowledge and outcomes had a larger mean effect size compared to parental behavior and skills.</li> <li>• After controlling for a large number of factors, program components associated with larger differences included: increasing positive parent-child interactions and emotional communication skills, teaching parents</li> </ul>



Review	Description	Findings
	<p>and 3) that “more is better” and that providing families with more services(e.g., anger or stress management, substance abuse treatment, or job skills training) leads to better outcomes.</p>	<p>to use time out and consistency, and requiring parents to practice new skills with their children during parent training sessions.</p> <ul style="list-style-type: none"> <li>• Program components consistently associated with smaller effects included teaching parents problem solving; promoting children’s cognitive, academic, or social skills; and providing additional services.</li> <li>• Greater benefits were not observed in studies that included child development instructions, manualized programs, or additional services.</li> </ul>
<p>Kendrick, D., Barlow, J., Hampshire, A., Stewart-Brown, S., &amp; Polnay, L. (2008). Parenting interventions and the prevention of unintentional injuries in childhood: Systematic review and meta-analysis. <i>Child: Care, Health &amp; Development</i>, 34(5), 682-695.</p>	<p>This peer-reviewed journal publication was included earlier in this table as part of the 2007 Cochrane Review.</p>	<p>Reviewed above.</p>
<p>Lucas, P., McIntosh, K., Petticrew, M., Roberts, H. M., &amp; Shiell, A. (2008). Financial benefits for child health and well-being in low income or socially disadvantaged families in developed world countries. <i>Cochrane Database of Systematic Reviews</i>. 2008:2. DOI: 10.1002/14651858.CD006358.pub2.</p>	<p>This review aimed to assess the effectiveness of direct provision of monies to socially or economically disadvantaged families in improving children’s health, well-being, and educational attainment. The selected studies provided money to relatively poor families (which included a child under the age of 18 or a pregnant woman), were randomized or quasi-randomized, measured outcomes related to child health or wellbeing, and were conducted in a high income country. The review considered nine randomized controlled trials, out of a pool of 70 potential studies, and involved more than 25,000 participants. All studies were conducted in the USA, except one in Canada. All studies combined cash incentives (e.g., negative taxation, income supplements) with work support or a requirement to work, along with other changes to provision of welfare</p>	<ul style="list-style-type: none"> <li>• There is some resistance to the use of trials in social interventions on practical, ethical, or political grounds. Universal policy interventions can be documented only across a cohort as a whole.</li> <li>• The monetary value of many interventions was low. In most studies the total increase in income to families was less than US\$11.50 per week, despite the fact that many parents were compelled to work full time to get more money.</li> <li>• Interventions did increase employment, but they also introduced new controls on participants. Enforcing that parents take low status jobs may increase stigma and stress rather than reducing it.</li> <li>• The studies found no effect on child health, mental health, or emotional state. There was a trend toward improved early language performance among children.</li> <li>• Non-significant effects favoring the intervention group were seen for child cognitive development and educational achievement.</li> <li>• The reviewers concluded that large scale evaluations of conditional small</li> </ul>

Review	Description	Findings
	payments.	payments had been thoroughly tested and, notwithstanding the limited child outcome data in the studies reviewed, probably did not need to be repeated.
Macdonald, G., Bennett, C., Dennis, J. A., Coren, E., Patterson, J., Astin, M., & Abbott, J. (2008). Home-based support for disadvantaged teenage mothers. <i>Cochrane Database of Systematic Reviews</i> . 2008:1. DOI: 10.1002/14651858.CD006723.pub2.	The review was withdrawn in response to feedback relating to its methodological quality. A revision has not yet been published.	Review withdrawn.
Piquero, A. R., Farrington, D., Jennings, W. G., Tremblay, R., Piquero, A., & Welsh, B. (2008). Effects of early family/parent training programs on antisocial behavior and delinquency. <i>Campbell Systematic Reviews</i> . 2008:11. DOI: 10.4073/csr.2008.11.	Reviewed studies between 1976 and 2008 that investigated the effects of early family/parent training on child behavior problems such as conduct problems, antisocial behavior, and delinquency. Studies were only included if they enrolled families with children under 5 years of age, used a randomized controlled evaluation design that provided before-and-after measures of child behavior problems, and had independent findings. Studies used individual or group-based parent training sessions led by professionals or non-professionals in a clinic, school, or other community-based site.	<ul style="list-style-type: none"> <li>• Early antisocial behavior is a key risk factor for continued delinquency and crime throughout the life course.</li> <li>• The main parenting intervention programs were the Incredible Years Parenting Program, the Triple P-Positive Parenting Program, and Parent-Child Interaction Therapy. The most internationally recognizable intervention was Webster-Stratton's Incredible Years Parenting Program.</li> <li>• There was an overall positive effect of parent training on children's subsequent delinquent behavior.</li> <li>• Involvement in early family/parent training was shown to result in fewer teacher-rated behavior problems at ages 8-11; fewer instances of running away; fewer arrests, convictions, and probation violations; fewer smoked cigarettes per day; fewer days consuming alcohol; and fewer behavioral problems related to use of alcohol and other drugs at age 15. It also was shown to result in lower rates of juvenile and violent arrests at age 18, and a lower prevalence of arrests for violent, property, drug, and other crimes up to age 27, as well as up to age 40.</li> </ul>
Barlow, J., Coren, E., & Stewart-Brown, S. (2009). Parent-training programs for improving maternal psychosocial health. <i>Cochrane Database of Systematic Reviews</i> . 2009:1. DOI: 10.1002/14651858.CD002020.pub2.	This is an updated version of the 2003 review.	There were no changes in the conclusions.
Chandan, U., & Richter, L. (2009). Strengthening families through early intervention in high HIV prevalence countries. <i>AIDS Care</i> , 21, 76-82.	Reviewed the evidence for family strengthening in the context of early childhood interventions, particularly in the	<ul style="list-style-type: none"> <li>• High quality home visits and ECD programs - for first-time, low-income pregnant mothers and their young children - have the potential to</li> </ul>

Review	Description	Findings
	context of high HIV prevalence and poorly resourced settings.	strengthen families. Consideration for the application of such interventions should occur on a country-by-country basis.
<p>Dretzke, J., Davenport, C., Frew, E., Barlow, J., Stewart-Brown, S., Bayliss, S., et al. (2009). The clinical effectiveness of different parenting programs for children with conduct problems: A systematic review of randomised controlled trials. <i>Child &amp; Adolescent Psychiatry and Mental Health</i>, 3(7). DOI: 10.1186/1753-2000-3-7.</p>	<p>This review included 57 studies, of which 40 had a control group. To be considered, Included studies were RCTs with parents/carers of children up to the age of 18. At least 50% of the sample had to have conduct problems as defined by objective clinical criteria, a clinical cut-off point on a well validated behavior scale, or informal diagnostic criteria. The intervention needed to be a structured, repeatable (manualized) parenting program with at least one standardized child behavior outcome measured. Studies were excluded if the intervention was aimed at prevention rather than treatment, aimed at children or teachers, or was unstructured (e.g., informal support group or unstructured home visits).</p>	<ul style="list-style-type: none"> <li>• Over the past 10 years, there has been a rapid expansion in a number of countries of group-based parent training programs aimed at the treatment of children with conduct problems.</li> <li>• Using both parent report and independent observations of outcomes, parenting programs were deemed effective in improving conduct problems.</li> <li>• Independent observations of change were on the whole smaller than parent reports.</li> <li>• There was insufficient evidence to determine the relative effectiveness of different approaches to delivering parenting programs (e.g., group vs. one-to-one; duration; child involvement; adjunctive treatment; etc.).</li> </ul>
<p>Law, J., Plunkett, C., Taylor, J., &amp; Gunning, M. (2009). Developing policy in the provision of parenting programs: Integrating a review of reviews with the perspectives of both parents and professionals. <i>Child: Care, Health &amp; Development</i>, 35(3), 302-312.</p>	<p>This paper aimed to integrate the findings from a summary of 27 systematic reviews. In addition, it included the results of a series of focus groups with parents and professionals involved in parenting across 3 agencies (health, education, and social work) in a region of the UK.</p>	<ul style="list-style-type: none"> <li>• The paper found a great deal of evidence to support the use of parenting interventions that focus on mother-infant relationship to promote infant mental health. Methods with a clear focus were more effective (e.g., skin contact and video feedback).</li> <li>• There was good evidence to support the use of parenting groups as an intervention for young children with emotional and behavioral difficulties. In these interventions cognitive and behavioral approaches were most effective.</li> <li>• There was evidence that behavioral parent training was particularly effective in reducing externalizing and disruptive behaviors in middle childhood.</li> <li>• There was little evidence to support the use of parenting intervention in the treatment of neglect. In cases of abuse, the evidence supporting the use of parenting interventions was mixed, except among teen mothers where the</li> </ul>

Review	Description	Findings
		<p>evidence was strong.</p> <ul style="list-style-type: none"> <li>• The use of incentives encouraged involvement in parenting groups.</li> <li>• There was limited evidence on the role of paraprofessionals in parenting support.</li> </ul>
<p>Lutz, K. F., Anderson, L. S., Pridham, K. A., Riesch, S. K., &amp; Becker, P. T. (2009). Furthering the understanding of parent-child relationships: A Nursing Scholarship Review Series. Part 1: Introduction. <i>Journal for Specialists in Pediatric Nursing</i>, 14(4), 256-261.</p>	<p>The review described and critiqued 165 nursing scholarship papers published between 1980 and 2008. It includes findings from McBride's 1984 review of 53 studies published in the nursing literature on the topic of being a parent. The papers were divided into four categories: parents' perspectives on early parenting, interaction and the parent-child relationship, parent-child relationships at risk, and parent-adolescent relationships.</p>	<ul style="list-style-type: none"> <li>• Increasing importance of fathers and social-cultural context.</li> <li>• The integrative review reported in four papers is to follow.</li> </ul>
<p>Lutz, K. F., Anderson, L. S., Riesch, S. K., Pridham, K. A., &amp; Becker, P. T. (2009). Furthering the understanding of parent-child relationships: A Nursing Scholarship Review Series. Part 2: Grasping the early parenting experience - The insider view. <i>Journal for Specialists in Pediatric Nursing</i>, 14(4), 262-283.</p>	<p>This is the second in a series of five papers that examined the contribution of nursing research to knowledge about the parent-child relationship. The review considered 41 qualitative and quantitative studies that focused on parental perceptions of and experiences with the parent-child relationship during infancy. The studies included families of preterm infants and term healthy infants. The review included studies from Australia (5), Canada (5), Europe (8) and the USA (23).</p>	<ul style="list-style-type: none"> <li>• Many of the barriers and facilitators that influence the parent-child relations are relevant to nursing. Therefore, nurses have the opportunity to play an important role in the development of positive parent-infant relationships.</li> <li>• Common themes across the studies were the parent-child relationship as a process, the importance and influence of support, and caregiving for the infant as a facilitator of parental commitment and connection.</li> <li>• The review also explored high-risk infants, the neonatal intensive care unit, the infant in the context of the partner relationship, and transition to the home.</li> <li>• Compelling evidence emerged from this review about parents' perceptions of the influence of nurses on the developing parent-infant relationship, particularly in the NICU.</li> <li>• Mothers were the primary participants in most investigations. However, interest in fathers' perceptions, experiences, and relationships has been growing.</li> <li>• Study participants were primarily White, middle class, and often married.</li> </ul>

Review	Description	Findings
<p>Matson, J. L., Mahan, S., &amp; LoVullo, S. V. (2009). Parent training: A review of methods for children with developmental disabilities. <i>Research in Developmental Disabilities, 30</i>(5), 961-968.</p>	<p>This paper provided an overview, but not a systematic review, of parent training for families with a child who has developmental difficulties.</p>	<ul style="list-style-type: none"> <li>• Children with developmental disabilities are a heterogeneous group.</li> <li>• There is an agreement on the need for parental involvement in programs for disabled children.</li> <li>• It is critical that parent training programs teach how to generalize skills from the clinic or school setting to the home setting.</li> <li>• Interventions should be based on sound theoretical principles and evidence demonstrating effectiveness of the treatments – these aims have typically been achieved in the framework of applied behavioral analysis and/or behavior therapy.</li> </ul>
<p>Maulik, P. K., &amp; Darmstadt, G. L. (2009). Community-based interventions to optimize early childhood development in low resource settings. <i>Journal of Perinatology, 29</i>(8), 531-542.</p>	<p>The review aimed to summarize evidence regarding the effectiveness of interventions targeting the early childhood period (between 0 and 3 years). Specifically the review looked at the effectiveness of play, reading, music, tactile and/or motor stimulation, and basic maternal and child care. The feasibility of implementing such strategies in low- and middle-income countries was also evaluated. Studies were obtained from searches in electronic databases, review of reference lists, and snow-balling techniques. Overall, 76 articles were identified dealing with 53 studies. Of these, 24 RCTs were identified (16 of which were from low- and middle-income countries).</p>	<ul style="list-style-type: none"> <li>• Music was evaluated primarily in intensive care settings and more research is needed to substantiate its effectiveness.</li> <li>• Play and reading were effective interventions in low- and middle-income countries.</li> <li>• Both Kangaroo care and massage showed beneficial effects; the latter to a lesser extent. Kangaroo care was found to be effective in resource poor settings for low birth weight infants; however, more research is needed in community settings. More rigorous research is needed to assess the effectiveness of massage; particularly in community-level interventions.</li> <li>• Improvements in parent-child interaction were common in all interventions; such improvements are thought to lead to better care for children and improved cognitive development.</li> </ul>
<p>Pridham, K., Lutz, K., Anderson, L., Riesch, S. &amp; Becker, P. (2010). Furthering the understanding of parent-child relationships: A Nursing Scholarship Review Series. Part 3: Interaction and the parent-child relationship – assessment and intervention studies. <i>Journal for Specialists in Pediatric Nursing, 15</i>, 33-61.</p>	<p>This is the third in a series of five articles that examined the contribution of nursing research to understanding the parent-child relationship. Nursing can influence and support parenting. The review covered assessment research and intervention research. The review identified 56 studies conducted between 1980 and 2008, but only 22 intervention studies were examined. The</p>	<ul style="list-style-type: none"> <li>• Nursing interventions aimed at assisting parents had uneven results.</li> <li>• The assessment review demonstrated clearly that prematurity and other medical conditions influenced parent-child interaction.</li> <li>• Health infant interventions included fetal palpation and massage (no effect); rooming in (positive effects on attachment); massage (no effect on child growth but improved mother-child play); information, demonstration</li> </ul>

Review	Description	Findings
	<p>article organized the studies by population.</p>	<p>or video about infant responsiveness (improved maternal contingency); and individualized support for nursing and crying (no effect in one study but effects on maternal sensitivity in others).</p> <ul style="list-style-type: none"> <li>• Additional health infant interventions included healthy infants in stressful conditions, such as circumcision (positive maternal support behavior); infant colic (ambiguous outcome); and maternal depression (increase in maternal responsiveness).</li> <li>• Some studies found that a variety of approaches for premature babies showed increased sensitivity and improved maternal coping; the findings were not significant in all the studies.</li> <li>• Father interaction skills using videotape feedback improved sensitivity.</li> </ul>
<p>Winokur, M., Holtan, A., &amp; Valentine, D. (2009). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. <i>Cochrane Database of Systematic Reviews</i>. 2009:1. DOI: 10.1002/14651858.CD006546.pub2.</p>	<p>The review included randomized experimental and quasi-experimental studies and outcomes examined related to well-being, permanency and safety. Sixty two quasi-experimental studies were included, out of a potential 251.</p>	<ul style="list-style-type: none"> <li>• 57 of the 62 studies were conducted in the USA; 5 were conducted in other high income countries.</li> <li>• The most common perceived benefits was that kinship care "enables children to live with persons whom they know and trust, reduces the trauma children may experience when they are placed with persons who are initially unknown to them, and reinforces children's sense of identity and self-esteem which flows from their family history and culture".</li> <li>• Controversies surrounded the unequal financial support, training, services, oversight, and certification that kin receive.</li> <li>• Data suggest that children in kinship foster care have better behavioral development, mental health functioning, and placement stability than do children in non-kinship foster care.</li> <li>• There was no difference in reunification rates.</li> <li>• Children in foster care were more likely to be adopted while children in kinship care were more likely to be in guardianship.</li> <li>• Children in foster care were more likely to utilize mental health services.</li> <li>• The included studies had pronounced methodological and design weaknesses.</li> </ul>

Review	Description	Findings
		Therefore, the conclusions of the review were tempered.
<p>Anderson, L. S., Riesch, S. K., Pridham, K. A., Lutz, K. F., &amp; Becker, P. T. (2010). Furthering the understanding of parent-child relationships: A Nursing Scholarship Review Series. Part 4: parent-child relationships at risk. <i>Journal for Specialists in Pediatric Nursing, 15</i>(2), 111-134.</p>	<p>This is the fourth in a series of five articles that examined the contribution of nursing research to understanding the parent-child relationship. Lutz et al (2009) provided the introduction to the series. The findings from the studies were classified into four categories: normalizing, extraordinary parenting, negative consequences for the parent-child relationship, and positive consequences for the parent-child relationship.</p>	<ul style="list-style-type: none"> <li>• The presence of a family member with a chronic illness may interfere with the parent-child relationship. In such cases, nurses have a role to play in supporting families.</li> <li>• The consequences of the at-risk parent-child relationship are not always negative. In fact, families can become stronger under conditions of adversity.</li> <li>• When someone has a chronic illness, family communication can become impaired, parenting stress can increase, and family functioning can decline. Many of these factors are amenable to nurse intervention. Nurses have tested a number of interventions intended to provide support for the parent-child relationship during these times of stress.</li> </ul>
<p>Barlow, J., McMillan, A. S., Kirkpatrick, S., Ghate, D., Barnes, J., &amp; Smith, M. (2010). Health-led interventions in the early years to enhance infant and maternal mental health: A review of reviews. <i>Child &amp; Adolescent Mental Health, 15</i>(4), 178-185.</p>	<p>The review aimed to identify effective health-led interventions that supported parents, parenting, and the parent-infant relationship during the perinatal period and beyond. Health-led interventions included methods for promoting closeness, sensitive parenting, awareness of infant sensory and perceptual capabilities, and positive parenting. Methods for addressing infant regulatory problems, maternal mental health problems, and parent-infant relationship problems were also included. The paper identified 33 systematic reviews and two reviews of reviews which met the inclusion criteria.</p>	<ul style="list-style-type: none"> <li>• The authors conclude that it is now clear that parent-infant interaction during the postnatal period is a strong determinant of early neurological development and thereby all aspects of later functioning.</li> <li>• Identified methods of debriefing included: addressing mental health problems, drug and alcohol use, and early parent-infant problems through anticipatory guidance, interaction guidance, attachment promotion, etc.; strengthening the parent-infant relationship through promotion of closeness, information about infant perceptual capacities, infant massage, supporting fathers, and parenting programs.</li> <li>• Evidence supports the use of a range of interventions and methods of supporting parents, parenting, and the parent-infant relationship during the perinatal period.</li> <li>• Recommends the use of the delivery of universal services to identify parents and infants with both moderate and high level needs, as well as the use of evidence-based approaches such as the Family Partnership Model.</li> </ul>
<p>Barlow, J., Smailagic, N., Ferriter, M., Bennett, C., &amp; Jones, H. (2010).</p>	<p>The review aimed to establish whether group-based parenting</p>	<ul style="list-style-type: none"> <li>• Emotional and behavioral problems in children are common. Parenting has an</li> </ul>

Review	Description	Findings
<p>Group-based parent-training programs for improving emotional and behavioral adjustment in children from birth to three years old. Cochrane Database of Systematic Reviews. 2010:3. DOI: 10.1002/14651858.CD003680.pub2.</p>	<p>programs are effective in improving the emotional and behavioral adjustment of children younger than 4 years of age. The review covered randomized controlled trials of group-based parenting programs that had used at least one standardized instrument to measure children's emotional and behavioral adjustment. Eight studies were included in the review. All of the studies were of behavioral, cognitive-behavioral, or video-tape modeling parenting programs. Six of the studies provided enough data to combine the results in a meta-analysis.</p>	<p>important role to play in helping children to become well-adjusted; the first few months and years are especially important.</p> <ul style="list-style-type: none"> <li>• The review provided some support for the use of group-based parenting programs to improve the emotional and behavioral adjustment of children.</li> <li>• Some of the evidence suggested that interventions longer than 10 weeks might be more beneficial.</li> <li>• There was insufficient evidence to reach firm conclusions regarding the role that parenting programs might play in the primary prevention of such problems.</li> <li>• There was limited data on the long-term effectiveness of these programs.</li> </ul>
<p>Beard, J., Biemba, G., Brooks, M. I., Costello, J., Ommerborn, M., Bresnahan, M., et al. (2010). Children of female sex workers and drug users: A review of vulnerability, resilience and family-centred models of care. <i>Journal of the International AIDS Society</i>, 13(Suppl 2), 1-8.</p>	<p>Many adult drug users and sex workers are also parents. Because their activities are often illegal and hidden, it is difficult to identify their children who are at an increased risk of vulnerability and marginalization. This paper provided a comprehensive overview of available literature relating to children of female sex workers and drug users.</p>	<ul style="list-style-type: none"> <li>• There is a lot of literature assessing the vulnerability and resilience of children of drug users and alcoholics in developed countries. There is a relatively long list of possible negative outcomes for children, ranging from cognitive developmental delays to neglect and abuse as a result of prenatal and postnatal exposure to parental addiction.</li> <li>• Research on the situation of the children of sex workers is extremely limited and, with a few exceptions, largely qualitative and ethnographic. The research has focused on identifying risks associated with separation from parents, sexual abuse, early sexual debut, introduction to sex work as adolescents, low school enrolment, psychosocial issues arising from witnessing their mothers' sexual interactions with clients, and social marginalization. Many of the studies have been on girls.</li> <li>• Almost all of the studies were done in high-income countries.</li> <li>• In order not to expose or further compromise fragile families frequently existing on the fringes of the law, any attempt to document children's needs or to provide them with interventions must be done with care.</li> </ul>
<p>Bryanton, J., &amp; Beck Cheryl, T. (2010). Postnatal parental education</p>	<p>The review aimed to examine interventions used to educate</p>	<ul style="list-style-type: none"> <li>• Generally poor quality studies and highly variable outcome measures</li> </ul>



Review	Description	Findings
<p>for optimizing infant general health and parent-infant relationships. Cochrane Database of Systematic Reviews. 2010;1. DOI: 10.1002/14651858.CD004068.pub3.</p>	<p>new parents about caring for their newborns and focused on structured postnatal education delivered by an educator to an individual or group on infant general health and parent–infant relationships. Included were randomized controlled trials of structured postnatal education provided by an educator to individual parents or groups of parents within the first two months post-birth related to infant care or parent–infant relationship. Excluded were studies of educational interventions for parents of infants in neonatal intensive care units. Of 25 trials, only 15 (2868 mothers and 613 fathers) reported useable data.</p>	<p>precluded detailed analysis.</p> <ul style="list-style-type: none"> <li>• Interventions included infant sleep enhancement, information about infant behavior, general post birth health, infant care, infant safety, and father involvement/skills with infants.</li> <li>• The benefits of educational programs to participants and their newborns remain unclear.</li> <li>• Education on sleep enhancement appears to increase infant sleep.</li> <li>• Education about infant behavior potentially enhances mothers’ knowledge.</li> </ul>
<p>Coren, E., J. Hutchfield, M. Thomae, &amp; C. Gustafsson. 2010. Parent training support for intellectually disabled parents. <i>Campbell Systematic Reviews</i>. Jun 16;(6):CD007987.</p>	<p>The review included only randomized controlled trials that compared parent training interventions for parents with intellectual disabilities with usual care or a control group. The measured outcomes included the attainment of parenting skills specific to the intervention, safe home practices and the understanding of child health. The diagnostic criteria for intellectual disability were broad. Three trials met the inclusion criteria for this review but no meta-analysis was possible.</p>	<ul style="list-style-type: none"> <li>• Parents with intellectual or learning disabilities may need support to provide adequate care for their children and prevent problems that can arise in children's welfare or development.</li> <li>• There is evidence that some parents with intellectual disabilities are able to learn parenting skills and provide adequate child care if they are given appropriate training and support.</li> <li>• Parent training interventions, particularly those based at home, can and do help intellectually disabled parents to learn a range of parenting skills.</li> </ul>
<p>Hoagwood, K., Cavaleri, M., Serene Olin, S., Burns, B., Slaton, E., Gruttadaro, D., &amp; Hughes, R. (2010). Family support in children’s mental health: A review and synthesis. <i>Clinical Child &amp; Family Psychology Review</i>, 13(1), 1-45.</p>	<p>This is a comprehensive review of structured family support programs in children’s mental health. Over 200 programs were examined, of which 50 met the author’s criteria for inclusion. The goals of the review were to identify typologies of family support services for which evaluation data existed and to identify research gaps.</p>	<ul style="list-style-type: none"> <li>• Programs were categorized by whether they were delivered by peer family members, clinicians, or teams.</li> <li>• Five components of family support were identified: informational, instructional, emotional, instrumental, and advocacy.</li> <li>• Most programs were delivered by clinicians.</li> <li>• Family and team-led programs were more often delivered in community settings.</li> <li>• In general, support services for parents</li> </ul>

Review	Description	Findings
		<p>produced superior child outcomes to standard treatment alone.</p> <ul style="list-style-type: none"> <li>• Family-delivered support may be an important adjunct to existing services for parents, although the research base is small.</li> <li>• Because of their personal experience, peer family advisors often have credibility with parents and are able to engender trust.</li> <li>• Family support services are designed to assist parents in clarifying their own needs or concerns; reducing their sense of isolation, stress, or self-blame; and empowering them to take an active role in their children's services.</li> </ul>
<p>Jayaratne, K., Kelaher, M., &amp; Dunt, D. (2010). Child health partnerships: A review of program characteristics, outcomes and their relationship. <i>BMC Health Services Research</i>, 10, 172-181.</p>	<p>In order to address the social determinants of health of children, approaches have been developed involving multiple stakeholders. A comprehensive search of literature published between 1989 and 2009 identified 11 major Child Health Partnerships in four comparable developed countries. The Child Health Partnerships are <i>Sure Start</i> and <i>Every Child Matters</i> (UK); <i>First 5 California</i> and <i>Early Head Start</i> (USA); <i>Healthy Child Manitoba</i> and <i>Toronto First Duty</i> (Canada); and <i>Families First, Stronger Families and Communities, Every Chance for Every Child</i>, and <i>Best Start</i> (Australia).</p>	<ul style="list-style-type: none"> <li>• Most partnerships consisted of a consortium of local government bodies with different sectors, civil society organizations, and community stakeholders.</li> <li>• Health services most often took the lead role.</li> <li>• Most programs started with antenatal support, breastfeeding promotion, early learning facilitation (which was the core of all programs), school education, and services for young people.</li> <li>• Most partnerships used outreach, home services, group sessions, reorganization of existing services, and collaboration across areas.</li> <li>• Family support consisted of financial support, provision of basic family needs, parenting support, and different modes of child care services.</li> <li>• Financial assistance was provided in different ways e.g., tax credits to cover childcare costs, health insurance enrolment assistance, and provision of basic family needs (e.g., food, clothing and housing).</li> <li>• Similarly with child care services, programs used a variety of approaches, including traditional child care services, child minding, out of school childcare, and assistance in childcare costs.</li> <li>• There was evidence of success in several major areas, including the formation of effective joint operations in different partnership models, and the</li> </ul>

Review	Description	Findings
		<p>improvement in both child well-being and parenting.</p> <ul style="list-style-type: none"> <li>• Better utilization of services by families resulted in improved child development, parenting, and immunization.</li> <li>• There is emerging evidence that Child Health Partnerships are cost-effective.</li> </ul>
<p>Pinquart, M., &amp; Teubert, D. (2010). Effects of parenting education with expectant and new parents: A meta-analysis. <i>Journal of Family Psychology</i>, 24(3), 316-327.</p>	<p>This meta-analysis integrated the effects of randomized controlled trials that focus on promoting effective parenting in the transition to parenthood. It covered 142 papers on interventions that started during pregnancy or in the first six months after birth.</p>	<ul style="list-style-type: none"> <li>• The birth of a child marks a major transition in parents' lives. It may be associated with positive experiences, but for many couples, and for mothers in particular, parenthood also causes negative experiences, such as decline in the quality of the couple relationship, physical exhaustion, increase in psychological distress, and difficulties with developing effective parenting behaviors.</li> <li>• The review found that early parenting education programs for expectant and new parents produced a significant positive effect on all assessed outcomes – including parenting, parental stress, child abuse, health-promoting behavior of parents, cognitive and social and motor development of the child, child mental health, parental mental health, and couple adjustment.</li> <li>• Larger effect sizes on parental mental health were found in studies that were comprised mothers rather than couples. Selective prevention had a large effect size compared to universal prevention.</li> <li>• Successful interventions included the promotion of sensitive parenting, effective baby care, and the promotion of cognitive development. These interventions were more likely to be led by professionals.</li> <li>• The largest effect sizes were found for interventions lasting for three to six months. There was no evidence for stronger effects of interventions that began during pregnancy.</li> <li>• Most of the effects were maintained at follow-up.</li> <li>• Interventions with parents at social risk included families with heterogeneous risk factors (e.g., lack of social support, substance abuse, and</li> </ul>

Review	Description	Findings
		poverty). It was important to identify which interventions were most beneficial for the different groups of parents.
<p>Pridham, K. A., Lutz, K. F., Anderson, L. S., Riesch, S. K., &amp; Becker, P. T. (2010). Furthering the understanding of parent-child relationships: A Nursing Scholarship Review Series. Part 3: Interaction and the parent-child relationship - Assessment and intervention studies. <i>Journal for Specialists in Pediatric Nursing, 15</i>(1), 33-61.</p>	<p>This is the third part of a series of five papers that examined the contribution of nursing research to knowledge about the parent-child relationship. This integrative review concerns nursing research on parent-child interaction and relationships published from 1980 through 2008. The review included assessment and intervention studies in clinically important settings (e.g., feeding, teaching, play). Fifty-six peer-reviewed studies were included in this paper – 34 dealt with observations and 22 dealt with interventions.</p>	<ul style="list-style-type: none"> <li>• Although there are a large number of studies in the assessment category, their contribution to knowledge of the parent-child relationship is diminished by the fragmented nature of the research. The assessment review demonstrated clearly that prematurity and other medical conditions influenced parent-child interaction.</li> <li>• Studies in the intervention category give some indication that nursing processes may enhance interaction and qualities of the parent-child relationship (e.g., sensitivity, responsiveness, mutuality).</li> <li>• Nursing interventions aimed at assisting parents had uneven results.</li> <li>• Health infant interventions included fetal palpation and massage (no effect); rooming in (positive effects on attachment); massage (no effect on child growth but improved mother-child play); information, demonstration or video about infant responsiveness (improved maternal contingency); and individualized support for nursing and crying (no effect in one study but effects on maternal sensitivity in others).</li> <li>• Additional health infant interventions included healthy infants in stressful conditions, such as circumcision (positive maternal support behavior); infant colic (ambiguous outcome); and maternal depression (increase in maternal responsiveness).</li> <li>• Some studies found that a variety of approaches for premature babies showed increased sensitivity and improved maternal coping; the findings were not significant in all the studies.</li> <li>• Father interaction skills using videotape feedback improved sensitivity.</li> <li>• However, further investigation is needed to determine whether these effects can be replicated with larger or different populations.</li> </ul>
<p>Reese, E., Sparks, A., &amp; Leyva, D.</p>	<p>This article reviewed parent-</p>	<ul style="list-style-type: none"> <li>• Given that parents are their children's</li> </ul>

Review	Description	Findings
<p>(2010). A review of parent interventions for preschool children's language and emergent literacy. <i>Journal of Early Childhood Literacy</i>, 10(1), 97-117.</p>	<p>training studies of children's language and literacy in three contexts: parent-child book-reading, parent-child conversations, and parent-child writing. Selection criteria for the review were: the study had to be experimental in nature (treatment and control groups); include a direct parent-training component (not just distribute books or information to parents); focus on parents of preschool or kindergarten children who were not receiving formal reading instruction; and the parent training attempted to improve children's language and/or emergent literacy.</p>	<p>first teachers, it is imperative to consider how parents can help improve their children's language and emergent literacy development prior to formal schooling.</p> <ul style="list-style-type: none"> <li>• The three most common interventions were: 1) teaching parents to read storybooks to children as a way to enhance their language and literacy; 2) parent-child conversations as a springboard for children's language and narrative development; and 3) focusing on parents' assistance for children's writing.</li> <li>• Shared book-reading interventions that trained parents to adopt dialogic reading techniques were an effective way to enhance children's expressive vocabulary, and in some studies, their receptive vocabulary.</li> <li>• Dialogic reading interventions were not as effective for children from low-income families or for older preschoolers.</li> <li>• Storytelling about personally experienced events could be used as an alternative or supplement to book reading for children from a range of social classes and cultures. It is especially useful in narrative development.</li> <li>• Few studies looked at emergent writing – a promising area that deserves future exploration. Used many of the same techniques that that are used for children with language delay - following the child's talk with particular types of questions, repeating and expanding upon the child's utterances, and using praise and encouragement.</li> <li>• Concluded that the most highly motivated tutors or parents are not always involved in intervention programs.</li> <li>• Programs, particularly those working with low-SES communities, preferred to train non-familial adults for several reasons: such adults were considered more easily trained, knowledgeable and skilled; they were seen as more reliable and as having a higher fidelity of implementation. In addition, parents struggled with competing duties at</li> </ul>

Review	Description	Findings
		<p>home and at work - asking them to participate in an intervention program might have added more stress to their life.</p> <ul style="list-style-type: none"> <li>The reviewed literature showed that low-SES parents, who typically had more stressful lives, were able to incorporate some of the language and literacy development strategies when interacting with their children. The review concluded that parents were an under tapped resource for children's early learning.</li> </ul>
<p>Riesch, S., Anderson, L., Prodhm, K., Lutz, K. &amp; Becker, P. (2010). Furthering the understanding of parent-child relationships: A Nursing Scholarship Review Series. Part 5: Parent-adolescent and teen parent-child relationships. <i>Journal for Specialists in Pediatric Nursing</i>, 15, 182-201.</p>	<p>This is the fifth in a series of five papers that examined nursing research contributions to understanding parent-child relationships. The review included 21 papers on parent-adolescent relationships and 11 papers on teen parents. The papers were reviewed under three headings: discovery, assessment, and intervention. The papers that dealt with the last heading are of major interest in this review (four papers).</p>	<ul style="list-style-type: none"> <li>Of the papers 21 papers on parent-adolescent relationships, four of them focused on interventions: one study was directed at general improvement in parent-child relationships, two were aimed at reducing sexual risk, and one focused on reducing diabetes risk among obese adolescents. Parent-adolescent relationship interventions are under-researched area in nursing scholarship and there were few conclusive findings.</li> <li>With respect to teen parenting, all four studies reviewed showed beneficial effects, including improved sensitivity to infant cues, and lower adverse parenting behaviors (e.g., marijuana smoking).</li> </ul>
<p>Anderson, T., &amp; Davis, C. (2011). Evidence-based practice with families of chronically ill children: A critical literature review. <i>Journal of Evidence-Based Social Work</i>, 8(4), 416-425.</p>	<p>The paper reviewed studies published between 1990 and 2004. The studies were classified into four levels:</p> <ul style="list-style-type: none"> <li>Level I evidence included a systematic review of all randomized controlled trials</li> <li>Level II evidence contained at least one randomized controlled trial</li> <li>Level III evidence included well designed controlled studies that were not randomized</li> <li>Level IV evidence included descriptive studies, case studies, and reports of expert committees.</li> </ul>	<ul style="list-style-type: none"> <li>Parents caring for children with chronic illness face two basic issues: learning to deal with their child's health and coping with the stress.</li> <li>Estimates are that about one third of children have a chronic illness - asthma, cancer, cardiac disease, cerebral palsy, congenital disabilities, cystic fibrosis, epilepsy, gastrointestinal disorders, haematological disease, juvenile rheumatoid arthritis, inflammatory bowel disease, nephritic syndrome, rheumatic disease, sickle cell disease, or spina bifida. These conditions are demanding for all family members and changes family life.</li> <li>The review found no Level I studies, three Level II, three Level III, and 11 Level IV studies. Most interventions had not been empirically tested.</li> <li>Generally, interventions consisted of</li> </ul>

Review	Description	Findings
		<p>disease-specific educational training interventions, stress interventions, problem solving training, or therapeutic interventions.</p> <ul style="list-style-type: none"> <li>• There was a marked lack of diversity in the literature; none of the articles identified culturally appropriate interventions.</li> <li>• Another limitation of the data was the absence of empirically based interventions for siblings.</li> <li>• There is a scarcity of evidence-based interventions despite the fact that the literature identified a plethora of risks, stressors, and needs of the families with a chronically ill child.</li> </ul>
<p>Barlow, J., Coren, E., Smailagic, N., Bennett, C., Huband, N., &amp; Jones, H. (2011). Individual and group based parenting for improving psychosocial outcomes for teenage parents and their children. <i>Campbell Systematic Reviews</i>. 2011:2. DOI: 10.4073/csr.20011.2.</p>	<p>The aim of the review was to examine the effectiveness of parenting programs in improving psychosocial outcomes for teenage parents and developmental outcomes among their children. Included in this review were randomized controlled trials that assessed short-term parenting interventions aimed specifically at teenage parents. The studies needed to have a control group that received no-treatment, were put on a waiting list, or received treatment-as-usual. A total of eight studies with 513 participants were included in the review. The eight studies provided a total of 47 comparisons of outcome between intervention and control conditions.</p>	<ul style="list-style-type: none"> <li>• Adolescent parents face a range of problems. They are often from very deprived backgrounds, they can experience a range of mental health problems with little social support, they often lack knowledge about child development and effective parenting skills, and they often have developmental needs of their own.</li> <li>• Nineteen comparisons showed statistically significant difference between intervention and control groups – with the intervention group doing better. Similar results were found using data from nine meta-analyses and four studies.</li> <li>• The review concluded that parenting programs may be effective in improving parent responsiveness to the child, and parent–child interaction; both post-intervention and at follow-up.</li> <li>• Infant responsiveness to the mother also showed improvement at follow-up.</li> <li>• With one exception all the studies were directed at teenage mothers only.</li> <li>• One study was specifically directed at African-Caribbean mothers and a number of other studies included a mixed ethnic profile. This suggests that the findings are relevant to parents from a range of ethnic groups. However, all of the studies were conducted in the USA or Canada.</li> </ul>

Review	Description	Findings
<p>Belsky, J., &amp; de Haan, M. (2011). Annual Research Review: Parenting and children's brain development: the end of the beginning. <i>Journal of Child Psychology and Psychiatry</i>, 52(4), 409-428.</p>	<p>This paper provided an overview of studies of how parenting may affect brain structure and function during early development. The overview relied particularly on studies of early neglect and maltreatment.</p>	<ul style="list-style-type: none"> <li>• Sections of the brain develop at different rates and so are differentially susceptible to environmental influences.</li> <li>• One intervention study, amongst parents of preterm infants, showed effects on brain structure.</li> <li>• Consideration should be given to the hypothesis that children vary in their susceptibility to parenting having an effect on the development of their brain.</li> </ul>
<p>Brett, J., Staniszewska, S., Newburn, M., Jones, N., &amp; Taylor, L. (2011). A systematic mapping review of effective interventions for communicating with, supporting and providing information to parents of preterm infants. <i>BMJ Open</i>, 1(1), e000023. DOI: 10.1136/bmjopen-2010-000023.</p>	<p>The aim of this systematic review was to identify and map effective interventions for communicating with and supporting parents of preterm infants. Studies were included if they provided parent-reported outcomes relating to information, communication, and/or support prior to birth, during care at the neonatal intensive care unit, and after going home. Of the 72 studies identified, 19 were randomized controlled trials, 16 were cohort or quasi-experimental studies, and 37 were non-intervention studies.</p>	<ul style="list-style-type: none"> <li>• The review highlighted the importance of encouraging and involving parents in the care of their preterm infant at the neonatal unit. Such involvement can enhance parents' ability and confidence in caring for their infant, which could lead to improved infant outcomes and reduced length of stay in the neonatal unit.</li> <li>• Interventions for supporting parents included: involving parents in individualized developmental care programs and behavioral assessment programs; breastfeeding, kangaroo-care and infant massage; support forums for parents; interventions to alleviate parental stress; preparation of parents, such as seeing their infant for the first time or preparing to go home; and home-support programs.</li> <li>• Parents reported feeling supported through care programs; through breastfeeding, kangaroo-care and baby massage programs; and through the instruction of behavioral assessment scales.</li> <li>• Parents also felt supported through organized support groups and through provision of an environment where parents could meet and support each other.</li> </ul>
<p>Charles, J. M., Bywater, T., &amp; Edwards, R. T. (2011). Parenting interventions: A systematic review of the economic evidence. <i>Child: Care, Health &amp; Development</i>, 37(4), 462-474.</p>	<p>The paper reported on the first specific systematic review of the published economic evidence for using parenting programs to support families with children with, or at risk of, developing conduct disorders (CD). Ninety-three papers were identified, of which six fulfilled the inclusion criteria.</p>	<ul style="list-style-type: none"> <li>• Close to half of all children with conduct disorders (CD) go on to develop antisocial personality problems. CD is also associated with failure at school, joblessness, failure in relationships, financial dependence on the state, and criminal behavior.</li> <li>• Parenting programs have been shown to reduce CD. Studies from the USA have shown the potential for long-term</li> </ul>



Review	Description	Findings
	<p>The search found one cost-effectiveness study, two partial economic evaluations, two cost studies, and one review article that focused mainly on clinical evidence with secondary focus on cost-effectiveness.</p>	<p>economic benefit of such programs, but there is a lack of cost-effectiveness research for programs in the UK.</p> <ul style="list-style-type: none"> <li>• Programs had a range of costs with the highest items being staff salaries, staff training, and mode of delivery.</li> <li>• The costs of group parenting programs ranged from £629.00 to £3839.00. Cost-effectiveness was influenced by intervention type and delivery method, e.g., individual versus group program.</li> <li>• The costs accrued by health, educational, and social services need to be taken into account.</li> <li>• The authors concluded that, If parenting programs have a positive effect on families facing the greatest socio-economic challenges, this may be more important than technical efficiency (absolute ratio of costs and benefits of such programs).</li> </ul>
<p>O'Brien, M., &amp; Daley, D. (2011). Self-help parenting interventions for childhood behavior disorders: A review of the evidence. <i>Child: Care, Health &amp; Development</i>, 37(5), 623-637.</p>	<p>201 abstracts were identified and 13 were included in this analysis. The inclusion criteria required the study be conducted in English, published in a peer-reviewed journal, and deal with children age 3 – 12 years. Studies were excluded if they focused on children with a learning disability or with evidence of behavioral difficulties. Studies also needed to be dependent on parental concern about the child's behavior - all but one of the studies depended on self-referral. Programs that included minimal therapist support were also included.</p> <p>The review evaluated 2 modes of delivery.</p> <ol style="list-style-type: none"> <li>1. Bibliotherapy: in which parents used written materials, in the form of an instruction manual, that included information about the problem, key strategies for managing it, and homework assignments.</li> <li>2. Multimedia: where parents used videotapes and</li> </ol>	<ul style="list-style-type: none"> <li>• Group-based parent training programs are resource- and cost intensive. They require extensive therapist time through training and supervision. There are also logistical barriers for some parents, such as lack of childcare, transport costs, and work schedules.</li> <li>• Overall, there is good evidence supporting the efficacy of self-help programs in improving child behavior, over the short and longer term.</li> <li>• Self-help programs led to outcomes similar to those achieved with more intensive therapist input.</li> <li>• Parents preferred including minimal levels of therapist support in addition to self-help materials. This also enhanced child outcomes.</li> <li>• There is a need for longer-term follow-ups in research, the identification of moderators of outcome, and economic evaluations.</li> <li>• The review concluded that more consideration needed to be paid to the type of parent and child that would benefit the most from a self-help intervention.</li> </ul>

Review	Description	Findings
<p>Sandler, I. N., Schoenfelder, E. N., Wolchik, S. A., &amp; MacKinnon, D. P. (2011). Long-term impact of prevention programs to promote effective parenting: Lasting effects but uncertain processes. <i>Annual Review of Psychology</i>, 62(1), 299-329.</p>	<p>televisions.</p> <p>This paper looked at the long-term effects of parenting programs on child outcomes, and the processes that accounted for them. Forty-six trials of preventive parenting interventions were included in the review. Included studies had participants randomly allocated into either an intervention or a comparison group; had a minimum of 1 year follow-up; and could be considered a prevention or promotion intervention that is universal (designed to reach the entire population), selective (targeted to selected sub-groups of the population), or indicated (directed at groups already showing early signs of difficulties).</p>	<ul style="list-style-type: none"> <li>• The findings provided evidence that parenting programs could prevent a wide range of problem outcomes and could promote competencies from one to 20 years after being administered.</li> <li>• There was a paucity of evidence concerning the processes that account for program effects.</li> <li>• The authors outlined three possible processes: 1) through program effects on parenting skills, perceptions of parental efficacy, and reduction in barriers to effective parenting; 2) through program-induced reductions in short-term problems of youth that persist over time, in youth adaptation to stress, in youth belief systems concerning the self, and in their relationships with others; and 3) through effects on contexts in which youth become involved and on youth-environment transactions.</li> <li>• The outcomes changed by parenting programs included problems with high individual and societal costs, such as mental disorder, child abuse, substance use, delinquency, risky sexual behaviors, and academic difficulties.</li> <li>• The reviewers recommended that a robust program of implementation and dissemination research was needed to integrate the proven effective programs into health, education, and community settings where they could have a significant public health impact.</li> </ul>
<p>Zeanah, C. H., Berlin, L. J., &amp; Boris, N. W. (2011). Practitioner review: Clinical applications of attachment theory and research for infants and young children. <i>Journal of Child Psychology and Psychiatry</i>, 52(8), 819-833.</p>	<p>This overview provided a synthesis of attachment research for practitioners, such as how attachments develop, how individual differences in attachments manifest themselves, and what clinical disorders of attachment exist. The authors described the clinical relevance of attachment research. They reviewed four interventions for young children and their families, which are closely derived from attachment theory and are supported by rigorous</p>	<ul style="list-style-type: none"> <li>• Attachment refers to the infant's or young child's emotional connection to an adult caregiver. The attachment figure is inferred from the child's tendency to turn selectively to that adult. The child will try to increase proximity when needing comfort, support, nurturance, or protection.</li> <li>• Human infants are born without being attached to any particular caregivers. Attachments develop during the first few years of life with landmark changes at 2-3 months of age, 7-9 months of age, and 18-20 months of age.</li> <li>• Risk factors increase insecure attachment, which itself predicts</li> </ul>

Review	Description	Findings
	evaluations.	<p>further risk.</p> <ul style="list-style-type: none"> <li>• Four intervention approaches are: Child-Parent Psychotherapy, Video-based Intervention to Promote Positive Parenting, which includes four visits to the home; Circle of Security, which includes short-term group psychotherapy using video feedback; and Attachment and Biobehavioral Catch-up, which is comprised of 10 sessions. All of these interventions are extremely training, labor, and cost intensive.</li> <li>• Re-attachment approaches include coercive holding and rebirthing.</li> </ul>
<p>Barlow, J., Smailagic, N., Huband, N., Roloff, V., &amp; Bennett, C. (2012). Group-based parent training programs for improving parental psychosocial health. <i>Campbell Systematic Reviews</i>. 2012:15. DOI: 10.4073/csr.2012.15.</p>	<p>This review included randomized controlled trials that compared a group-based parenting program with a control condition. To be included, the trials needed to have used at least one standardized measure of parental psychosocial health. Control conditions included waiting-list, no treatment, treatment as usual, or a placebo. Forty-eight studies, involving 4937 participants, were included in the review and covered three types of program: behavioral, cognitive-behavioral, and multimodal.</p>	<ul style="list-style-type: none"> <li>• Parental psychosocial health can have a significant effect on the parent-child relationship, with consequences on the psychological health of the child. Parenting programs have been shown to have an impact on the emotional and behavioral adjustment of children, but there have been no reviews of their impact on parental psychosocial wellbeing.</li> <li>• Group-based parenting programs led to statistically significant short-term improvements in depression, anxiety, stress, anger, guilt, self-confidence, and satisfaction with the partner relationship.</li> <li>• Only stress and confidence continued to be statistically significant at six month follow-up, and none were significant at one year.</li> <li>• There was no evidence of any effect on self-esteem.</li> <li>• There was only limited data for fathers, but the programs that were tested showed a statistically significant short-term improvement in paternal stress.</li> <li>• The review supports the use of parenting programs to improve the short-term psychosocial well-being of parents.</li> <li>• Further input may be required to ensure that results are maintained.</li> <li>• More research is needed that explicitly addresses the benefits of group-based parenting programs for fathers. They should examine the comparative effectiveness of different types of</li> </ul>

Review	Description	Findings
		<p>programs and the mechanisms by which such programs bring about improvements in parental psychosocial functioning.</p> <ul style="list-style-type: none"> <li>• Evidence about the importance of paternal psychosocial functioning on the wellbeing of children and the numerous policy directives highlighting the need for better support for fathers, suggest that parenting programs should also be offered to fathers.</li> </ul>
<p>Einfeld, S. L., Stancliffe, R. J., Gray, K. M., Sofronoff, K., Rice, L., Emerson, E., &amp; Yasamy, M. T. (2012). Interventions provided by parents for children with intellectual disabilities in low and middle income countries. <i>Journal of Applied Research in Intellectual Disabilities</i>, 25(2), 135-142.</p>	<p>This paper aimed to review programs which could ameliorate the effects of intellectual disability, and assess if they could be delivered by non-specialist community workers or by parents of handicapped children. Twenty papers were obtained that matched the authors' purpose. GRADE methodology was used to rate the quality of evidence for interventions provided by parents for children with intellectual disabilities.</p>	<ul style="list-style-type: none"> <li>• In low- and middle-income (LAMI) countries, there is a lack of well-trained therapists who can provide specialist interventions to support children with intellectual disabilities and their families.</li> <li>• The quality of evidence for parent-led interventions was generally low across all domains of outcomes - this does not necessarily mean that the interventions were ineffective, but that more evidence is needed.</li> <li>• Few intervention studies for children with intellectual disabilities have been conducted in LAMI countries and many of those that have been conducted are methodologically flawed.</li> <li>• Manualized interventions supplemented with media reduce the necessity for expensive and scarce individual specialist care. These strategies have been proven to be efficacious in high income countries and could be adapted for use in LAMI countries.</li> </ul>
<p>Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., &amp; Donnelly, M. (2012). Behavioral and cognitive-behavioral group-based parenting programs for early-onset conduct problems in children aged 3 to 12 years. <i>Cochrane Database of Systematic Reviews</i>. 2012:2. DOI: 10.1002/14651858.CD008225.pub2.</p>	<p>The review included randomized controlled trials or quasi-randomized controlled trials of behavioral and cognitive-behavioral group-based parenting interventions for parents of children aged 3 to 12 years with conduct problems. The trials incorporated an intervention group versus a waiting list, no treatment or standard treatment control group, and used at least one standardized instrument to measure child conduct problems. The review covered 13 trials (ten RCTs and three quasi-randomized</p>	<ul style="list-style-type: none"> <li>• Early-onset child conduct problems are common and costly. The prognosis for early-onset conduct problems is poor and negative outcomes in adolescence and adulthood, such as antisocial and criminal behavior; psychiatric disorders; drug and alcohol abuse; higher rates of hospitalization and mortality; higher rates of school drop-out and lower levels of educational attainment; greater unemployment; family breakdown; and intergenerational transmission of conduct problems to children.</li> <li>• Both parental and independent reports produced moderate clinically statistically significant effects in favor of parent training.</li> <li>• There were also statistically significant</li> </ul>

Review	Description	Findings
	<p>trials), as well as two economic evaluations based on two of the trials. Overall, there were 1078 participants - 646 in the intervention group and 432 in the control group.</p>	<p>improvements in parental mental health, and positive parenting skills, based on both parent and independent reports.</p> <ul style="list-style-type: none"> <li>• Training of parents also produced a statistically significant reduction in negative or harsh parenting practices according to both parental self-reports and independent assessments.</li> <li>• The intervention demonstrated evidence of cost-effectiveness. When compared to a waiting list control group, there was a cost of approximately \$2500 per family to bring the average child with clinical levels of conduct problems into the non-clinical range. However, these costs were modest when compared with the long-term health, social, educational and legal costs associated with childhood conduct problems, estimated to be approximately \$355,100.</li> <li>• The return on investment is likely to be underestimated as economic analyses typically do not examine wider societal benefits, including the generalization of positive effects to other family members and the potential societal benefits of improved parental mental health.</li> </ul>
<p>Mejia, A., Calam, R., &amp; Sanders, M. (2012). A review of parenting programs in developing countries: Opportunities and challenges for preventing emotional and behavioral difficulties in children. <i>Clinical Child &amp; Family Psychology Review</i>, 15(2), 163-175.</p>	<p>Many children in developing countries are at risk of emotional and behavioral difficulties, and this risk is likely elevated by the effects of poverty. Parenting programs have shown to be effective in high-income countries, but research on programs in lower-income countries is limited. A call for interventions in developing countries was recently made by the World Health Organization, specifically to prevent behavioral difficulties and child maltreatment through the development of stable relationships between children and their parents. This review reports on international organizations for an overview</p>	<ul style="list-style-type: none"> <li>• The featured interventions were offered either as home visits or center-based.</li> <li>• None of the studies provided information on who delivered the intervention or contained sufficient information to calculate effect sizes.</li> <li>• Most studies evaluated programs for enhancing psychosocial stimulation at home or for preventing malnutrition and anemia; however, few evaluated parenting programs designed to prevent or treat psychological difficulties in children.</li> <li>• The authors conclude that, while there are efforts toward the prevention of growth failure and illness in children from developing countries, less has been done to prevent or manage emotional and behavioral problems.</li> <li>• The reviewers recommend cost-</li> </ul>

Review	Description	Findings
	<p>of the field, and a nonsystematic review was also carried out. Only 1 study out of 44 published from 1990 onwards used rigorous methods. Selection criteria were: qualitative or quantitative evaluations of a parenting program; the intervention targeted children up to 12 years of age.</p>	<p>effectiveness analyses of interventions.</p> <ul style="list-style-type: none"> <li>• They also recommend further examination of the effectiveness of remotely accessible interventions such as technology-based interventions.</li> <li>• The reviewers conclude that more resources need to be invested in the evaluation and implementation of evidence-based parenting interventions in developing countries; they also caution that consideration of culturally appropriate measures and intervention protocols is essential,</li> </ul>
<p>Miller, S., &amp; Eakin, A. (2012). Home-based child development interventions for pre-school children from socially disadvantaged families. <i>Campbell Systematic Reviews</i>. 2012:1. DOI: 10.4073/csr.2012.1.</p>	<p>Social disadvantage can have a significant impact on early childhood development, health, and wellbeing. Both parenting and the quality of a child's environment play an important role in supporting development and in mitigating the negative effects of social disadvantage. Home-based child development programs administered by trained lay or professional family visitors aim to optimize children's development by educating, training, and supporting parents to provide a more nurturing and stimulating environment for their child. A number of interventions were not included in the review either because they were not exclusively a child development program - for example, the Nurse Family Partnership of Olds et al.) - or because they contained a group parenting element, such as Early Head Start. The review included seven studies, which involved 723 participants. Four trials involving 285 participants measured cognitive development, and the data was synthesized in a meta-analysis. As only three studies reported socio-emotional outcomes, there was insufficient data to combine into a meta-analysis.</p>	<ul style="list-style-type: none"> <li>• The studies identified for inclusion were conducted in the USA, Canada, Bermuda, Jamaica, and Ireland.</li> <li>• The interventions had no statistically significant impact on cognitive development when compared to the control group.</li> <li>• A meta-analysis of the other outcomes was unfeasible because of insufficient data; these outcomes included: socio-emotional development, physical development, parenting behavior, parenting attitudes, and the quality of the home environment.</li> <li>• Nevertheless, no consistent pattern of findings emerged from the individual studies in relation to these particular outcomes.</li> <li>• Details pertaining to the randomization process and allocation, levels of and reasons for attrition were poorly reported, if at all, and it is this poor reporting that makes it difficult to draw reliable conclusions about the effectiveness of such programs in improving child development outcomes.</li> </ul>

Because of its particular relevance, we also include a systematic review published in 2013.

<p>Knerr, W., Gardner, F. &amp; Cluver, L. (2013). Improved positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: A systematic review. <i>Prevention Science</i>, published online 12 January 2013 doi:10.1007/s11121-012-0314-1.</p>	<p>The review was undertaken in line with <i>Cochrane Review Handbook</i> guidelines. The search identified 12 studies that included 1,580 parents in nine countries (Brazil, Chile, China, Ethiopia, Iran, Jamaica, Pakistan, South Africa, and Turkey). Although the title of the review refers to the reduction of harsh and abusive parenting, the studies included aimed more generally to improve parenting across a wide range of children's ages, from birth to 12 years of age. Seven of the studies aimed to improve parenting in the first three years of life, while four included only pregnant women. Dates of publication ranged from 1983 to 2010.</p>	<ul style="list-style-type: none"> <li>• Methodologies were too varied to allow meta-analysis.</li> <li>• The reviewed studies showed the benefits of intervention on a range of parenting measures.</li> <li>• Enrollment in the study was based on either the participants' residence and attendance at child care centers or health services.</li> <li>• Although most interventions involved home visits, two took place in group settings.</li> <li>• Every intervention but one was delivered by professionals or paraprofessionals.</li> <li>• Common components of interventions included individual or group counseling; role play, videotaped modeling and guided positive parenting; educational communication materials, and use of homemade toys.</li> <li>• The studies included 10 different parenting outcomes.</li> <li>• All five studies that aimed to improve parent-child interaction reported positive results.</li> <li>• Both studies that aimed to reduce harsh punishment reported positive results.</li> <li>• One study to reduce child abuse was inconclusive.</li> <li>• Three studies that aimed to improve parenting knowledge and attitudes showed mixed results.</li> </ul>
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## APPENDIX 4

# BRIEF DESCRIPTIONS OF PARENT SUPPORT PROGRAMS

The following is a list of the parent support interventions identified during the review process. Many of these programs are constructed around strengthening child-caregiver relationships, and use a variety of theoretical and methodological approaches to do so. Others, while recognizing the importance of child-parent interactions and the need to improve them, have other primary objectives, such as the prevention of child maltreatment or the prevention and treatment of children's conduct problems.

Program	Country	Description
<p><b>I-2-3 Magic Program</b> Phelan, T. W. (1984). <i>I-2-3 magic: Effective discipline for children 2–12</i> (1st ed.). Glen Ellyn, IL: Child Management, Inc. Phelan, T. W. (2003). <i>I-2-3 magic: Effective discipline for children 2-12</i> (3rd ed.). Glen Ellyn, IL: Parent Magic, Inc.</p>	USA	This program was designed primarily to target, manage, and reduce undesirable behavior among children aged 2–12 years old. The core goals are to stop 'unwanted' behavior, encourage 'positive' behavior, and enhance the parent-child relationship. The design is based on the premise of "skills acquisition," in which simple techniques are provided directly to caregivers by trained practitioners. These skills can be refined and consolidated through a combination of group discussion, role-play, feedback from the practitioner and real-world application. Throughout the training process emphasis is placed on improving confidence in parent skills and abilities.
<p><b>A child abuse prevention program</b> Ahn, H.-Y. (2004). The effect of a child abuse prevention program for parents with disabled children (Korean). <i>Taehan Kanho Hakhoe Chi</i>, 34(5), 663-672.</p>	South Korea	A community child abuse prevention program held in an early education center. The program consists of handouts, small group lectures, and support group meetings in which participants learn relevant skillsets and information related to understanding children with disabilities, parenting relationships, improving communication, non-punitive discipline techniques, and the effects of child abuse.
<p><b>A parenting psycho-educational group</b> Berge, J.M., Law, D.D., Johnson, J., &amp; Wells, M.G. (2010). Effectiveness of a psycho-educational parenting group on child, parent, and family behavior: A pilot study in a family practice clinic with an underserved</p>	Minneapolis, USA	This psychoeducational parenting group within a primary care clinic targets child behavioral problems with the aim of improving integrated care options for children and their families. Parenting psycho-education groups in primary care clinics can be a resource to the primary care doctor, the parent, and the child. In addition, they provide an avenue to access and engage populations that are usually hard to reach. The weekly program consists of 12 two-hour-long sessions and includes 10–14

<p>population. <i>Families, Systems and Health</i>, 28(3), 224-235.</p>		<p>parents and their five- to ten-year-old children. Each two-hour sessions ran weekly. Parents attend the parenting group while older children attend a skills-based class that focuses on teaching basic social skills through activities and play. A babysitting service is available younger children. After the class has ended, parents and children would reconvene to eat a family meal and participate in a 'family connecting activity'.</p>
<p><b>ABCD Parenting Young Adolescents Program</b>          Burke, K., Brennan, L., &amp; Roney, S. (2010). A randomized controlled trial of the efficacy of the ABCD Parenting Young Adolescents Program: Rationale and methodology. <i>Child &amp; Adolescent Psychiatry &amp; Mental Health</i>, 4, 22-35.</p>	<p><b>Australia</b></p>	<p>ABCD is a group program for parents of children aged 9–14 years old. This brief psychoeducational intervention places an emphasis on active skills building and problem solving, together with other strategies that have been shown to reduce distress in interpersonal relationships. Parents are provided with information and skills for developing and maintaining trusting, positive, and accepting relationships with their young adolescents. The program is delivered over six consecutive weeks. During each two-hour session parents have an opportunity to discuss, practice and receive feedback on a range of parenting strategies and concepts. The program's content is designed to enhance parental understanding and give them skills to assist their children during their transition to adolescence. Content is organized under four themes: 1) developing understanding and empathy for adolescents, 2) building strong relationships, 3) building responsibility and autonomy in children, and 4) parental self-care.</p>
<p><b>ACT Raising Safe Kids Program (ACT RSK)</b>          Silva, J., Sterne, M. L., &amp; Anderson, M. P. (2000). ACT against violence training. Washington, DC: American Psychological Association and National Association for the Education of Young Children.</p>	<p><b>USA</b></p>	<p>The ACT RSK Program is a community-based violence prevention intervention that provides skills training and education to families with young children. The program is based on the CDC's <i>Best Practices of Youth Violence Prevention</i> guidelines. These practices include social-cognitive interventions that use didactic instruction, modeling, and role-play to help children master positive social skills and social problem solving as well as developing or maintaining a nonviolent belief system. These practices also promote parent- and family-based activities involving training in parenting skills, lessons on both child development and the factors that predispose children to violence. Activities to improve effective communication between parents and children are also included. The program is built around eight sessions and is fully manualized in both English and Spanish.</p>
<p><b>Active Parenting</b>          Popkin, M. (2002). <i>Active Parenting Now: Parent's guide for parents of children ages 5–12</i>. Kennesaw, GA: Active Parenting Publishers.</p>	<p><b>USA</b></p>	<p>The Active Parenting Program covers children between the ages of 5 and 12 years old. The program is delivered in six two-hour sessions and involves group discussion, role-play, and video vignettes. The core elements of the program are focused on parenting skills and child development: what children need to succeed and why they misbehave, parenting styles, building mutual respect and cooperation, handling problems, active communication, teaching responsibility, effective discipline techniques, 'I' messages, logical consequences, why children misbehave, self-esteem, teaching responsibility and independence, the power of encouragement, and family council meetings.</p>

<p><b>Adventures in Parenting Program</b></p> <p>Bert, S. S. C., Farris, J. R., &amp; Borkowski, J. G. (2008). Parent training: Implementation strategies for Adventures in Parenting. <i>The Journal of Primary Prevention</i>, 29, 243–261.</p>	<p><b>USA</b></p>	<p>The National Institute of Child Health and Human Development (NICHD) developed an information booklet, <i>Adventures in Parenting</i>, designed to educate parents on basic principles of parenting and encourage them to build on these principles in their daily lives using a cognitively based model of parenting. The booklet offers five principles (RPM3) that parents can use: Responding, Preventing, Monitoring, Mentoring, and Modeling. The <i>Adventures in Parenting</i> booklet was structured to inform parents about the value of the RPM3 principles and to provide examples of how they can be applied in everyday parenting. Sets of vignettes are provided featuring children who range from birth to age 3, ages 4–10, and ages 11–14. In each section, parents are provided with an age-appropriate vignette for each of the five principles followed by discussion questions and an explanation of the vignette.</p>
<p><b>Apoyo Personal y Familiar (APF; Personal and Family Support Program)</b></p> <p>Rodrigo, M. J., Correa, A. D., Maiquez, M. L., Martin, J. C., &amp; Rodriguez, G. (2006). Family preservation services on the Canary Islands: Predictors of the efficacy of a parenting program for families at-risk of social exclusion. <i>European Psychologist</i>, 11, 57–70.</p>	<p><b>Canary Islands</b></p>	<p>Apoyo Personal y Familiar (Personal and Family Support Program) is part of the Family Preservation Services portfolio developed by the Canary Islands. The 32-week program, which is held in local community centers, is designed for poorly educated parents whose children, between infancy and adolescence are at high psychosocial risk. Throughout the program, parents are exposed to various parental views and practices in specific child-rearing episodes and are encouraged to reflect on their own views and the consequences of their actions on their child's development.</p>
<p><b>Attachment and Biobehavioral Catch-up (ABC) Program</b></p> <p>Dozier, M., Peloso, E., Lindhiem, O., Gordon, M.K., Manni, M., Sepulveda, S., &amp; Ackerman, J. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. <i>Journal of Social Issues</i>, 62, 767-785.</p>	<p><b>USA</b></p>	<p>The Attachment and Biobehavioral Catch-up (ABC) Program is a 10-week home-based skills-training program that helps the foster parents of children between birth and five years old provide a nurturing environment for their charges. The program targets dysregulation (a disorder in which emotional responses are poorly modulated) in children by teaching foster care parents nurturing skills to create environments that enhance regulatory capabilities. The intervention works towards this goal using three techniques: 1) helping caregivers reinterpret children's alienating behaviors, 2) helping caregivers overcome personal issues that interfere with their ability to provide nurturing care, and 3) helping caregivers provide an environment that helps children develop regulatory capabilities. Both foster parents and foster children participate in the sessions, which are led by a trained paraprofessional. Sessions are interactive in nature and involve the parent and trainer discussing concepts, practicing learned techniques with the child and discussing successes and failures in the use of the concepts learned in the prior weeks.</p>
<p><b>Baby Business Program</b></p> <p>Cook, F., Bayer, J., ND Le, H., Mensah, F., Cann, W., &amp; Hiscock, H. (2012). Baby Business: A randomized controlled trial of a</p>	<p><b>Australia</b></p>	<p>The Baby Business program provides parents with information about infant sleep and crying via a DVD and booklet (mailed to parents soon after birth), a telephone consultation when the infant is 6–8 weeks old. and a parent group session (when the infant is 12 weeks old).</p>

<p>universal parenting program that aims to prevent early infant sleep and cry problems and associated parental depression. <i>BMC Pediatrics</i>, 12(1), 13-13.</p>		<p>All English-speaking parents of healthy newborn infants born after over 32 weeks of gestation are eligible and can be referred by their maternal and child health nurse at their first postpartum home visit (between seven to ten days postpartum). The 27-page booklet provides parents with information about normal infant sleep patterns and sleep cycles. Various other issues are discussed, such as benefits of infants falling asleep independently, the disadvantages of infants relying on parent dependent cues to fall asleep at the beginning of the night, the dangers of sharing a bed with children, normal infant crying patterns, strategies for managing infant crying and signs and symptoms of uncommon medical causes of crying. The DVD covers similar content but also includes footage of parents discussing the methods they use to settle their infants, the signs of tiredness their infant displays, etc. Both the telephone consultation and parent groups are facilitated by trained health professionals with a background in infant care. During the telephone consultation, the facilitator helps the parent apply the contents of the booklet and the DVD in a way that is suitable for the family and encourages them to discuss the issues covered in both resources. Finally, parents are invited to a 1.5 hour group troubleshooting session at a local venue.</p>
<p><b>Better Beginnings</b> Barratt-Pugh, C. N. (2011). Making a difference: Findings from Better Beginnings, a family literacy intervention programme. <i>Australian Library Journal</i>, 60(3), 195.</p>	<p><b>Australia</b></p>	<p>Better Beginnings is an early intervention family literacy program that provides families with strategies and resources to promote and support book-sharing from birth. Better Beginnings is introduced to parents and caregivers by the community child health nurse at their child's 6–8-week health check. The nurse shares a reading pack with the parent(s) and explains the importance of sharing books and accessing early literacy resources and activities through the local libraries. The program consists of: a handbook and training module developed for librarians and community child health nurses, a reading pack for parents of young babies, "Baby Rhyme Time" and story time sessions and workshops for parents, Outreach Story Time Boxes that contain a range of literacy resources for children and families, family resource centers located in libraries and that provide interactive early childhood learning and parenting resources, and a website that provides information about Better Beginnings.</p>
<p><b>Better Parenting Programme (BPP)</b> Brown, J. (2000). <i>Evaluation report of the Better Parenting Project</i>. Amman, Jordan: UNICEF. Al-Hassan, S. (2009). <i>Evaluation of the better parenting program: A study conducted for UNICEF</i>. Amman: UNICEF.</p>	<p><b>Jordan</b></p>	<p>The Better Parenting Program (BPP), a Jordan-based program that has been implemented in more than 2000 centers nationwide, was created after the results of a national KAP survey revealed gaps in parents' knowledge in effective child rearing. It is supported by UNICEF and other key government and civil partners. The program's current aim is to empower parents and caregivers of 0–8-year-old children to provide a stimulating, loving, and protective environment at home by equipping them with skills and information to enable them to promote the psychosocial, cognitive, and physical development of their children. The BPP was</p>

		revised in 2003. In a 2000 evaluation, it was found that the cost of reaching out to parents and their children was U.S.\$3 per child. The evaluation also highlighted the need to expand the BPP scope to a more holistic early childhood care and development approach, including protection of children from abuse and neglect.
<p><b>Boot Camp for New Dads</b>          Capuozzo, R. M., Sheppard, B.S., &amp; Uba, G. (2010). Boot Camp for New Dads: The importance of infant-father attachment. <i>Young Children</i>, 65(3), 24-28.</p>	<b>USA</b>	<p>Boot Camp for New Dads is a program for expectant fathers where men learn how to make the home safe and secure for their newborn child, how to support their partners before and after birth, and prepare to bond with the baby. Both expectant fathers and fathers with children are involved in the program and participate in a 'men-mentoring-men' activity. The program responds to what the rookie and veteran fathers indicate they want to learn about. Veteran fathers bring their children to sessions and many rookie fathers are able to interact with the attending children. Coaches run the sessions and follow a 'game plan,' which is contained in the resource guide. Generally, sessions begin with the coach describing what can be expected during the session, and then questions and concerns from rookie fathers are taken. Each man is also encouraged to talk about their own experience with their father. Some of the topics focused on in the sessions include: supporting the mother, preparations for the hospital stay, what to do during delivery, bonding with the newborn at the hospital, adjustments at home and in family responsibilities, and bringing the baby home. Sessions are often interrupted by crying, diaper changes, feedings, and playing; these interruptions are used as 'teachable moments.'</p>
<p><b>Brazelton Neonatal Behavioral Assessment Scale (BNBAS)</b>          Beeghly, M., Brazelton, T.B., Flannery, K.A., Nugent, J.K, et al. (1995) Specificity of preventative pediatric intervention effects in early infancy, <i>Journal of Developmental &amp; Behavioral Pediatrics</i>, 16,158-166.</p>	<b>USA</b>	<p>Originally designed as an assessment tool for newborns, the Brazelton Neonatal Behavioral Assessment Scale (BNBAS) has also been used as a means of enhancing parent-infant interaction and attachment in both high- and low-risk families by increasing the parents' awareness of the infant's individuality and capabilities. The scale contains 32 behavioral and 18 reflex items to assess the infant's capabilities across different developmental areas. Using the scale, responses are elicited from the infant to assess his or her neurological condition as well as how the different developmental areas (autonomic, motor, social-interactive system, etc.) are integrated as the infant adapts to his or her environment. The infant's responses are demonstrated to parents in order to increase their awareness and responsiveness to the infant and enhance their feelings of nurturance.</p>
<p><b>Brief parent discussion group</b>          Morawska, A., Haslam, D., Milne, D., &amp; Sanders, M.R. (2011). Evaluation of a brief parenting discussion group for parents of young children. <i>Journal of Developmental &amp; Behavioral</i></p>	<b>Brisbane, Australia</b>	<p>The article assesses the use of a new brief discussion group format for the provision of parenting advice based on the Triple-P Positive Parenting model of intervention, in the context of managing child disobedience. The discussion group's key objectives include: increasing parents' skills in promoting social, emotional, and behavioral competence in their children; reducing parents' use of coercive and punitive methods of</p>

		<p>discipline; improving communication about parenting; and reducing the parental stress associated with raising children. The intervention is a two-hour discussion group facilitated by a psychologist, with an average of six families per group. The group is interactive and discussion-based, and a PowerPoint presentation with embedded video clips is used to aid the facilitator. Additionally, parents receive a workbook that includes the content covered in the discussion group. The intervention also includes two brief telephone consultations for each family in the two weeks after the discussion group. These consultations are used to help parents tailor the program's strategies to their family situation and to maximize potential gains from the program.</p>
<p><b>Building Blocks (BB)</b> Mendelsohn, A.L., Huberman, H.S., Berkule, S.B., Brockmeyer, C.A., Morrow, L.M., Dreyer, B.P. (2011). Primary care strategies for promoting parent-child interactions and school readiness in at-risk families: The Bellevue Project for Early Language, Literacy, and Education Success (BELLE). <i>Archives of Pediatrics &amp; Adolescent Medicine</i>, 165(1), 33-41.</p>	<p><b>New York, USA</b></p>	<p>Building Blocks (BB) is focused on children from birth to three years of age. The center of the program is a curriculum focused on supporting verbal interaction (in the context of pretend play), shared reading, and daily routines to enhance child development and school readiness. This curriculum is delivered both by practitioners and through monthly mailings that include written pamphlets and learning materials. These resources include age-specific newsletters suggesting interactive activities, learning materials, and parent-completed developmental questionnaires.</p>
<p><b>Butler County Success Program (BCSP)</b> Bush, K., &amp; D. Bergen (2010). Evaluation of an holistic case management intervention program for low-income families of K-6 grade children: The Butler County Success Program (BCSP). <i>International Journal of Interdisciplinary Social Sciences</i>, 5(8), 337-352.</p>	<p><b>Ohio, USA</b></p>	<p>The Butler County Success Program (BCSP) was designed to assist students from kindergarten through sixth grade who qualify for Temporary Aid to Needy Families (TANF) by assessing and meeting their basic non-cognitive needs. A key concept of the program is the connection to the community through home visits to families and working with local agencies and resources. A liaison is assigned to work in one of the participating schools but is based out of the school. The liaison person meets with students and their families, attends individualized education plan meetings and works with school personnel to coordinate and provide services. Once clients are in the program, the liaison provides support and assistance based on the specific needs of the family and connects the child and his or her family to the appropriate resources and/or services. These may include access to childcare, health care, financial assistance, food banks and related services, employment services, parenting classes/, counseling, and transportation. An integral component of the BCSP is the partnership between the program, community resources and agencies, schools, and families in need. Each school and school district uses specific agencies and resources that are unique to the area, although a few resources work across all the schools. The program's objectives are: to develop and maintain an infrastructure between schools and communities and link these to TANF families; to identify, secure, and provide needed resources; to coordinate the provision</p>

		of services; to help families access services; and to provide children and parents opportunities to develop the necessary skills for long-term sufficiency.
<p><b>Child FIRST</b>  Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., &amp; Briggs-Gowan, M. J. (2011). A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. <i>Child Development</i>, 82(1), 193-208. 10.1111/j.1467-8624.2010.01550.x</p>	<b>USA</b>	<p>Child FIRST (Child and Family Interagency, Resource, Support, and Training) is a comprehensive therapeutic intervention that targets multi-risk families and young children in order to prevent serious emotional disturbance, learning and developmental disabilities, and abuse and neglect. Services are offered in the client's home in order to reduce barriers to treatment, increase engagement with the child and intervene in the child's natural environment. The first of two components in Child FIRST is a system-of-care approach that provides comprehensive and integrated services and supports in an attempt to decrease psychosocial stress and promote positive outcomes. These services and supports include early education programs, housing assistance, and substance abuse treatment for the child and his or her family. Secondly, the program uses a relationship-based approach to enhance nurturing, responsive parent-child interactions and promote positive socioemotional and cognitive development in the child.</p>
<p><b>Child-Parent Relationship Therapy (CPRT)</b>  Landreth, G. L., &amp; Bratton, S. C. (2006). <i>Child parent relationship therapy: A 10-session Filial therapy model</i>. New York: Routledge.</p>	<b>Multi-country</b>	<p>Child-Parent Relationship Therapy (CPRT) is a manualized therapeutic method based on the belief that that the relationship between a caregiver and child is fundamental to their child's development. The main objectives of CPRT are to make positive changes within the child-parent relationship and to empower parents to become primary agents of change by increasing their enjoyment of parenthood by improving their communication skills and interactions with their child. Therapists trained in play therapy use didactic instruction, demonstrations of play sessions, and supervision throughout the 10-week course to teach parents how to use play as a therapeutic agent in the home. Through CPRT parents and caregivers learn to communicate effectively, regain control as a parent, and help their children develop self-control. Skills learnt throughout the process include reflective listening, recognizing and responding to children's feelings, limit setting, and building children's self-esteem.</p>
<p><b>Circle of Security (COS) Project</b>  Marvin, R. S., Cooper, G., Hoffman, K., &amp; Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-preschool child dyads. <i>Attachment and Human Development</i>, 1, 107-124.</p>	<b>USA, Japan, Italy, New Zealand</b>	<p>The Circle of Security (COS) protocol is a manualized 20-week program for parents (generally mothers) of children from 11 months to 5 years old. A series of taped interactions helps to discern where a parent is able to meet a child's needs and where they are unable. Vignettes are chosen to illustrate particular aspects of the parent-child relationship. Interventions are delivered in groups where highly trained and experienced therapists deliver the intervention to six to eight parents at a time, including extensive and careful review of videotaped child-parent interactions for each parent in the group.</p>
<p><b>Communities for Change (CfC)</b></p>	<b>Australia</b>	<p>Communities for Change is a large-scale area-based initiative that is designed to enhance the development of children in disadvantaged community sites around</p>

<p>Edwards, B., Gray, M., Wise, S., Hayes, A., Katz, I., Muir, K., &amp; Patulny, R. (2011). Early impacts of Communities for Children on children and families: Findings from a quasi-experimental cohort study. <i>Journal of Epidemiology &amp; Community Health</i>, 65(10), 909-914. 10.1136/jech.2010.118133</p>	<p>Australia. The overall aim is to improve the coordination of services for children from zero to five years old and their families, which includes providing services to address unmet needs, building community capacity, and engaging in service delivery. Services include home visiting, programs on early learning and literacy, parenting and family support, child nutrition and community events. The initiative provides funding to a large nongovernmental organization in each area who is considered a 'facilitating partner.' The facilitating partner then establishes committees composed of other local service providers and community representatives, who together decide on the services required in specific communities. Funding for these services is allocated to local service providers. The facilitating partners are also funded to increase service coordination and cooperation between service providers.</p>
<p><b>Comprehensive Child Development Program (CCDP)</b>  St. Pierre, R.G., &amp; Layzer, J.I. (1999). Using home visits for multiple purposes: The Comprehensive Child Development Program. <i>The Future of Children</i>, 9(1), 134-151.</p>	<p><b>USA</b></p> <p>Comprehensive Child Development Program (CCDP) is a comprehensive five-year intervention targeting low-income families. The goals of CCDP are to enhance the physical, social, emotional and intellectual development of children in low-income families from birth to age five. In addition, the program aimed to provide support to parents and other family members and assist families living below the federal poverty line in becoming economically self-sufficient. CCDP was the center of a five-year demonstration project funded by the U.S. Administration on Children, Youth and Families. Two key services, case management and early childhood education, were delivered to families through hour-long bimonthly home visits. These visits began during the child's first year of life and continued until the child entered school. Case managers conducted visits and assessed the goals and service needs of individual family members and of the family as a whole, developed a service plan, referred the family to services in the community, monitored and recorded the family's receipt of services, and provided counseling and support to family members, especially mothers. A formal needs assessment was conducted within three months of a family's enrollment in the program. This needs assessment formed the basis for a service-delivery plan developed by both the case manager and family members. The plan was updated every three months and included an assessment of the progress of the family goals. The goals most commonly specified by families were obtaining better housing, improving parenting skills, accessing childcare and health care, obtaining transportation, increasing income, and accessing community resources.</p>
<p><b>Confident Parenting Program</b>  Center for the Improvement of Child Caring. (1987). <i>Confident Parenting: Contemporary skills and techniques for achieving harmony in</i></p>	<p><b>USA</b></p> <p>The Confident Parenting Program is a series of 10 two-hour-long sessions that teach parents a restricted range of social principles, primarily those that govern the effectiveness of various kinds of positive and negative reinforcement. These consequences can be non-social (food, money, privileges, etc.) or social (praise,</p>



the home. North Hollywood, CA: Authors.

punishment, attention). As a starting point, parents are taught that their children's behavior is shaped by its consequences. Although the program was initially intended for use in clinical mental health settings with parents whose two- to twelve-year old children were experiencing behavior or emotional problems, it has been extended to a wider range of institutional settings and to parents of both older and younger children. Although a one-day seminar version of the program for large numbers of parents has recently been created, sessions are normally restricted to small groups of parents. This allows for individualized consultation with the instructor on the home behavioral change projects that are assigned; group discussions and role-playing are also included in small group sessions.

**Creating Opportunities for Parent Empowerment (COPE)**

Melnyk, B. M., Alpert-Gillis, L., Feinstein, N.F., Crean, H.F., Johnson, J., Fairbanks, E., Small, L., Rubenstein, J., Slota, M., & Corbo-Richert, B. (2004). Creating Opportunities for Parent Empowerment: Program effects on the mental health/coping outcomes of critically ill young children and their mothers. *Pediatrics*, 113(6), e597-e607.

**USA**

A three-phase preventive educational-behavioral intervention program initiated early in the intensive care unit to improve the mental health/psychosocial outcomes of critically ill young children and their mothers. It is a program for parents at the neonatal unit focusing on aspects such as the behavioral characteristics of preterm infants, how parents can participate in their infant's care and have more positive interactions with their infant. Mothers received a three-phase educational-behavioral intervention program: 1) 6 to 16 hours after PICU admission, 2) 2 to 16 hours after transfer to the general pediatric unit, and 3) 2 to 3 days after their children are discharged from the hospital. The COPE program, which was delivered with audiotapes and matching written information, as well as a parent-child activity workbook that facilitated implementing the audiotaped information, focused on increasing 1) parents' knowledge and understanding of the range of behaviors and emotions that young children typically display during and after hospitalization and 2) parent participation in their children's emotional and physical care. The COPE workbook, which was provided to parents and children after transfer from the PICU to the general pediatric unit, contained three activities to be completed before discharge from the hospital: 1) puppet play to encourage expression of emotions in a nonthreatening manner, 2) therapeutic medical play to help give children some sense of mastery and control over their hospital experience, and 3) reading and discussing *Jenny's Wish*, a story about a young child who successfully copes with a stressful hospitalization.

**Criando a Nuestros Niños hacia el Éxito (CANNE) (Spanish adaptation of PACE)**

Dumas, J. E., Arriaga, X., Begle, A. M., & Longoria, Z. (2010). "When will your program be available in Spanish?" Adapting an early parenting intervention for Latino

**Midwestern USA**

CANNE is the Spanish-language adaptation of the Parenting Our Children to Excellence PACE program, which was developed in response to feedback from the Indianapolis communities in which PACE was evaluated. CANNE is the outcome of a systematic adaptation process that balanced insider and outsider considerations by relying on 1) extensive consultation with parents, service providers, and community leaders; 2) translation of the manual from English to Spanish and

families. *Cognitive and Behavioral Practice*, 17, 176–187.

evaluation of the degree of correspondence between the two versions; and 3) translation and cross-language comparison of measures available in English only. This resulted in a Spanish program with concepts and methods in common with the original, but with a distinct cultural and practical orientation that makes it much more than a translation. Conceptually, CANNE is a health promotion, not a treatment, program. It focuses on bicultural effectiveness to help participants promote their own and their children’s ability to navigate effectively within and across both Latino and American cultures. Methodologically, the program’s contents and presentation methods were modified to integrate Latino cultural assumptions and priorities and to address child-rearing differences between the United States, Mexico, and other Latin American countries. For example, the adaptation took Latino cultural values (e.g. *respeto*, *familismo*) into account when and facilitated families’ access to community resources by presenting ideas like encouragement, reward, and discipline strategies and knowledge and communication issues with these values in mind. Sessions cover eight topics, and group leaders present each one with guided discussions, role-plays, and short video clips.

**DADS Family Project**

Cornille, T. A., Barlow, L. O., & Cleveland, A. D. (2005). DADS Family Project: An experiential group approach to support fathers in their relationships with their children. *Social Work with Groups*, 28(2), 41-57.

**USA**

The Dads Actively Developing Stable Families Family Project (DADS) is an eight-week program designed to help fathers improve their understanding of the essential role of fathering, develop new attitudes towards parenting, and teach them new parenting skills. The program can be adapted to various settings, including schools, churches, prisons, and businesses. Each two-hour session is based on group processes and experiential activities, and instructors use role-plays, video modeling, and group interaction as learning tools. The goals of the program are for fathers to recognize their potential positive impact on children, improve attitudes towards wanting to be an equal parent, understand and learn how to establish a safe and secure home environment, develop an appreciation of the value of play for children, and improve their communication, stress management, and discipline skills.

**Early Head Start**

Love, J., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., Brooks-Gunn, J., Chazan-Cohen, R., Tarullo, L. B., Brady-Smith, C., Fuligni, A. S., Schochet, P. Z., Paulsell, D., & Vogel, C. (2005). The Effectiveness of Early Head Start for 3-year-old children and their parents: Lessons for policy and programs. *Developmental Psychology*, 41(6), 885-901.

**USA**

Early Head Start is a subprogram of Head Start. The comprehensive two-generation multiprogram intervention began in 1995 for low-income women and families with infants and toddlers and focuses on enhancing children’s development while strengthening families. It comprises a combination of home- and center-based programs; services can be provided in the home of the family, at a licensed family childcare home or at a center. This comprehensive early education program includes young children with disabilities. In addition to comprehensive early education, other services include providing and linking families with health, mental health, disability, nutrition, and social services. Early Head Start has strong parent involvement and services specifically designed for pregnant women.

		Families are eligible if the family income is below the federal poverty line.
<p><b>Empowering Parents, Empowering Communities (EPEC)</b></p> <p>Day, C., Michelson, D., Thomson, S., Penney, C., &amp; Draper, L. (2012). Innovations in Practice: Empowering Parents, Empowering Communities: A pilot evaluation of a peer-led parenting programme. <i>Child &amp; Adolescent Mental Health</i>, 17(1), 52-57.</p>	<b>UK</b>	<p>EPEC is a community-based program that trains parents to run parenting groups in their own communities. The assumption is that this method is cost-effective and provides accessible help for parents whose children are experiencing behavioral difficulties. There are two manualized components to the EPEC program. The first is a Peer Facilitator Training Course and the second is a Being A Parent (BAP) intervention. Parents are selected for training as peer facilitators based on a semi-structured interview conducted by the EPEC trainers. Selection is based on the potential facilitator's ability to self-reflect, understand, and empathize with the difficulties of others as well as the capacity to understand and deliver the tasks involved in facilitating the parenting groups. Many peer facilitators gain experience from being part of the BAP groups. Facilitator training involves didactic teaching, group discussion, role-play, skills practice, and written assignments. Facilitators receive payment and an accredited qualification. These trained facilitators deliver BAP in areas of high social disadvantage. BAP is designed for caregivers of children aged 2–11 years of age and aims to improve parent-child relationships and interactions, reduce child disruptive behavior and other problems, and increase participants' confidence in their parenting abilities. The intervention spans eight weekly two-hour sessions to groups of between six and 14 parents.</p>
<p><b>Even Start</b></p> <p>St Pierre, R.G., Robert, G., &amp; Swartz, J.P. (1995). The Even Start Family Literacy Program. In Smith, S. (Ed). <i>Two generation programs for families in poverty: A new intervention strategy</i>. Advances in Applied Developmental Psychology, Vol 9, (pp 37-66). Westport, CT, US: Ablex Publishing.</p> <p>U.S. Department of Education. (2003). Third national Even Start evaluation: Program impacts and implications for improvement. <a href="http://www.ed.gov/rschstat/eval/disadv/Evenstartthird/execsum.html">www.ed.gov/rschstat/eval/disadv/Evenstartthird/execsum.html</a>.</p>	<b>USA</b>	<p>Even Start is a one-year, family-focused program that includes three core services: early childhood education, adult literacy training, and parent education. Criteria for participation in the program include one adult with eligibility for an adult basic education program and a child under the age of eight in the family. The early childhood education component of the program focuses on enhancing cognitive, language, and social skills as well as general school readiness among children from birth up to eight years of age. The adult education component aims to develop parents' basic educational and literacy skills. The parenting education aspect focuses on improving parents' understanding of their child's development, child behavior management training, enhancing parents' capacity to support their child's education, and life skills. Supplementary services also offered by Even Start include transportation, sibling childcare, counseling, and referrals for employment.</p>
<p><b>Every Person Influences Children (EPIC)</b></p> <p>EPIC. (1993). A family involvement and support program for parents of young children. Parent Manual. Buffalo: NY: Authors.</p>	<b>USA</b>	<p>Every Person Influences Children, Inc., is a national not-for-profit organization that provides effective programs and resources for parents, teachers, and school administrators that help adults raise responsible and academically successful children. EPIC offers a comprehensive program that links the home, the school, and the community. EPIC's Parent Program offers training for facilitators from their own communities and</p>

		<p>prepares them to lead parenting workshops. Through small, supportive discussion groups, parents come together to discuss parenting concerns and to exchange ideas and parenting techniques. EPIC workshops are offered to parents of children from birth through adolescence with accompanying parenting manuals, which are available in both English and Spanish. These workshops help parents and guardians strengthen their parenting skills. The workshops also empower parents to become more involved in their child's education.</p>
<p><b>Families OverComing Under Stress (FOCUS)</b>  Lester, P., Saltzman, W. R., Woodward, K., Glover, D. A., Leskin, G. A., Bursch, B., et al. (2012). Evaluation of a family-centered prevention intervention for military children and families facing wartime deployments. <i>American Journal of Public Health</i>, 102 (Suppl 1), S48-S54.  Lester, P., Mogil, C., Saltzman, W., Woodward, K., William, N., Leskin, G., Bursch, B., Green, S., Pynoos, R., &amp; Beardslee, W. (2011). Families OverComing Under Stress: Implementing family-centered prevention for military families facing wartime deployments and combat operational stress. <i>Military Medicine</i>, 176(1),19-25.</p>	<p><b>USA, Japan</b></p>	<p>FOCUS is a manualized, family-centered prevention intervention that centers on resiliency training. It provides education and skills training for military parents and children. Training is designed to enhance coping with deployment-related issues and experiences, including the injury of a service member. Using a structured-narrative approach, family members are able to share unique experiences in efforts to improve shared understandings, communication, and family cohesion. Core intervention components include psycho-education, emotional regulation skills, goal setting and problem solving skills, reminders about how to manage traumatic stress, , and family communication skills.</p>
<p><b>Family Check-up (FCU)</b>  Dishion, T.J., Shaw, D., Connell, A., Gardner, F., Weaver, C., &amp; Wilson, M. (2008). The Family Check-Up with high-risk indigent families: Preventing problem behavior by increasing parents' positive behavior support in early childhood. <i>Child Development</i>, 79(5), 1395-1414.</p>	<p><b>USA</b></p>	<p>This is a brief intervention that contains a broad assessment of the family context and parenting practices. The overall goal is to reduce problem behavior and promote emotional well-being in children and families. The program comprises three sessions—the initial contact session, the multi-agency, multi-method assessment session, and the feedback session. The first step is a meeting with parents to explore their perceptions and concerns regarding their family and child's behavior. The second step is a comprehensive assessment that includes videotaping parent-child interactions. The third step is a structured feedback session that is based on the results of the assessment and that emphasizes parenting and family strengths yet draws attention to possible areas of change. The intervention is motivational in that it stimulates caregivers to address key problems in parenting either on their own or with the support of a professional. Interventions that follow the FCU are thus tailored to each family's needs on the basis of the assessment and of the parents' motivation to change. Some parents may focus on only one dimension of their parenting; this differs from conventional parenting intervention programs, which tend to emphasize a standard</p>

		curriculum of parenting practices for all parents.
<p><b>Family Connections (FC)</b> DePanfilis, D. &amp; Dubowitz, H. (2005). Family Connections: A program for preventing child neglect. <i>Child Maltreatment</i>, 10, 108-123.</p>	<p><b>San Mateo County, California</b></p>	<p>FC is a multifaceted, community-based program that works with families in their homes and communities to help them meet the basic needs of their children and reduce the risk of child neglect. Nine practice principles guide FC interventions: community outreach, individualized family assessment, tailored interventions, helping alliance, empowerment approaches, strengths perspective, cultural competence, developmental appropriateness, and outcome-driven service plans. Individualized intervention is geared to increase protective factors and decrease risk factors. The core components of the intervention are set out in a manual for practitioners—emergency assistance, home-based family intervention, service coordination with referrals targeted toward risk and protective factors, and multifamily supportive recreational activities.</p>
<p><b>Family Foundations (FF)</b> Brown, L. D., Feinberg, M. E., &amp; Kan, M. L. (2012). Predicting engagement in a transition to parenthood program for couples. <i>Evaluation &amp; Program Planning</i>, 35(1), 1-8.</p>	<p><b>USA</b></p>	<p>Family Foundations (FF) is a universal preventive intervention to help couples manage the transition to parenthood. Couples attend eight interactive, skills-based classes, each lasting approximately two hours. Four classes occur before childbirth and four afterward. Couples also complete homework assignments between classes. Relationship skills and parenting skills are combined so as to aid in the development of mutually supportive co-parenting strategies, which are delivered as part of hospital childbirth education classes.</p>
<p><b>Fast Track</b> Greenberg, M. T. (1998). Testing developmental theory of antisocial behavior with outcomes from the Fast Track Prevention Project. Paper presented at the American Psychological Association, Chicago, IL.</p>	<p><b>USA</b></p>	<p>Fast Track is a long-term, multi-site, multi-component preventive intervention addressing classroom, school, individual child, and family risk factors. The universal component comprises a curriculum delivered in classrooms by the teacher and covers four domains of skills—skills for emotional understanding and communication, friendship skills, self-control skills, and social problem-solving skills. The selective component involves parent groups, child social skills training, parent-child sharing time, home visiting, child peer pairing (to promote friendship), and academic tutoring. These are offered to high-risk children and their parents and are delivered by counselors and social workers. Parent skills training focuses on establishing positive family-school relationships, building parental self-control, promoting developmentally appropriate expectations for child behavior, and improving parent-child interaction. Various delivery strategies are used. The high-risk family-focused component includes 5–22 sessions per year of family group meetings, 30-minute parent-child sharing sessions after family group meetings, and bi-weekly home visitations aimed at improving parenting skills, enhancing feelings of efficacy and empowerment, and increasing problem-solving skills.</p>
<p><b>Good Beginnings Program</b> Stipek, D.J., Feiler, R., Byler, P., Ryan, R., Milburn, S., Salmon, J.M. (1998). Good Beginnings: What</p>	<p><b>Australia</b></p>	<p>The Good Beginnings Program is a home visiting program with the objective to build strong parent-child relationships, foster positive attachments, and subsequently reduce the incidences of child abuse and</p>

<p>difference does the program make in preparing young children for school? <i>Journal of Applied Developmental Psychology</i>, 19(1), 41-66.</p>		<p>neglect. The program provides education and support to first-time, at-risk pregnant and parenting young women through home visiting, prenatal and parenting groups, and labor or birthing assistance.</p>
<p><b>Hands-On Parent Empowerment (HOPE) program</b>  Leung, C., Tsang, S., &amp; Suzanne, D. (2011). Outcome evaluation of the Hands-On Parent Empowerment (HOPE) Program. <i>Research on Social Work Practice</i>, 21(5), 549-561.  10.1177/1049731511404904  Leung, C., Tsang, S., Dean, S., &amp; Chow, P. (2009). Development and pilot evaluation of the “Hands on Parent Empowerment” (HOPE) project—a parent education programme to establish socially disadvantaged parents as facilitators of preschool children’s learning. <i>Journal of Children’s Services</i>, 4, 21-32.</p>	<p><b>China</b></p>	<p>The HOPE program is designed as a targeted preventive intervention. It aims to equip socially disadvantaged parents with the skills to promote the development of their children and enables them to take responsibility for their children’s development. There is also a strong focus on building positive parent-child relationships. In addition, the HOPE program provides training for new immigrant parents and aims to enhance social support for these parents through the development of a social network. The program comprises 30 weekly two-hour group sessions and is delivered within a preschool setting by social workers, with the support of preschool teachers. A variety of teaching methods and activities is used, including mini lectures, interactive group discussions, role-play, and homework activities for both parents and children. The program is codified in a manual, with instructions for facilitators, PowerPoint slides, class worksheets, and parent homework activities.</p>
<p><b>Head Start Program</b>  Administration on Children, Youth, and Families. (1999). <i>Leading the way: Characteristics and early experiences of selected Early Head Start programs</i>. Vol. I: Cross-site perspectives (Publication U. S. Government Printing Office-2000-519-425/94725). Washington, DC: U. S. Department of Health and Human Services.</p>	<p><b>USA</b></p>	<p>Head Start is a federally funded preschool program for low-income families, and provides and coordinates a variety of services for children and families with multiple needs, including nutrition, family social services, and physical, oral, and mental health. It is designed to provide high-quality, comprehensive child development services delivered through home visits, childcare, case management, parenting education, health care and referrals, and family support. Head Start is family-centered and is aimed at fostering parents’ role as the principal influence on their children’s development and as their children’s primary educators, nurturers, and advocates. Parents are encouraged to become involved in all aspects of Head Start, including direct involvement in policy and program decisions that respond to their interests and needs. Head Start programs are community based, with services based on the unique needs of the diverse communities they serve. Services are offered to meet the special needs of children with disabilities. The target group is low-income families with children aged two to three years.</p>
<p><b>Healthy Families America</b>  Healthy Families America (2009). Retrieved from: <a href="http://www.healthyfamiliesamerica.org/about_uus/index.shtml">http://www.healthyfamiliesamerica.org/about_uus/index.shtml</a>  LeCroy, C. W. &amp; J. Krysik (2011). Randomized trial of the Healthy</p>	<p><b>USA</b></p>	<p>The main aims of the program are to promote positive parenting, enhance child health and development, and prevent child abuse and neglect. The program works with prenatal and new parents to provide a range of services and supports. Once families agree to participate, they receive home visiting services. Families are screened in a hospital and need to meet cutoff scores that identify them as at-risk and having potential</p>

<p>Families Arizona home visiting program. <i>Children and Youth Services Review</i>, 33(10), 1761-1766.</p>	<p>to benefit from the program. Home visitors assist parents with their life circumstances, personal issues, parenting needs, and successful adaptation to new infants. Home visitors are also available to help mobilize critical services to address substance abuse, domestic violence, and mental health issues. The home visitors model good parenting behavior, follow the child's developmental progress, ensure home safety, and provide emotional support to parents.</p>
<p><b>Healthy Steps for Young Children Program</b>          Caughy, M. O. B., Huang, K.-Y., Miller, T., &amp; Genevro, J. L. (2004). The effects of the Healthy Steps for Young Children Program: Results from observations of parenting and child development. <i>Early Childhood Research Quarterly</i>, 19(4), 611-630.          10.1016/j.ecresq.2004.10.004</p>	<p><b>USA</b></p> <p>The Healthy Steps for Young Children Program is designed to be universally applicable to all families with children up to three years old, not only families at risk. In its family-centered model of health care, the Healthy Steps (HS) specialist is introduced into pediatric practice, and he or she offers expertise in child development and oversees the delivery of the HS services.</p> <p>HS is a package of services including enhanced well-child visits, home visits, telephone support for development and behavioral concerns, written informational materials for parents, parent groups, and links to community resources.</p> <p>During the first three years, HS families are offered nine standard pediatric office visits and six home visits. Unlimited telephone contact and participation in parenting group sessions are also offered. The well-child appointments are conducted jointly or sequentially by a team consisting of a physician/pediatric nurse practitioner and the HS specialist.</p>
<p><b>Help Us Grow Successfully (HUGS)</b>          McCabe, B. K., Potash, D., Omohundro, E., &amp; Taylor, C. R. (2012). Design and Implementation of an Integrated, Continuous Evaluation, and Quality Improvement System for a State-Based Home-Visiting Program. <i>Journal of Maternal &amp; Child Health</i>. DOI 10.1007/s10995-011-0906-6</p>	<p><b>Tennessee, USA</b></p> <p>Help Us Grow Successfully (HUGS) is a statewide home visiting program that provides services to at-risk pregnant, and post-partum women with children (0–5 years) and their families in 95 counties in Tennessee. The program goals are to improve parenting skills and connect families to needed services and thus improve the health of the service population. The HUGS program actively targets the following populations: low-income families, teen mothers, premature infants/low-birth-weight infants and infants with significant medical problems, community and public health system referrals for at-risk families, and families in the state child welfare system. When a family accepts services, the core family is enrolled; this includes the referred client or one parent/guardian and all children younger than six years. Additional child caregivers may be enrolled. Once enrolled, the family must have an initial assessment within 60 days and a home visit at least every 30 days.</p>
<p><b>Home Visit Service for Newborns/Home Visit Project for All Infants</b>          Fujiwara, T., Natsume, K., Okuyama, M., Sato, T., &amp; Kawachi, I. (2012). Do home-visit programs for mothers with infants reduce parenting stress</p>	<p><b>Japan</b></p> <p>Since 1961, this home visiting program has existed in Japan for mothers in need with newborns based on the Maternal and Child Health Act. Visits are conducted by a public health nurse or midwife following discharge from the maternity ward. In the program, the nurse or midwife instructs mothers in need (e.g., mothers with premature infants) on how to take care of their infants. Some municipalities have expanded this program to all mothers of one-to-two-month-old infants who express</p>

<p>and increase social capital in Japan? <i>Journal of Epidemiology &amp; Community Health</i>. DOI:10.1136/jech-2011-200793</p>	<p>interest in the service. Under the Child Welfare Law, the Ministry of Health, Labor, and Welfare initiated the Home Visit Project for All Infants in 2007, in which trained community staff visit all families with infants younger than four months of age to focus on parenting stress and share information to aid parenting. This home visit was designed to be the point of first contact between mothers and their infants with the community. By fostering social connections, the home visit program could be considered to be a “social capital” intervention because the program provides mothers with greater access to social services and other resources in the community.</p>
<p><b>Home-Start Program</b>  Frost, N., Johnson, L., Stein, M., &amp; Wallis, L. (1996). Negotiated friendship: Home-Start and the delivery of family support. Leicester: Home-Start UK.  Frost, N., Johnson, L., Stein, M., &amp; Wallis, L. (2000). Home-Start and the delivery of family support. <i>Children and Society</i>, 14, 328–342.</p>	<p><b>UK</b></p> <p>This program is designed to support parents with young children; it is offered to families who have at least one child under the age of six years and are experiencing difficulties in child rearing. The program is delivered by Home-Start volunteers who attend a three-day training program, where they are taught to be supportive in a nondirective way. The volunteers attend training once a year and receive supervision once a month. Volunteers visit mothers for half a day, once a week. These volunteers provide social support, which aims to increase maternal well-being. The range of support is varied according to the individual mother’s needs.</p>
<p><b>Incredible Years Parenting Program</b>  Webster-Stratton, Carolyn. 1992. <i>The Incredible Years: A Troubleshooting Guide for Parents of Children Aged 3 to 8</i>. Toronto, Ontario: Umbrella Press.  Webster-Stratton, C. (2001). The Incredible Years: Parents, Teachers, and Children Training Series. <i>Residential Treatment for Children &amp; Youth</i>, 18(3), 31-45.</p>	<p><b>Multi-country</b></p> <p>Primarily a behavioral parenting program, the aims are to prevent, reduce, and treat aggression and conduct problems in young children, and enhance child social competence. A multidisciplinary approach works to cooperate with families to reduce risk factors and support protective factors. The primary goals of the program are to improve the parent’s skill and confidence at managing their child’s aggression and problem behavior and to improve the parent-child relationship. The comprehensive set of interventions includes sessions lasting about two hours each, once a week for 10 weeks. The Incredible Years Parenting Program is a 15-week psycho-education program for parents of children ages 6–12. It is offered in group format through weekly two-hour sessions. Activities include video vignettes of parent-child interactions, group discussions, role-play, rehearsal of parenting techniques, and home practice. About 60 percent of a session is group discussion, problem solving, and support; 25 percent is allocated to video modeling (about 25–30 minutes of video footage); and 15 percent set aside for teaching. Techniques covered include play and positive interaction with the child, clear commands, limit setting, ignoring undesirable behavior, praising and rewarding desirable behavior, and following through with discipline. Curriculum topics include parent-child play skills, praise, limit setting, ignoring, reward systems, and effective consequences. The Incredible Years parenting series includes three programs targeting parents of high-risk children and/or those displaying behavior problems. The BASIC program emphasizes</p>



		<p>parenting skills known to promote children’s social competence and reduce behavior problems, such as how to play with children; ways to promote children’s cognitive, language, social, and academic skills; effective praise and use of incentives; effective limit setting; and strategies to handle misbehavior. The ADVANCE program emphasizes parent interpersonal skills, such as effective communication skills, anger and depression management, problem solving between adults, and ways to give and get support. The SUPPORTING YOUR CHILD’S EDUCATION program (known as SCHOOL) emphasizes parenting approaches designed to promote children’s academic skills, such as reading skills, parental involvement in setting up predictable homework routines, and building collaborative relationships with teachers.</p> <p>One notable feature of the Incredible Years series is the use of video modeling and feedback. The BASIC parent training series involves group discussion of a series of 250 brief video vignettes of parents interacting with children in family life situations to demonstrate child-rearing concepts. These video vignettes are used to facilitate group discussion and problem solving, and principles and skills are then practiced through role-play and home practice activities. Theoretically, video modeling approaches to learning suggest that parents can improve their parenting skills by watching videotaped examples of parents interacting with their children in ways that promote prosocial behaviors and decrease undesirable behaviors. This method is more accessible and has been shown to promote generalization and long-term maintenance of positive behaviors.</p>
<p><b>Marte Meo (MM)</b> Aarts, M. (2000). <i>Marte Meo: Basic manual</i>. Harderwijk, the Netherlands: Aarts Productions.</p>	<p><b>Scandinavian countries, Ireland</b></p>	<p>Marte Meo (MM) is a method based on the notion that children develop and grow in interaction with supportive adults. It was designed to help children and adults restore and build a supportive dialogue when their communication has been adversely affected by disturbances. The two elements of MM are analysis and intervention. The first step is to take a 5–10 minute video recording of the child-parent or child-teacher interaction, which is later analyzed by a therapist. After analysis, the therapist and adults view and discuss the video. The focus of the discussion is to help the adult see the supportive needs of the child and to stimulate the adult to modify his or her behavior accordingly so as to promote the child’s development. The adult is given the task of practicing new types of behavior in daily situations. During the next recording and reviewing, feedback is generated on whether the previous intervention was successful.</p>
<p><b>Mellow Parenting</b> Puckering, C. (2004). <i>Mellow Parenting: An intensive intervention to change relationships</i>. <i>The Signal, Bulletin of</i></p>	<p><b>Glasgow, Scotland, Germany, Russia, New Zealand</b></p>	<p>Mellow Parenting is a family of early intervention programs designed to promote positive relationships in vulnerable, hard-to-reach families. This is an intensive course with both mother and child, involving psychotherapy, behavioral techniques, and videoing of</p>

the World Association for Infant Mental Health, 12, 1-5.

parent-child interactions. The program goal is to support parents whose relationships with their children are under severe stress. The program enables parents to find their own solutions to family management problems through mutual support, with a minimum of guidance from professionals. The program is designed for children under the age of five and lasts 14 weeks. It combines personal group therapy with parenting support using behavior modification techniques. Mellow Bumps is an antenatal program aimed at reducing parental stress and engaging parents at the earliest stages in understanding the emotional needs of their babies. The six-week group-based antenatal program supports families with additional health and social care needs.

**Mentor mother support intervention**

Loeffen, M. J., Lo Fo Wong, S. H., Wester, F. P., Laurant, M. G., & Lagro-Janssen, A. L. (2011). Implementing mentor mothers in family practice to support abused mothers: study protocol. *BMC Family Practitioner*, 12, 113.

**The Netherlands**

Mentor mother support is a low-threshold intervention for abused mothers in family practice. The training for mentor mothers was further developed focusing on empowerment, exploring four main themes: 1) safety, 2) social support, 3) depressive symptoms, and 4) children witnessing intimate partner violence. Mentor mother support consists of one-hour weekly visits by a mentor mother over a period of four months, providing non-judgmental active listening and support, developing a trusting relationship, and empowering. The aims of the support are to 1) achieve a reduction of the violence, 2) expand social support networks, 3) increase the acceptance of professional help, 4) help the abused mother to cope with depression/depressive symptoms, and 5) assist abused mothers to become aware of the effect on their children. To lower the threshold for acceptance of help, mentor mother support is offered as support for mothers who experience difficulties with children living at home and not as a domestic violence support. Visits take place at home, at the family practice, or any other place where the mother feels safe and comfortable.

**Mindful Parenting Program (MPP)**

Altmaier, E. and R. Maloney (2007). An initial evaluation of a mindful parenting program. *Journal of Clinical Psychology*, 63(12), 1231-1238.  
 Placone-Willey, P. M. (2002). A curriculum for mindful parenting: A model development dissertation. *Dissertations Abstracts International*, 63 (01), 568B. (UMI No. 3040781)

**USA**

The MPP was proposed as a method to integrate mindfulness training into a parent-focused intervention. The objectives are to enhance and sustain connectedness between parent and child by facilitating parents' self-awareness, mindfulness, and intentionality in parenting. MPP helps parents identify interactions that lead to disconnectedness with their children, such as criticism, projecting anger, humiliating children, and emotional withdrawal. These are replaced with intentional, connectedness-focused interactions that are characterized by listening, the display of affection, calm responses, and the modeling of self-soothing behaviors. Mindfulness practices include breathing, body awareness, centering, and mediation. Parents use these techniques to learn to be more intentional in their parenting and thus choose ways that enhance and sustain a positive emotional connection. The program delivers training over 8–12 weeks in small groups according to an MPP manual.

<p><b>Mindfulness-Based Cognitive Therapy (MBCT)</b></p> <p>Bailie, C., Kuyken, W., &amp; Sonnenberg, S. (2012). The experiences of parents in mindfulness-based cognitive therapy. <i>Clinical Child Psychology &amp; Psychiatry</i>, 17(1), 103-119.</p>	<p><b>Multi-country</b></p>	<p>MBCT is a relatively new intervention, derived from cognitive therapy and mindfulness-based stress reduction. It is especially useful for people with a history of recurrent depression. It teaches people to become aware of their bodily sensations, thoughts, and feelings and relate constructively to these experiences. The aim is to cultivate mindfulness and compassion so that individuals can be more responsive to stress, and work to improve their mood. Parenting is enhanced by parents' becoming more aware of their feelings and needs and more responsive in their interactions with their children. MBCT is generally delivered to groups of 9–14 individuals in two-hour sessions that span eight weeks. Four subsequent follow-up sessions are spread out over a year. The sessions follow a MBCT manual and include guided mindfulness practice, enquiry into the participant's experiences of practice, weekly homework reviews, and cognitive behavior therapy skills.</p>
<p><b>Mindfulness-Enhanced Strengthening Families Program (MSFP)</b></p> <p>Coatsworth, J. D., Duncan, L. G., Greenberg, M. T., &amp; Nix, R. L. (2010). Changing parent's mindfulness, child management skills and relationship quality with their youth: Results from a randomized pilot intervention trial. <i>Journal of Child and Family Studies</i>, 19(2), 203-217.</p> <p>Duncan, L. G., Coatsworth, J. D., &amp; Greenberg, M. T. (2009). A model of mindful parenting: Implications for parent–child relationships and prevention research. <i>Clinical Child &amp; Family Psychology Review</i>, 12(3), 255-270.</p>	<p><b>USA</b></p>	<p>A model of mindful parenting was proposed drawing on concepts and practices of psychological mindfulness and mindfulness-based interventions. This model highlights five dimensions of parenting that complement mindfulness training for parents. These include listening with full attention, non-judgmental acceptance of self and child, emotional awareness of self and child, self-regulation in the parenting relationship, and compassion for self and child. The evidence-based Strengthening Families Program (SFP): For Parents and Youth 10–14 was adapted to incorporate mindfulness activities. The format of MSFP remains the same as the SFP. Mindfulness activities were incorporated into the parent sessions only. This was done by shortening some activities in the original SFP, shifting around some activities, and modifying language so that messages of mindful parenting were emphasized. New activities were developed based on the five dimensions of parenting. Facilitators lead didactic presentations of mindfulness principles, teach mindfulness practices, practice exercises, and lead interactive group activities. Short reflections are done at the beginning and end of the sessions.</p>
<p><b>Mother-Infant Transaction Programme (MITP)</b></p> <p>Rauh, V.A., Nurcombe, B., Achenbach, T., &amp; Howell, C. (1990). The Mother-Infant Transaction Program. The content and implications of an intervention for the mothers of low-birthweight infants. <i>Clinics in Perinatology</i>, 17,31e45.</p>	<p><b>USA</b></p>	<p>The Mother-Infant Transaction Programme (MITP) is designed to help parents to appreciate their infant's unique characteristics, temperament, and developmental potential, sensitizing parents to their infant's cues so that can respond appropriately. It aims to sensitize the mother to the infant's signals, and teach her to be sensitive to and respond in a sensitive and contingent way, in particular to avoid stimulus overload and to respond when the infant is in a state most conducive to interaction; to teach the mothers to respond appropriately and in a timely fashion; to enable the mother to imbed her sensitivity and contingent responsiveness in everyday tasks; and to enhance the mother's enjoyment of her baby. The program consists of seven sessions before discharge, and four home visits</p>

		within three months after discharge. The revised MITP includes a one-hour debriefing session initially and encourages both parents to participate in the sessions.
<p><b>Mothers and Toddlers Program (MTP)</b></p> <p>Suchman, N. E., DeCoste, C., Castiglioni, N., McMahon, T.J., Rounsaville, B., &amp; Mayes, L. (2010). The Mothers and Toddlers Program, an attachment-based parenting intervention for substance using women: Post-treatment results from a randomized clinical pilot. <i>Attachment &amp; Human Development</i>, 12(5), 483-504.</p>	<b>USA</b>	The Mothers and Toddlers Program (MTP) is a 12-week individual psychotherapy intervention designed as an adjunct to outpatient substance abuse treatment. Mothers meet weekly with an individual clinician for one hour. Mothers and children also complete a brief, videotaped, structured interaction to assess maternal sensitivity and responsiveness to child cues and child responsiveness to the mother.
<p><b>Neonatal Individualized Developmental Care and Assessment Program (NIDCAP)</b></p> <p>Als, H., Gilkerson, L., Duffy, F.H., McAnulty, G.B., Buehler, D., Vandenburg, K., Sweet, N., Sell, E., Parad, R.B., Ringer, S., Butler, S., Blickman, J., &amp; Jones, K.J., (2003). A three-center, randomized, controlled trial of individualized developmental care for very low birth weight preterm infants: Medical, neurodevelopmental, parenting, and caregiving effects. <i>Journal of Developmental &amp; Behavioral Pediatrics</i>, 24,399e408.</p> <p>Als, H. (1982). Toward a synactive theory of development: promise for the assessment and support of infant individuality. <i>Infant Mental Health Journal</i>, 3, 229-243.</p>	<b>USA, Europe, South America</b>	The Neonatal Individualized Developmental Care and Assessment Program (NIDCAP) provides family-centered, developmentally supportive care of very-low-birth-weight infants, stimulates preterm infants, and improves the interaction between mothers and infants. A key focus of the NIDCAP program is educational and consultative support and assistance in the neonatal intensive care unit (NICU) and special care nursery settings. The therapeutic framework and method of NIDCAP provides early developmental support and preventive intervention, beginning immediately with birth. The NIDCAP approach uses methods of detailed documentation of an infant's ongoing communication to teach parents and caregivers skills in observing an infant's behavioral signals. These sometimes subtle signals provide the basis for interpreting what the infant is trying to communicate and can be used to guide parents and caregivers to adapt interaction and care to be supportive of the infant's behavior. Suggestions for care are made in support of the infant's self-regulation, calmness, well-being, and sense of competence and effectiveness. Such suggestions begin with support, nurturance, and respect for the infant's parents and family, who are the primary co-regulators of the infant's development. These practices ensure that a developmental perspective and an infant's environment are incorporated into the infant's care.
<p><b>New Beginnings Program</b></p> <p>Baradon, T., Fonagy, P., Bland, K., Lenard, K., &amp; Sled, M. (2008). New Beginnings - an experience-based programme addressing the attachment relationship between mothers and their babies in prisons. <i>Journal of Child Psychotherapy</i>, 34(2), 240-258.</p> <p>Sandler, I. N., Schoenfelder, E. N., Wolchik, S. A., &amp; MacKinnon, D. P. (2010). Long-Term Impact of</p>	<b>USA</b>	This accredited learning and experience-based parenting program addresses the early attachment relationship between mothers and babies in prison. It also aims to prepare both the mother and baby for potential separation. The program rests on the premise that, in the early months, a mother's pattern of relating to her baby is potentially fluid and so intervention is directed at this time. Importantly, it recognizes the baby as a partner in the process and a participant in the process in his or her own right. The program works with the baby's attachment needs and capacities through mirroring emotional states, verbalizing experience and anxieties that are perceived in the baby, and then

<p>Prevention Programs to Promote Effective Parenting: Lasting Effects but Uncertain Processes. <i>Annual Review of Psychology</i>, 62(1), 299-329.</p>		<p>creates opportunities for inter-subjective connectedness through the use of play. In addition to recognizing the impact of the prison environment on the mother's state of mind and consequent abilities for emotional attachment, the program incorporates the effects of the mother's own experiences of being parented on her attitude and behavior toward the baby; in this way, intergenerational repetitions likely to pose as risks to the baby are addressed. The program consists of eight two-hour sessions that run over four consecutive weeks for up to six mother-and-baby pairs in a group. These sessions are structured around eight topics, covering the history of the pregnancy, the family tree of the baby, the mother's representations of her own childhood experiences, the mother's perceptions of her baby, her experiences of motherhood, and her aspirations for herself and her baby. Illustrated handouts, worksheets, and homework are part of the program. Mothers are encouraged to add to their folders drawings, poetry, or letters that they produce during the course. The New Beginnings Program is also designed to improve parenting by residential mothers following divorce in an 11-session program.</p>
<p><b>New Parent Infant Network (NEWPIN)</b> Pound, A. (1994). NEWPIN: A befriending and therapeutic network for carers of young children. London: HMSO.</p>	<p><b>Australia</b></p>	<p>NEWPIN is a center-based, early intervention program directed at strengthening family functioning and supporting stressed families, with a particular focus on the mother-child relationship. The program provides parent education, development, and support as well as play therapy and instruction. Specific programs using the NEWPIN model include Our Skills as Parents, a 10-week program in which participants explore their feelings and share their knowledge around parenthood. The aim is to improve parenting skills by building self-esteem, confidence, and a deeper understanding of children's needs. Another program, Weekly Support Group, encourages members to explore issues from their own lives that are impacting their parenting. Keeping Children Safe is a six-week program offering practical strategies designed to keep children safe and free from abuse and neglect. The Family Play Program is an eight-week program aimed at increasing the understanding of the importance of creative play in a child's development and assisting the parent-child attachment process. The SEER Program explores the five core NEWPIN values of support, equality, empathy, and respect, which guide every aspect of the intervention and govern the behaviors in relation to a member's personal life, the NEWPIN center, and society as a whole. Learning for Life, the NEWPIN foundation course, prepares established members to befriend others. Regular Self-Evaluation and Child Appraisal is a program in which members are invited to identify and reflect on their own and their child's progress with staff members.</p>
<p><b>Nobody's Perfect Program</b> Kennett, D. J., Chislett, G., &amp;</p>	<p><b>Canada</b></p>	<p>The Nobody's Perfect Program is an education and support program for parents of children up to five years</p>

Olver, A. L. S. (2012). A reappraisal of the Nobody's Perfect program. *Journal of Child and Family Studies*, 21(2), 228-236.

of age. It is designed for parents who are young, single, socially or geographically isolated, or who have limited formal education or low income. Parent development is the primary goal, although Nobody's Perfect helps parents to increase their knowledge and skills and promote the healthy development of their children. Groups of parents usually meet once a week in a series of eight two-hour sessions. Trained facilitators lead the group following a program manual. Topics include child development, child behavior management, nutrition, health, safety, financial management, mood management, and healthy relationships. Parents are invited to select from these topics according to their needs, examine their experiences, relate their observations to their lives, problem-solve, and apply their learning. The program is offered free of charge, and parenting books, transportation assistance, childcare, and snacks are provided. At completion, parents earn a certificate based on attendance.

**Nurse Family Partnership (NFP)**

Olds, D.L., Henderson, C.R. Jr., & Kitzman, H. (1994). Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life? *Pediatrics*, 93, 89–98.

<http://www.nursefamilypartnership.org/Communities/Model-elements>

**USA**

The NFP is an evidence-based community health program whose outcomes include long-term improvements in family health, education, and economic self-sufficiency. The Nurse-Family Partnership National Service Office, a nonprofit organization, provides implementing agencies with the specialized expertise and support necessary to deliver NFP. This home visiting intervention for first-time mothers utilizes trained nurses who visit mothers at home during the pregnancy and/or during the first two years of the child's life to provide education about healthy prenatal behaviors, competent early childcare, and strategies to improve the maternal life-course, such as planning future pregnancies and seeking education and employment. The NFP model comprises 18 elements: the client participates voluntarily in the NFP Program; is a first-time mother who meets low-income criteria at intake; is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy; is visited one-to-one at home, one nurse home visitor to one first-time mother or family; is visited throughout her pregnancy and the first two years of her child's life in accordance with the NFP guidelines; nurse home visitors and nurse supervisors are registered professional nurses; they complete core educational sessions required by the NFP National Service Office and deliver the intervention with fidelity to the NFP model; using professional knowledge, judgment, and skill, they apply the NFP visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains; they also apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods; each full-time home visitor carries a caseload of no more than 25 active clients; a supervisor provides supervision to no more than eight nurse home visitors; supervisors provide

		<p>nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision; home visitors supervisors collect data as specified by the NFP National Service Office and use NFP reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity. An NFP implementing agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families; it convenes a long-term community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability. Adequate support and structure is put in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.</p>
<p><b>Nursing Child Assessment Teaching Scale (NCATS)</b>  Sumner, G., &amp; Spietz, A. (1994). NCATS Caregiver/Parent-Child Interaction Teaching Manual. Seattle, WA: NCATS Publications, University of Washington, School of Nursing, 1994.</p>	<b>USA</b>	<p>NCATS examines the mother-child relationship in conjunction with teaching mothers how to interact with their babies, teaching behavioral cues, and teaching how to play. The Nursing Child Assessment Teaching Scale (NCATS) is used to assess the quality of the caregiver-child teaching interaction for children from birth to three years of age. The 73-item teaching scale is organized into six subscales, four of which assess the caregiver's behavior and two the child's. The four caregiver subscales assess the caregiver's sensitivity to cues, response to the child's distress, fostering of socioemotional growth, and fostering of cognitive growth. The two child subscales assess the clarity of the child's cues and responsiveness to the caregiver. The teaching scale identifies areas of strengths and weaknesses in the caregiver-child teaching interaction. The results can be used to build the caregiver's skills to facilitate the development of the child. To learn essential childcare skills, users of NCATS are strongly recommended to view NCATS's "Keys to Caregiving" video series. Workshops are also available through NCATS or NCATS certified instructors.</p>
<p><b>Nurturing Parent</b>  Family Development Resources. (2007). Community-based education in nurturing parenting. Park City, UT: Authors.</p>	<b>USA</b>	<p>This is a community-based education intervention in nurturing parenting. In the 10 sessions, which involve group discussion, role-play, and homework tasks, the following issues are covered: the philosophy and practices of nurturing parenting; ages and stages of growth; enhancing brain development in children and teens; communicating with respect; building self-worth; understanding feelings; understanding and developing family morals, values, and rules; praising children; alternatives to spanking; and learning positive ways to deal with stress and anger.</p>
<p><b>Nurturing Parenting</b></p>	<b>USA</b>	<p>The Nurturing Parenting Program for Children (Birth to</p>

<p><b>Program</b></p> <p>Bavolek, S., &amp; Dellinger-Bavolek, J. (1985). Increasing the nurturing parenting skills of families in head start: Validation of the Nurturing Parenting program for parents and children birth to five years. Retrieved from <a href="http://www.nurturingparenting.com/research_validation/validation_b-5_program.pdf">http://www.nurturingparenting.com/research_validation/validation_b-5_program.pdf</a></p>		<p>Age 5) aims to build positive parent-child interactions in families enrolling in home-based and center-based Head Start programs. Emphasis is placed on building personal growth and growth as a nurturing parent. By establishing a positive self-concept and self-esteem and becoming more empathically aware of children's needs, parents are less likely to engage in child maltreatment. Unlike other parent education programs whose focus is primarily teaching child development and behavior management to parents, the focus of the Nurturing Parenting Program is to work with the entire family in building more empathic parent-child interactions.</p> <p>The Nurturing Parenting Program consists of 45 individual sessions following a sequential curriculum. Separate curricula are developed for parents and children. The content of the program focuses on increasing the self-esteem and self-concept of parents while teaching nurturing parenting skills appropriate for children up to five years of age.</p> <p>In the home-based program, sessions are run on a weekly basis and last about one and a half hours. During these home visits, the first half is spent with the whole family and home visitor working together. Parents are encouraged to take the role of the primary teacher, and the home visitor serves as a source of support. The second half of the visit is spent with only parents and the home visitor dealing with their role as parents or on issues related to self.</p> <p>In the center-based program, parents and their children attend weekly separate group sessions, coming together for a meal, which is aimed at building family cohesion and nurturing interactions through play and food. Generally, one facilitator leads the parent group while two or three facilitate the children's program.</p>
<p><b>Parent Management Training (PMT)</b></p> <p>Kazdin, A. E., Esveldt-Dawson, K., French, N. H., &amp; Unis, A. S. (1987). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behavior. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 26, 416-424.</p>	<p><b>USA</b></p>	<p>PMT works on the principle that since family interaction may cause, maintain, or aggravate a conduct disorder, the mobilization of family relationships as a potential therapeutic agent can reduce undesirable behaviors. Parents are trained to identify, define, and observe behaviors in new ways, to positively reinforce prosocial behaviors, and to mildly punish antisocial behavior. The program is directed at children aged 3–10 years. The course combines cognitive, behavioral, and affective components with features such as video clips, structured sequences of topic (e.g., play, praise, incentives, limit setting, discipline), and a detailed manual. Children do not participate in the program. Generally in PMT, parents will be seen individually for up to 16 sessions over a period of six to eight months.</p>
<p><b>Parent Plus</b></p> <p>Byrne, E., Holland, S., &amp; Jerzembek, G. (2010). A Pilot Study on the Impact of a Home-based Parenting Intervention: Parents Plus. <i>Child Care in Practice</i>,</p>	<p><b>UK</b></p>	<p>Parent Plus is a parenting intervention offered by Flying Start (formerly Sure Start) in South Wales, United Kingdom. The Welsh Assembly Government subsumed Sure Start into its own initiative—Flying Start. Parent Plus offers home-based, time-limited, targeted, and individualized programs to families who have difficulties with their children aged 0–4 years. These families are</p>



16(2), 111-127.		either self-referred or referred by health visitors who have visited the home. The components of the program are mainly behaviorally based and use counseling skills and motivational interviewing. Service delivery takes a “parenting positively” approach and is aimed at promoting ownership and empowerment; it is expected that parents work out successful ways to play with their children and deal with their child’s behavior themselves.
<p><b>Parent-Child Interaction Therapy (PCIT)</b>  Budd, K. S., Hella, B., Bae, H., Meyerson, D. A., &amp; Watkin, S. C. (2011). Delivering parent-child interaction therapy in an urban community clinic. <i>Cognitive and Behavioral Practice</i>, 18(4), 502-514.</p>	<b>Multi-country</b>	PCIT is a manualized intervention for children ages 2–7 with disruptive behavior problems. PCIT draws on Baumrind’s development research on authoritative parenting, social learning theory, and attachment theory in its effort to promote positive, consistent parenting practices. There are two phases of PCIT treatment, child-directed interaction (CDI) and parent-directed interaction (PDI). Both phases start with a “teach” session that introduces skills through instruction, demonstration, and role-play. Coach sessions follow the “teach” sessions, in which the therapist observes from behind a one-way mirror and provides immediate feedback and support on the parent’s use of skills through an inner-ear hearing device while the parent and child play. Both the CDI and PDI phases are considered necessary for the treatment, along with individualized live coaching sessions, coding of parent-child interactions in coaching sessions, homework assignments, and the use of standardized assessment instruments to guide the treatment.
<p><b>Parent-Child Psychological Support Programme (PCPS/PAPMI, Spanish version)</b>  Cerezo, M. A., Pons-Salvador, G., &amp; Trenado, R. (2008). Child abuse potential and quality of mother-child attachment in the context of a community based prevention program. Paper presented at the XVIIth ISPCAN International Congress on Child Abuse and Neglect. Hong Kong, China  Bujia-Couso, P., O'Rourke, A., and Cerezo, M. Á. (2010). Criteria based case review: The Parent Child Psychological Support Program. <i>Irish Journal of Applied Social Studies</i>, 10(1).</p>	<b>Spain</b>	The PCPS aims to support the tasks of parenting, the child’s development, and the parent-child relationship during the infant’s first two years of life, through a calendar of six visits, from 3 to 18 months, preceded by an introductory visit. The program provides support to parenting through checking the development and growth of the child and anticipating the child’s next expected developmental changes and needs. The parents receive specific information about their child’s progress, forthcoming developments, and guidelines about solving or preventing conflict. The empowerment of parents in solving conflicts (e.g., feeding, sleeping, and crying) is coupled with encouragement and modeling synchronous interaction, which is tailored to each specific parent-child dyad. Likewise, factors that affect parenting are addressed with the parents, to find solutions that make their task more manageable and predictable, thus impacting positively on the parent-child relationship. The program is delivered by a multidisciplinary team with backgrounds including public health nursing, psychology, social care, psychotherapy, and family therapy, and may include social work, speech and language therapy, and occupational therapy.
<p><b>ParentCorps</b>  Brotman, L. M., Calzada, E., Huang, K.-Y., Kingston, S., Dawson-McClure, S., Kamboukos, D., Petkova, E.</p>	<b>USA</b>	This culturally informed family intervention is designed to be distributed as a universal preventive intervention for ethnically diverse children attending pre-K programs in public schools in disadvantaged urban communities. Intervention content and delivery strategies were

<p>(2011). Promoting effective parenting practices and preventing child behavior problems in school among ethnically diverse families from underserved, urban communities. <i>Child Development</i>, 82(1), 258-276.</p>	<p>designed to be relevant and engaging to all families and, at the same time, to be sufficient to address the needs of the highest-risk children. The intervention focuses on issues relevant to living in disadvantaged urban communities and is based on the understanding that families living in high-risk environments have a broad spectrum of strengths. ParentCorps recognizes that parenting practices vary within and between cultures and that a parent's culture informs nearly all aspects of being a parent, including family roles and responsibilities, concerns about child behavior, expectations and aspirations for the future, and the kind of parenting strategies that are deemed appropriate to use. The intervention is delivered in school settings and co-facilitated by pre-K teachers and other school staff. Thirteen weekly groups are held in school settings, and assessments include home visits with videotaped observations of parent-child interactions.</p>
<p><b>Parenting Now!</b> Saks, M., Rusch, J. &amp; Poasa, K. (2001). <i>Parenting Now! A group-based positive parenting curriculum</i>. Eugene, Oregon: Birth to Three.</p>	<p><b>Multi-country</b></p> <p>Parenting Now! is a community-based parenting education program aimed at strengthening families. In this curriculum-based group program, parents observe and interact with their own and others' children. Parent groups are set up according to the date of a child's birth; each group includes a broad range of parental socioeconomic status, culture, and education and both mothers and fathers are invited to participate in the program. The program has a manual-guided, group-based positive parenting curriculum for parent educators who work with parents of children between the ages of birth and six years. The curriculum is adaptable for home visiting and geared for the universal population. The contents of the curriculum include seven modules, 15 parent booklets with reproducible handouts, two short videos, and graduation certificates. The seven modules of the Parenting Now! curricula focus on identifying parent values, stress and anger management, realistic expectations, positive discipline, learning questions, effective communication skills, and what to do when things break down. The strategies used are group discussion, homework activities, and small group discussions.</p>
<p><b>Parenting Our Children to Excellence (PACE)</b> Dumas, J.E. (2001). <i>PACE—Parenting Our Children to Excellence</i>. A program to promote parenting effectiveness and child coping-competence in the preschool years. Unpublished manuscript.</p>	<p><b>Indianapolis, USA</b></p> <p>PACE is a research-based preventive intervention designed to support parents of preschoolers through discussions and activities that address practical child-rearing issues and promote child-coping competence. It is a prevention intervention designed to promote parenting effectiveness and reduce child maltreatment. This is a structured group parenting program on parenting and child outcomes, with emphasis on the process of engagement and its relationship to those outcomes. The program includes eight two-hour sessions designed for groups of 10–15 parents of preschoolers ages 3–6 years and is delivered at the day care centers the children attend. To decrease barriers to engagement, the program is delivered at a time that is most convenient for the participating parents (i.e.,</p>

		following school, in the evenings); dinner is served to parents and children; childcare is provided; and parents are reimbursed for transportation costs.
<p><b>Parenting Through Change</b></p> <p>Forgatch, M.S., &amp; DeGarmo, D.S. (1999). Parenting Through Change: an effective prevention program for single mothers. <i>Journal of Consulting and Clinical Psychology</i>, 67(5), 711-724.</p>	<b>USA</b>	<p>This intervention aims to prevent internalizing and externalizing conduct behaviors and promote healthy child development. It is based on the Oregon Parent Management Training model. The intervention is generally used with recently separated single mothers, but has been used with two-parent families. The program structure consists of 14 weekly group sessions in which parents learn effective parenting practices, including encouragement of children's skills, limit setting, problem solving, monitoring, and positive involvement. Parents are also taught how to decrease coercive interactions with their children and use more contingent positive reinforcements in their parenting practices. Among the outcome categories that the program targets are family relationships.</p>
<p><b>Parenting Wisely</b></p> <p>Gordon, D. (2004). Parenting Wisely program workbook young children's version. Athens, OH: Family Works, Inc.</p>	<b>USA</b>	<p>Parenting Wisely is a self-administered, highly interactive, computer-based program that teaches parents and children ages 9–18, skills to improve their relationships and decrease conflict through support and behavior management. The program uses an interactive website (or CD-ROM) with nine video scenarios depicting common challenges with adolescents. Parents are provided the choice of three solutions to these challenges and are able to view the scenarios enacted, while receiving feedback about each choice. Parents are quizzed periodically and receive feedback. Computer experience or literacy is not required. Parents and children can use the program together as a family intervention. Parenting Wisely uses a risk-focused approach to reduce family conflict and child behavior problems. With younger children, issues of redirection, active listening, "I" statements, non-directive play, fostering social skills, communication with the school, time out and setting limits/consequences are dealt with.</p>
<p><b>Parents in Partnership: Parent Infant Network (PIPPIN)</b></p> <p>Parr, M. (1995). Why PIPPIN was developed: Some research findings. Stevenage, UK: PIPPIN.</p>	<b>UK</b>	<p>PIPPIN works with expecting and new parents and their partners. It offers fathers and mothers advice on how to build strong and nurturing relationships with their babies. The program complements traditional antenatal classes, where the focus is primarily giving women advice on coping with pregnancy, childbirth, and practical aspects of infant care. Both mothers- and fathers-to-be, starting in the fourth month of pregnancy and continuing for four months after birth with babies, actively participate in the program. Parents work in small groups and are given help and information in understanding the emotional aspects of pregnancy, the birth, and the effects of a new baby on the mother, the father, and the other members of the family. Parents are trained on how to improve their communication, listening, and problem-solving skills, as well as how to respond sensitively and confidently to their baby's needs. The full PIPPIN program comprises 35 hours of education and support to families. This is structured into</p>

		6–8 group sessions before birth, a home visit shortly after birth, and eight postnatal sessions with the mother, father, and baby. A second delivery model is the Informed Birth and Parenting Model, in which a National Health Service (NHS) midwife and the PIPPIN facilitator run four antenatal sessions that integrate the medical and social/emotional aspects of becoming a parent. After birth, parents are visited at home by the facilitator and attend six postnatal sessions. PIPPIN also trains family and social workers who work one-on-one with vulnerable young mothers.
<p><b>Parents Matter! Program (PMP)</b>  Miller, K. S., Maxwell, K. D., Fasula, A. M., Parker, J. T., Zackery, S., &amp; Wyckoff, S. C. (2010). Pre-risk HIV-prevention paradigm shift: The feasibility and acceptability of the Parents Matter! Program in HIV risk communities. <i>Public Health Reports</i>, 125, 38-46.</p>	<b>USA</b>	PMP, a parent-focused, community-level intervention developed by the Centers for Disease Control and Prevention (CDC), is an innovative pre-risk HIV-prevention program for parents of children aged 9–12 years aimed at promoting positive parenting and effective parent-child communication about sexuality and sexual risk reduction through overcoming parent-child communication barriers and enhancing parenting skills. PMP is delivered in five 2.5-hour sessions over a five-week period. Sessions are delivered by trained PMP facilitators and include activities for increasing parents' awareness of the sexual risks that teens may face and encouraging general parenting practices such as relationship building and monitoring.
<p><b>Philani Plus (+) Intervention Program</b>  Rotheram-Borus, M., Roux, I., Tomlinson, M., Mbewu, N., Comulada, W., Roux, K., et al. (2011). Philani Plus (+): A Mentor Mother Community Health Worker Home Visiting Program to Improve Maternal and Infants' Outcomes. <i>Prevention Science</i>, 12(4), 372-388.</p>	<b>South Africa</b>	The Philani Plus (+) Intervention Program builds on the original Philani Community Health Worker home visiting intervention program for maternal and child nutrition by integrating content and activities to address HIV, alcohol, and mental health. Mentor Mothers were trained over a two-month period initially, and a comprehensive intervention manual was designed. The Mentor Mothers work halftime (four hours daily), making home visits on four days and attending supervision one day weekly. Twice monthly, a supervisor attends the home visits with the Mentor Mother. A mobile phone intervention gives delivery support through specific applications loaded onto it. When a Mentor Mother prepares to enter a home for a visit, she enters the client's identifying information into the phone and receives a confirmatory prompt as to which pre- or postnatal session needs to be delivered. Four antenatal and four postnatal sessions are specifically targeted for mothers at risk (MAR); and Mentor Mothers visit MAR once every two weeks over two months to deliver the four antenatal sessions, and then once every two weeks over two months after birth to deliver the four postnatal sessions. They check in once a month afterward to deliver support as needed. Mentor Mothers address topics such as living with HIV, alcohol use, nutrition, child assistance grants and other resources, and self-care and social support.
<p><b>Prenatal to Three Initiative (Pre to 3)</b>  Peifer, K. (2002). Prenatal to Three Initiative Evaluation. San</p>	<b>California, USA</b>	The Prenatal to Three Initiative is a collaboration of agencies and individuals working together to provide information, support, and care for families of pregnant women and children up to the age of five years in the

<p>Mateo, California.</p>		<p>San Mateo County. The goals of Pre to 3 are to build parenting skills and confidence, facilitate early identification and treatment of potential problems, and improve access to the health care system. The multidisciplinary program offers a range of services. The Home Visiting and Case Management component includes health screenings and linkages to resources/services, information on growth and development, referrals to recovery programs related to substance abuse, nutrition counseling, parenting classes, and drop-in support groups. Under the Healthy Moms, Health Children Program, a registered dietician provides in-home nutrition/breastfeeding assessment and links to service providers and resources. Under the Substance Abuse/Recovery Support component, a Perinatal Addiction Outreach Team conducts home visits and provides a range of comprehensive services, such as education on child development, parenting, and chemical dependency; developmental screenings; and advocacy and supportive counseling to pregnant and/or parenting women identified to be at risk for substance use. Parenting Education Classes are built around a 14-week course that focuses on building a positive parent-child relationship, learning the importance of culture in the family, teaching positive discipline, involving the family and the community in rearing children, and creating a healthy family environment.</p>
<p><b>Pride in Parenting (PIP)</b>  Katz, K., Jarrett, M., El-Mohandes, A., Schneider, S., McNeely-Johnson, D., &amp; Kiely, M. (2011). Effectiveness of a combined home visiting and group intervention for low income African American mothers: The Pride in Parenting Program. <i>Maternal &amp; Child Health Journal</i>, 15(S1), 75-84.  10.1007/s10995-011-0858-x.</p>	<p><b>USA</b></p>	<p>The PIP intervention model aims to influence parenting knowledge, attitudes, and skills in order to improve child-rearing environments and health care utilization for mothers and their infants. PIP uses an ecological intervention model focused on parenting, infant health, individual coping skills, and recruitment and maintenance of social support systems. Lay home visitors deliver the home-based interventions, and as paraprofessionals, enhance trust and communication. Target groups are women identified as having inadequate prenatal care (five or fewer prenatal visits, care initiated in the third trimester, or no prenatal care). The home visit curriculum is designed to improve knowledge, influence attitudes, and promote life skills that would assist low-income mothers in offering a more optimal health and developmental environment for their infants. The main objectives are to improve use of maternal and child health and social service resources, identify and maintain existing community systems, develop effective coping strategies, establish family routines and personal goals, and improve responsiveness to the child's needs. A parent group curriculum supplements the home visits. Group sessions comprise 45-minute parent-infant play group and focus on developmental issues, followed by a 45-minute parent group discussion.</p>
<p><b>Project 12-Ways</b>  Lutzker, J. R., Bigelow, K. M., Doctor, R. M., Gershater, R. M., &amp; Greene, B. F. (1998). An</p>	<p><b>USA</b></p>	<p>Project 12-Ways is a comprehensive program aimed at preventing child abuse and neglect, using an ecobehavioral approach. Families are referred to the program through the Illinois Department of Child Abuse</p>

<p>ecobehavioral model for the prevention and treatment of child abuse and neglect. In J. R. Lutzker (Ed.), <i>Handbook of child abuse research and treatment</i> (pp. 239-266). New York: Plenum.</p>		<p>and Neglect. Participating families receive training in parent-child interaction, structuring daily routines, health maintenance and nutrition, stress reduction, home safety and cleanliness, infant care and development, teaching basic childhood skills, problem solving, and money management. Parents also receive self-esteem and assertiveness training in resolving conflicts in a positive way. Assistance in obtaining employment and access to community services is also provided. Project 12-Ways is the precursor to the SafeCare program.</p>
<p><b>Project Healthy Grandparents</b> Kelley, S. J., Yorker, B. C., Whitley, D. M., &amp; Sipe, T. A. (2001). A multimodal intervention for grandparents raising grandchildren: Results of an exploratory study. <i>Child Welfare</i>, 80(1), 27–50.</p>	<p><b>Georgia, USA</b></p>	<p>This case management program uses a strengths-based nurse/social work team approach and serves both the urban and rural populations. The program includes social work case management, grandparent support groups, parenting education classes, nursing visitations, and legal consultation. The nursing interventions include monthly health assessments of the children and grandparents, along with medication monitoring, individualized health promotion guidance, and referrals based on the family's goals and strengths.</p>
<p><b>Project Teens and Adults Learning to Communicate (TALC)</b> Rotheram-Borus, M. J., Lee, M. B., Gwadz, M., &amp; Draiman, B. (2001). An intervention for parents with AIDS and their adolescent children. <i>American Journal of Public Health</i>, 91, 8, 1294-1302. Rotheram-Borus, M. J., D. Swendeman, et al. (2011). Interventions for families affected by HIV. <i>Translational Behavioral Medicine</i>, 1(2), 313-326.</p>	<p><b>Multi-country</b></p>	<p>Project TALC (Teens and Adults Learning to Communicate) is designed to improve behavioral, social, and mental health outcomes among parents living with AIDS and their adolescent children. The intervention, based on social learning theory, includes 24 sessions spaced out over a period of 12 weeks. The first eight sessions are delivered only to parents. These sessions address issues of disclosure, emotional reactions to AIDS, and coping with stigma. The remaining 16 sessions are delivered to both parents and adolescents. These sessions address issues such as making custody plans, expressing love and affection, and maintaining positive family routines with a very ill parent. Each of these sessions involves some activities for which parents and children are separated and some activities for which parents and children meet together. All sessions include goal-setting and problem-solving activities. Modified versions of Project TALC are used around the world with variations in the setting, delivery agent, intervention format, and session structure.</p>
<p><b>Protecting Families Program (PFP)</b> Boyd, R. C., Diamond, G. S., &amp; Bourjolly, J. N. (2006). Developing a family-based depression prevention program in urban community mental health clinics: A qualitative investigation. <i>Family Process</i>, 45(2), 187-203.</p>	<p><b>USA</b></p>	<p>PFP targets low-income urban children whose mothers are in treatment for depression at community mental health clinics. This 10-week family-based, multi-component prevention program is designed for depressed mothers and their school-aged children (ages 9–14). Each session begins with a community meal that serves to build relationships and social support among participating families. After the meal, mothers participate in a 90-minute parent training program that 1) provides psycho-education about depression, its impact on children, and child development; and 2) teaches parenting skills that can improve children's affect regulation and behavioral control. At the same time, children participate in a cognitive-behavioral group that teaches cognitive restructuring and coping skills. In</p>

		<p>addition to group training sessions, individual family sessions are forums where family members can discuss the impact of depression on the family.</p>
<p><b>Reading Together Program</b>  Sukhram, D. P., and A. Hsu (2012). Developing reading partnerships between parents and children: A reflection on the reading together program. <i>Early Childhood Education Journal</i>, 40(2), 115-121.</p>	<p><b>USA</b></p>	<p>The Reading Together Program has its roots in the Family Strengths Model, which is designed to effectively meet children's literacy needs. The importance of the family environment and culture in the development of meaningful literacy and language experiences is emphasized, along with the significance of the active role and engagement of families in this development. The family-centered approach to the reading process empowers parents and children to build positive relationships through daily interactions, which eventually lead to developed literacy skills. Parents are taught various strategies to build the early literacy skills of their children through modeling. The six-week program is generally carried out in a public library and is open to all children between 6 and 36 months of age and their caregivers. The sessions last about 45 minutes and begin with an overview of the day's activities. Topics covered during the sessions include concerns and questions raised by caregivers. Parents work individually with children as they read and employ the strategies of Reading Together.</p>
<p><b>Ready Set Parent! (RSP)</b>  Tomasello, N. M., Kazi, M. A. F., Prabhu, S., Harvey, S. J., &amp; Rittner, B. (2011). Ready Set Parent: Evaluation of a parenting education program in New York State. <i>International Journal of Interdisciplinary Social Sciences</i>, 5(9), 1-14.</p>	<p><b>USA</b></p>	<p>RSP is provided by Every Person Influences Children (EPIC), a nonprofit organization, and Baker Victory Services (BVS). RSP follows an active learning delivery model that provides services to parents who are identified as having potential parenting problems based on identified risk factors such as low birth weight, living in poverty, lower parent education levels, living in communities with limited resources, and inexperience as parents. RSP focuses on parenting skills, literacy, and maternal and baby wellness. There are three components within the RSP program model. The first is visitation; RSP coordinators visit parents in maternity hospitals within 48 hours of the birth of the baby. During these visits, parents are informed about community resources and are provided with written and oral information on parenting, literacy, nutrition, safety, and health and wellness. The second component is a newborn class held at the hospital, where parents are invited to a one-hour program to learn more about infant development. Specific parenting skills are taught during this class, including the benefits of regularly reading to children; parents are also given children's books. The final component is an eight-week workshop series designed to increase knowledge, attitudes, and confidence about being parents. The aim of this workshop is to promote high-quality interaction with infants and to enhance development of cognitive, language, social, gross motor, and fine motor skills in children. During the workshop, parents are provided with information on parent-child interaction, the role of playing in child development, coping strategies, benefits of structured parenting, discipline, and literacy</p>

		enhancement. After the workshop, participants are regularly updated on programs scheduled in their communities.
<p><b>Right from the Start Programme</b></p> <p>Niccols, A. (2008). "Right from the Start": Randomized trial comparing an attachment group intervention to supportive home visiting. <i>Journal of Child Psychology and Psychiatry</i>, 49, 754-764. DOI: 10.1111/j.1469-7610.2008.01888.x.</p>	<p><b>West Virginia, USA</b></p>	<p>The Right from the Start (RFTS) Project is a statewide program in West Virginia committed to producing improvements in birth outcomes for low-income pregnant women and their families. RFTS uses a program of home visitation provided by registered nurses and licensed social workers, who work and reside in the community they serve. The home visitors help women to achieve the following goals: 1) Improve pregnancy outcomes by helping women engage in good preventive health practices including early comprehensive prenatal care, good nutrition, and reducing use of cigarettes, alcohol, and illegal substances; 2) increase their knowledge of child development, by offering parent education, and facilitating access to community resources; 3) improve their families' economic and personal self-sufficiency by empowering parents to develop a vision for their own future, plan future pregnancies, continue their education, and find jobs. An eight-session parent group is also used to enhance caregiver skills in reading infant cues and responding sensitively.</p>
<p><b>SafeCare Model (originally Project 12-Ways)</b></p> <p>Lutzker, J., &amp; Bigelow, K.M. (2002). <i>Reducing Child Maltreatment: A Guidebook for Parent Services</i>. New York, NY: Guilford Press; 2002.</p> <p>Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., &amp; Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. <i>Pediatrics</i>, 129(3), 509.</p>	<p><b>USA</b></p>	<p>The SafeCare model was developed as a home-based treatment for parents as part of the U.S. Child Protection Service for child neglect. This structured behavioral skills training program focuses on concrete caregiving, household management, and parenting skills. The manual-based structure of SafeCare addresses 1) parent-child or parent-infant interaction, basic caregiving structure, and parenting routines; 2) home safety; and 3) child health. The SafeCare model can be delivered as a freestanding intervention or as a component of a broader home visiting service. Trained professionals work with at-risk families in their home environments to improve parents' skills in several domains. SafeCare is generally provided in weekly home visits lasting one to two hours. The program typically lasts 18–20 weeks for each family.</p>
<p><b>Steps to Effective and Enjoyable Parenting (STEEP) Programme</b></p> <p>Egeland, B., &amp; Erickson, M. F. (2004). Lessons from STEEP: Linking theory, research, and practice for the well-being of infants and parents. In A. Sameroff, S. C. McDonough, &amp; K.L. Rosenblum (Eds.), <i>Treating parent-infant relationship problems: Strategies for intervention</i> (pp. 213-242). New York: The Guilford Press.</p>	<p><b>USA</b></p>	<p>STEEP works on the premise that a secure attachment between parent and infant establishes ongoing patterns of healthy interaction and promotes sensitivity in maternal caregiving. Through home visits and group sessions, STEEP facilitators work alongside parents to help them understand their child's development. Parents learn to respond sensitively and predictably to their child's needs and to make decisions that ensure a safe and supportive environment for the whole family. The approach involves home visits and group sessions beginning prenatally and continuing for two years (the original program was designed for one year). Seeing Is Believing training is a component of STEEP, but can also be used independently from STEEP. Through filming and guided viewing, parents are enabled to increase their sensitivity and responsiveness to their babies' cues. The</p>



		primary goal of using filming is to promote the parents' self-observation and reinforce their growing knowledge of and sensitivity to their babies.
<p><b>Strengthening Families Program</b></p> <p>Kumpfer, K.L. (1998). The Strengthening Families Program. In R.S. Ashery, E. Robertson, &amp; K.L. Kumpfer (Eds.) (1998). <i>Drug Abuse Prevention Through Family Interventions</i>, NIDA Research Monograph #177, DHHS, National Institute on Drug Abuse, Rockville, MD, NIH Publication No. 97-4135.</p>	<b>Multi-country</b>	<p>The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program for high-risk and regular families. The original 14-session SFP for high-risk families with children aged 6–11 years was developed in the 1980s (known as SPF6-11). In the 1990s, a shorter, seven-session version was developed for low-risk families with pre- and early teens. In the 2000s, new 14-session versions for high-risk families were developed for families with younger children (SPF3-5) and those with early teens (SPF12-16). In 2011 a 10-session home-use DVD version and group curriculum were developed. SFP is used internationally and has been translated into numerous languages. The three components of SFP include Parent Skills Training, Children's Skills Training, and Family Life Skills Training. The Parent Skills Training course is implemented using lectures, exercises, discussions, and role-plays, and focuses on developing parents' ability to increase desirable behaviors in children by using attention and rewards, clear communication, effective discipline and limit setting. Parental problem-solving skills, stress and anger management skills, and substance abuse education are also provided. The parent-and-child sessions generally end with the Family Life Skills Training, which aims to increase cooperation between family members. The skills acquired through the child-and-parent training are practiced in structured family activities, therapeutic child play, and family meetings.</p>
<p><b>Strong African American Families Program (SAAF)</b></p> <p>Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., McNair, L., Brown, A. C., Wills, T. A., Molgaard, V., Spoth, R. L., Luo, Z., &amp; Chen, Y. (2006). The Strong African American Families program: Prevention of youths' high-risk behavior and a test of the model of change. <i>Journal of Family Psychology</i>, 20(1), 1-11.</p>	<b>USA</b>	<p>SAAF builds on other family-centered programs that enhance parent and youth competence to protect youths from engaging in substance use and high-risk sexual behavior. SAAF was designed for low-income African-American children who are nearing adolescence. The intervention consists of seven consecutive weekly meetings lasting 2.5 hours each, held at community facilities. At sessions, families eat a meal together and then divide into parent-and-child small groups for discussion. For the final hour of each session, the groups reunite for a large-group meeting. The focus of the sessions are on effective parenting behaviors, providing guidance and support for children, helping children appreciate their parents, and teaching children skills to deal with stress and peer pressure. To facilitate attendance, families in the program are provided with transportation and childcare if needed. Sessions are taught by community members who are trained in the curriculum.</p>
<p><b>Sure Start Local Programmes (SSLP)/Sure Start Children's Centres</b></p> <p>Melhuish, E., &amp; Hall, D. (2007). The policy background to Sure</p>	<b>UK</b>	<p>Sure Start is a large government initiative aimed at preventing the social exclusion of disadvantaged children. The original programs (set up between 1999 and 2003) were area based, with all young children and their families living in a prescribed geographic area being</p>

<p>Start. In: Belsky J, Barnes J, Melhuish E, eds. The national evaluation of Sure Start: does area-based early intervention work? Bristol: Policy Press, 2007.</p>	<p>targets of the intervention. These area-based interventions aimed to improve services for young children and their families in deprived communities, promote health and development, and reduce inequalities. Programs were managed by a partnership of health, education, social services, and voluntary sectors. The Sure Start programs initially did not have a prescribed set of services; instead, each local program was responsible for working with the community to improve existing services according to local needs while covering core services. Sure Start aims to promote physical, emotional, intellectual, and social development in preschool children by increasing childcare availability, supporting parents in employment and in developing their careers, providing parent skills training and education on child development, and providing health and family support services. During 2004–2006, the model of service delivery changed by becoming Sure Start Children’s Centres. With it came clearer specifications of services, with a strong emphasis on child well-being and the need to reach the most vulnerable, in addition to the adjustment of service provision to the degree of family disadvantage. Sure Start services include childcare, children’s centers, children’s information services (information on nursery education and childcare availability), early excellence centers (a range of educational and care services for parents and children), extended schools (coordinating childcare services), health and family support (parental education on child development, promoting awareness of healthy living, early identification of difficulties), neighborhood nurseries, out-of-school childcare, and local programs (including family support, advice on nurturing, health services, and early learning opportunities).</p>
<p><b>Survival Skills for Healthy Families program</b> Family Wellness Association. (2004). <i>Survival skills for healthy families</i>. Instructor manual, six session video package and couple workbooks. Scotts Valley, CA: Author.</p>	<p><b>USA</b></p> <p>The Survival Skills for Healthy Families program was designed to serve low-income multicultural communities in California. The program is offered to families involved in court-ordered violence- and gang-prevention services and in drug and alcohol, child abuse, and domestic violence prevention and intervention programs. The content focuses on several areas: 1) building stronger families, 2) enhancing the couple relationship, 3) skills necessary to prevent domestic violence, and 4) intervention with stepfamilies. Several features of the program are directed to low-income populations.</p>
<p><b>Systematic Training for Effective Parenting (STEP)</b> Dinkmeyer, D., McKay, G. D. &amp; Dinkmeyer, D. (1997). <i>Systematic Training for Effective Parenting: The parent’s handbook</i>. Bowling Green, KY: STEP Publishers. Angeli, N. (1997) STEPs for positive parenting. <i>Health Visitor</i>, 70, 336–338.</p>	<p><b>Multi-country</b></p> <p>STEP targets families with parent-child relationship problems, including those at risk for child maltreatment, in addition to families interested in enhancing child social and cognitive development. The STEP course is an educational program for parents that teaches them the ideas and skills they need for raising responsible children and feeling more adequate and satisfied as parents. A package of materials designed for nine training sessions is available. Each session provides an opportunity to 1) discuss specific activity assignments that involve the</p>

		<p>application of the ideas with one's own children, 2) discuss readings presented in the book accompanying the course, 3) listen to a brief professional lecture by the authors, 4) participate in skill building exercises, and 5) consider general problem situations as well as the application of these ideas to one's own concerns. The purpose of STEP is to help 1) develop understanding of a practical theory of human behavior; 2) learn new procedures for developing more effective relationships with your children; 3) improve communication between parents and children through developing skills for listening and resolving conflicts with children; 4) develop skills in using encouragement, logical consequences, and other active oriented procedures; and 5) develop more self-confidence in one's ideas about children and one's abilities as a parent. Early Childhood STEP is tailored for parents with children younger than six years of age and deals with understanding young children, understanding their behavior, building self-esteem in the early years, communicating with young children, helping young children learn to communicate, and nurturing their emotional and social development.</p>
<p><b>The Boomerangs Parenting Program</b>  Lee, L., Griffiths, C., Glossop, P., &amp; Eapen, V. (2010). The Boomerangs Parenting Program for Aboriginal parents and their young children. <i>Australasian Psychiatry</i>, 18(6), 527-533. 10.3109/10398562.2010.499435.</p>	<p><b>Australia</b></p>	<p>The Boomerangs Program is a parenting program based on the Circle of Security Program (an early intervention group program based on attachment theory) and the Marte Meo Program (a developmental support program aimed at enhancing constructive interaction between parent and child). Combining the two approaches, the Boomerangs Program aims to promote a healthy mother-child relationship at both interactional and relational levels. Videotapes are used as a therapeutic tool and video clips of interactions between mother and child are used to reflect and improve on parental sensitivity and communicating capacity. The program comprises 20 sessions and focuses on brain development, attachment, reading, and highlighting parent competencies and vulnerabilities.</p>
<p><b>The Children and Parents Service (CAPS)</b>  White, C., &amp; Verduyn, C. (2006). The Children and Parents Service (CAPS): A multi-agency early intervention initiative for young children and their families. <i>Child &amp; Adolescent Mental Health</i>, 11(4), 192-197. 10.1111/j.1475-3588.2006.00410.x.</p>	<p><b>England</b></p>	<p>CAPS is a multi-agency partnership whose model of service delivery is based on four principles: 1) evidence-based practice using the Incredible Years Webster Stratton model of parent training, 2) the provision of a conceptual model that professionals deliver focusing on user involvement, 3) emphasis on community capacity building, and 4) a flexible approach where need can be converted into demand and services are responsive. The parent training courses take place at children's centers and includes referral to other family- and community-based resources and supplementary individual work where needed. Participation is by professional or self-referral and is targeted at parents experiencing difficulties with their young children's behavior. Courses run for 10–12 weeks at a time and are based on the Incredible Years Programme. Co-leaders facilitate the course through videotape modeling and role-play. Telephone contact is maintained before each session and co-leaders provide individual sessions at home for</p>

		<p>parents who are unable to attend a session. The second component is the training of community-based professionals in running effective parent courses in their own agencies. The third component comprises supervision of professions running the parent training courses. Video-based supervision is provided every six weeks on which accreditation is based.</p>
<p><b>The Early Risers “Skills for Success” Program</b>        August, G. J., Realmuto, G. M., Hektner, J. M., &amp; Bloomquist, M. L. (2001). An integrated components preventive intervention for aggressive elementary school children: The Early Risers program. <i>Journal of Consulting and Clinical Psychology</i>, 69(4), 614-626.</p> <p>August, G. J., Bloomquist, M. L., Realmuto, G. M., &amp; Hektner, J. M. (2007). The Early Risers “Skills for Success” Program: A targeted intervention for preventing conduct problems and substance abuse in aggressive elementary school children. In P. H. Tolan, J. Szapocznick, &amp; S. Sambrano (Eds.). <i>Preventing youth substance abuse: Science-based programs for children and adolescents</i> (pp. 137–158). Washington, DC: American Psychological Association.</p>	<p><b>USA</b></p>	<p>The Early Risers “Skills for Success” Program aims to reduce aggressive behaviors using a summer program for children as well as a parent education and skills training program. The goal is to promote positive socio-emotional development into middle childhood and adolescence by targeting younger children who exhibit aggressive behaviors. There are two main components to the Early Risers intervention program: a child-focused intervention (CORE) and a family-focused support and empowerment program (FLEX). The CORE component includes a series of evidence-based education, skill-building, and mentoring interventions that are delivered during annual six-week summer school sessions; ongoing teacher consultation and student mentoring during the course of the school year; and a bi-weekly family program that involves parent education and skills training in addition to child social skills training groups. The FLEX component is delivered along with the CORE component and can be seen as a prevention case management tool designed to deal with unique family issues that the CORE component may not be able to address. The FLEX component is a home visitation program in which families work with family advocates to decide what actions are necessary for family and child wellness.</p>
<p><b>The Family Tree’s (TFT) Positive Parenting Program</b>        Woodruff, K., &amp; Young, R. H. (2009). Evaluating outcomes for at-risk families participating in the Family Tree’s Positive Parenting Program: A retrospective study—Interim report. <i>Community &amp; School-based Research: Systematic Reviews</i>. Center for Families and Children. University of Maryland, Baltimore.</p>	<p><b>USA</b></p>	<p>The Family Tree (TFT) is a nonprofit organization with the goal of strengthening families to prevent child abuse and neglect. TFT’s Positive Parenting Program (PPP) is designed to help parents and caregivers acquire life skills and parenting skills that promote positive family functioning and strengthen families in order to prevent abuse and neglect, as well as to preserve families. The program rests on the assumption that child maltreatment is associated with multiple risk factors. Group-based skills training targets these risk factors and enhances protective factors, enabling parents to provide more appropriate care for their children and preserving the family unit. Family educators follow a TFT PPP manual, which includes information on self-awareness, values and beliefs, communication, stress reduction and anger management, nurturing children’s self-esteem, child development, managing children and discipline, home safety and child well-being, and goal setting.</p>
<p><b>The Helping Families Programme</b>        Day, C., S. Kowalenko, et al. (2011). <i>The Helping Families</i></p>	<p><b>UK</b></p>	<p>This program aims to help multi-stressed families who have children with severe conduct problems by reducing conduct problems in children, reducing family harm, and increasing parent and family resilience. Five domains are addressed: 1) improving interpersonal conflict</p>

<p>Programme: A new parenting intervention for children with severe and persistent conduct problems. <i>Child &amp; Adolescent Mental Health</i>, 16(3), 167-171.</p>		<p>management by increasing parents' ability to interact positively, build and maintain relationships, and reduce conflict with the child (or children), partner, family, and/or key professionals; 2) improving mood stability and regulation by increasing parents' abilities to be tolerant, and feel calm, happy, and satisfied; 3) improving supportive social and family networks by increasing the frequency and availability of constructive parenting support; 4) reducing the harmful effects of drugs and/or alcohol by working toward cessation or harm minimization; and 5) strengthening instrumental and emotional coping by increasing adaptive problem management and improving emotional regulation and distress tolerance in relation to problems that cannot be immediately managed. The program consists of a manual and a parent toolkit. Program structure comprises 20 sessions over a maximum of six months, with the possibility of additional contact sessions during each week.</p>
<p><b>Through the Looking Glass (TtLG)</b>  Aylward, P., Murphy, P., Colmer, K., &amp; O'Neill, M. (2010). Findings from an evaluation of an intervention targeting Australian parents of young children with attachment issues: The 'Through the Looking glass' (TtLG) project. <i>Australasian Journal of Early Childhood</i>, 35(3), 13-23.</p>	<p><b>Australia</b></p>	<p>The Through the Looking Glass project provides intensive psychosocial support, therapeutic intervention, and childcare as a package for high-risk families, in order to develop and support secure attachment relationships between mother and child. The primary target group is mothers of children aged birth to five years. The intervention involves a multifaceted approach, with each childcare center site employing a clinician (an experienced social worker trained in attachment and the "Circle of Security"), a co-facilitator, and a primary caregiver (both of whom are experienced childcare workers) to work with each recruited family. Parents are required to attend weekly psychosocial group work sessions, and individual counseling is available for mothers as needed. The weekly therapeutic sessions follow a schedule that introduces mothers to concepts of attachment theory and uses video footage of each of the mothers interacting with their child for group reflection.</p>
<p><b>Triple-P Positive Parenting Program</b>  Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. <i>Clinical Child and Family Psychology Review</i>, 2, 71-89.</p>	<p><b>Multi-country</b></p>	<p>The Triple-P Positive Parenting Program is a multilevel system of family intervention, which provides five levels of intervention, of increasing strength. Triple-P emphasizes the development of parental self-regulation as a central skill. Specifically, the program focuses on developing parental self-sufficiency, self-efficacy, self-management skills (self-monitoring, self-determination of goals, self-evaluation, and self-selection of change strategies), and personal agency or empowerment. These skills are considered necessary for achieving the key principles of positive parenting. The five levels of intervention include a universal population-level media information campaign targeting all parents, two levels of brief primary care consultations targeting mild behavior problems, and two more intensive parent training and family intervention programs for children at risk for more severe behavioral problems. The program aims to determine the minimally sufficient intervention a parent</p>

		<p>requires in order to deflect a child from a trajectory toward more serious problems. The dose or strength of intervention required is determined by the severity of child behavioral problems. Level 1, a universal parent information strategy, provides all interested parents with access to useful information about parenting through a coordinated media and promotional campaign using print and electronic media, as well as user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies. This level of intervention aims to increase community awareness of parenting resources, improve receptivity of parents to participating in programs, and create a sense of optimism by depicting solutions to common behavioral and developmental concerns. Level 2 is a brief, one-to-two-session, primary health care intervention providing early anticipatory developmental guidance to parents of children with mild behavior difficulties. Level 3, a four-session intervention, targets children with mild to moderate behavior difficulties and includes active skills training for parents. Level 4 is an intensive, 8–10-session individual or group parent training program for children with more severe behavioral difficulties. It comprises group-based interventions; this level is also referred to as Group Triple-P, and is conducted for groups of 10–12 parents. Level 5 is an enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g., marital conflict, parental depression, or high levels of stress). Triple-P International offers the course translated into a number of languages.</p>
<p><b>UCLA Family Development Project</b>  Heinicke, C. M., Fineman, N., Ponce, V. A., &amp; Guthrie, D. (2001). Relationship based intervention with at-risk mothers: Outcome in the second year of life. <i>Infant Mental Health Journal</i>, 22,431-462.</p>	<p><b>Los Angeles, USA</b></p>	<p>The UCLA Family Development Project is a relationship-based home visiting program for pregnant mothers at risk for inadequate parenting. This intervention is designed to start in the third trimester and continue until the infant is 24 months old. UCLA researchers created the Family Development Project with five goals: 1) to decrease maternal depression and anxiety; 2) to increase partner and family support; 3) to increase responsiveness of the new mothers and increase infant security in attachment to their mothers; 4) to encourage child autonomy; and 5) to encourage child task involvement. To realize these goals, a social worker begins visiting the mother’s home weekly during the third trimester of her pregnancy. During these visits, the worker’s goal is to establish trust and give social support to the expecting mother. Then, the visits focus on giving positive reinforcement to the mother to increase her sense of competence. Finally, the mother receives specific interventions designed to increase her knowledge in parenting, family systems, and infant health. The mother also receives referrals to other health programs and additional contacts for support as needed.</p>
<p><b>Video Interaction Project (VIP)</b></p>	<p><b>New York, USA</b></p>	<p>The VIP intervention takes place from birth to three years of age, with 15 30–45-minute sessions taking place</p>

<p>Mendelsohn, A.L., Huberman, H.S., Berkule, S.B., Brockmeyer, C.A., Morrow, L.M., Dreyer, B.P. (2011). Primary care strategies for promoting parent-child interactions and school readiness in at-risk families: The Bellevue Project for Early Language, Literacy, and Education Success (BELLE). <i>Archives of Pediatrics &amp; Adolescent Medicine</i>, 165(1), 33-41.</p>		<p>primarily on the day of primary care visits. Sessions are facilitated by a child development specialist who meets one-on-one with families, providing an individualized, relationship-based intervention. The specialist delivers a curriculum focused on supporting verbal interactions in the context of pretend play, shared reading, and daily routines to enhance child development and school readiness. The VIP intervention uses three strategies: videotaping of mother-child interaction followed by review with the child development specialist, provision of learning materials, and provision of parenting pamphlets.</p>
<p><b>Video-feedback Intervention to Promote Positive Parenting (VIPP)</b> Lawrence, P., Davies, B., &amp; Ramchandani, P.G. (2012). Using video feedback to improve early father-infant interaction: A pilot study. <i>Clinical Child Psychology and Psychiatry</i>, DOI: 10.1177/1359104512437210.</p>	<p><b>UK</b></p>	<p>VIPP is an early preventive intervention used in the first two years of life. It is used to engage and work with fathers in an attempt to improve their parenting capacities and thereby improve children's outcomes. The optimal case is to include both mothers and fathers in the intervention. VIPP incorporates both attachment and social learning perspectives and specifically targets parenting capacities that are implicated in the etiology of a range of childhood problems. The intervention comprises a brief (4–6-session), home-based intervention. It focuses primarily on positive aspects of parent-child interaction and builds on them through the use of video. Instead of a generic film, video mirroring the parents' own daily interactions with their child allows for individual tailoring of the treatment in each case. The aim is not to make fathers more like mothers but to improve the important aspects of father-infant interaction. VIPP-R is an adaptation of the original intervention with an additional focus on mothers' mental representations of attachment. VIPP-SD is another adaptation, with a focus on sensitive discipline, used with mothers of children aged one to three years.</p>
<p><b>Videotaped self-modeling and feedback</b> Benzies, K., Magill-Evans, J., Harrison, M.J., MacPhail, S., &amp; Kimak, C. (2008). Strengthening new fathers' skills in interaction with their 5-month-old infants: Who benefits from a brief intervention? <i>Public Health Nursing</i>, 25(5), 431-439.</p>	<p><b>Canada</b></p>	<p>This program is delivered during home visits when infants are between five and six months old, because this stage is characterized by a variety of interactive behaviors. Each family is assigned a trained nurse, and a one-hour home visit is scheduled by phone for a time when the child is likely to be awake. During the visit, the nurse explains that the intervention focuses on father-infant interaction, and only the father and the infant are to remain in the room. After reviewing a standardized list of activities, the father is asked to choose one that is new to the infant. The play interaction between the father and the infant is videotaped, and the nurse and the new father review the session together immediately after. The nurse provides the father with suggestions and feedback, and handouts are left behind to reinforce the verbal feedback. The second visit builds on the first visit and follows the same structure.</p>
<p><b>What Were We Thinking! (WWWT)</b> Rowe, H. J., &amp; Fisher, J. R. W. (2010). Development of a universal psycho-educational</p>	<p><b>Australia</b></p>	<p>What Were We Thinking! (WWWT) is a structured psycho-educational program, designed to be integrated into community health care and built for first-time mothers and fathers. The aims of the program are to promote confident caregiving, optimize infant</p>

<p>intervention to prevent common postpartum mental disorders in primiparous women: A multiple method approach. <i>BMC Public Health</i>, 10, 499-513.</p>		<p>manageability and family functioning, and reduce common postnatal mental disorders in women by providing couples with specific skills and knowledge about infant caretaking and managing the change to the intimate partner relationship after the baby is born. The theoretical foundation of the WWWT program proposes that both maternal anxiety and depression are important in affecting the caregiver-child relationship and are addressed most effectively together. Working from this premise, the program looks to decrease caregiver-child interactions that contribute to maternal depression and anxiety, and increase those that promote maternal confidence and competence. The program consists of group discussion, focused tasks to be done individually and then discussed as a couple, problem-solving and negotiation practice, hands-on supported practice in infant settling, short talks, and practical demonstrations. The program content has been codified into a manual with 13 chapters and two main sections: "About Babies," and "About Mothers and Fathers." The program itself is designed to be delivered in one half-day session with groups of up to five couples and their 4–6-week-old babies. A half-day training session has also been developed to train facilitators on the program's underlying theory, the use of gender-sensitive language, and how to support parents in practicing infant settling.</p>
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## APPENDIX 5

# LIST OF REFERENCES INCLUDED IN THE LITERATURE REVIEW

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