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Development, Evaluation, and Multinational Dissemination of the Triple P-Positive Parenting Program

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public health, parenting, child health, child behavior, dissemination, evidence-based practice, Triple P-Positive Parenting Program

Abstract

The quality of parenting children receive has a major influence on their development, well-being, and life opportunities. Of all the potentially modifiable influences that can be targeted through preventive interventions, none are more important than the quality of parenting children experience. Prevention interventions targeting parenting should be widely used to promote positive developmental outcomes for children and adolescents. This review argues that the development of comprehensive evidence-based strategies to improve the quality of parenting is best viewed as a major public health challenge. Using the Triple P-Positive Parenting Program as an exemplar, the initial development, gradual transformation into a public health model, and then global dissemination of the approach is described. The assumptions underpinning the public health approach to parenting support are discussed, along with key criteria that need to be met for the approach to work. Factors that facilitate and impede the global implementation and dissemination of evidence-based parenting programs are considered along with implications for future research, policy, and practice.

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INTRODUCTION

There is a growing international consensus among developmental, family and clinical psychologists, public health researchers, policy advocates for evidence-based practices, and prevention scientists that safe, nurturing, and positive parent-child interactions lay the foundations for healthy child development (Collins et al. 2000, Coren et al. 2002, Dretzke et al. 2009, Embry 2004, Gutman & Feinstein 2010, Kirp 2011, Stack et al. 2010). How children are raised in the early years and beyond affects many different aspects of their lives including brain development, language, social skills, emotional regulation, mental and physical health, health risk behavior and their capacity to cope with a spectrum of major life events (Beaver & Belsky 2011, Belsky & de Haan 2011). These life events and transitions include parental separation and divorce (e.g., Hetherington et al. 1989, Stallman & Sanders 2007), loss (e.g., Bradley 2007), chronic illness (e.g., Gustafsson et al. 2002), recovery following natural disasters (e.g., Jones et al. 2009) and parental mental illness (e.g., McFarland & Sanders 2003).

Adverse family experiences such as interrupted maternal care, living with one biological parent, exposure to criticism and harsh, punitive disciplinary practices, family dysfunction and lower marital adjustment, parental distress, and parental psychopathology are all associated with an increased risk of psychopathology among children and adolescents (Baker et al. 2005, Chadwick et al. 2008, Emerson 2003, Hastings et al. 2006, Hastings & Lloyd 2007, Koskentausta et al. 2007, Wallander et al. 2006). Conversely, exposure to competent

parenting (defined here as warm, responsive, consistent parenting that provides boundaries and contingent limits for children in a low-conflict family environment) affords children many developmental and life advantages including secure attachment, accelerated language development, greater readiness for school, higher academic achievement, reduced risk of antisocial behavior and substance abuse problems, an increased likelihood of involvement in higher education, improved physical health, and greater capacity for later intimate relationships (Guajardo et al. 2009, Gutman & Feinstein 2010, Moffitt et al. 2011, Stack et al. 2010). Clearly, how parents raise their children is an important determinant of the well-being of children, and there is no more important potentially modifiable target of preventive intervention.

Why Parenting Programs Are So Important

The case for strengthening efforts to improve the quality of parenting children receive is compelling. Four decades of experimental clinical research have demonstrated that structured parenting programs based on social learning models are among the most efficacious and cost-effective interventions available to promote the mental health and well-being of children, particularly children at risk of child maltreatment and developing social and emotional problems (Collins et al. 2000, Foster et al. 2008, Mercy & Saul 2009, Mihalopoulos et al. 2011, Nat. Res. Council. Inst. Med. 2009, Serketich & Dumas 1996, Taylor & Biglan 1998).

Positive parenting programs based on social learning and cognitive-behavioral principles are the most effective in reducing problem behaviors in children and adolescents (Dretzke et al. 2009, Kazdin & Blase 2011, Serketich & Dumas 1996). These interventions typically provide active skills training or coaching to parents involving video or live modeling of skills, practice of skills, feedback following direct observation of parent-child interaction, and between-session homework assignments



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Triple P: a multilevel system of parenting support known as the Triple P-Positive Parenting Program

in how to apply positive parenting (e.g., descriptive praise, incidental teaching, simple reward charts, clear instructions) and contingency management principles (e.g., logical consequences, nonexclusionary timeout, and exclusionary timeout) to daily interactions with their children. Different delivery formats have been successfully trialed including individual programs, small group programs, large group seminar programs, self-directed programs, telephone-assisted programs, and more recently, online parenting programs (see Dretzke et al. 2009, Nowak & Heinrichs 2008, Sanders 2008, Sanders et al. 2011a).

Numerous meta-analyses of parenting interventions attest to the benefits that parents and children derive (particularly children with conduct problems) when parents learn positive parenting skills (Brestan & Eyberg 1998; Coren et al. 2002; de Graaf et al. 2008a,b; Nowak & Heinrichs 2008). These benefits include children having fewer behavioral and emotional problems and more positive interactions with their parents and siblings, improved parental practices, improved mental health, and less parental conflict.

There is growing evidence that parenting programs are also useful in the prevention or management of a range of other child problems. These include challenging behavior in children with developmental disabilities (Plant & Sanders 2007; Sanders & Mazzucchelli 2011; Whittingham et al. 2006, 2009, 2011), persistent feeding problems (Adamson et al. 2011, Sanders et al. 1997, Turner et al. 1994), recurrent pain syndromes (Sanders et al. 1994, 1996), anxiety disorders (Rapee et al. 2010), and those who are overweight and obese (West et al. 2010). Positive intervention effects on child and parent outcome measures have been reported across diverse cultures (e.g., Matsumoto et al. 2010, Morawska et al. 2010, Turner et al. 2007), family types (e.g., Stallman & Sanders 2007), age groups (e.g., Boyle et al. 2010, Ralph et al. 2003), and delivery settings (e.g., Morawska et al. 2011, Sanders et al. 2011a). In most studies, positive intervention effects are maintained over time (e.g., Sanders et al. 2007a).

The cumulative evidence clearly supports the efficacy and robustness of social learning-based parenting interventions, and there is a strong case for such programs to be made more widely available. However, the limited reach of most evidence-based parent programs ensures that these programs make little impact on prevalence rates of social and emotional problems of children and child maltreatment at a population level. The limited impact of available parenting interventions on children's problems at a population level underpinned the development of the Triple P-Positive Parenting Program as a public health intervention (Sanders 1999, 2008, 2010; Sanders & Murphy-Brennan 2010a).

The Triple P-Positive Parenting Program

The Triple P-Positive Parenting Program (hereafter referred to as Triple P) has its origins in social learning theory and the principles of behavior, cognitive, and affective change articulated in the 1960s and 1970s. The public health model of parenting support used in Triple P took 30 years to develop and involved the collective efforts of a number of staff and postgraduate students at the University of Queensland (see Sanders et al. 2002).

The aim of Triple P is to prevent severe behavioral, emotional, and developmental problems in children and adolescents by enhancing the knowledge, skills, and confidence of parents. To achieve this goal, Triple P incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children from birth to age 16. The suite of multilevel programs comprising the Triple P system are designed to create a family-friendly environment that better supports parents in the task of raising their children, with a range of programs tailored to the differing needs of parents. Triple P is best thought of as a blended, multilevel intervention comprising both universal and targeted interventions within a comprehensive system of parenting support.

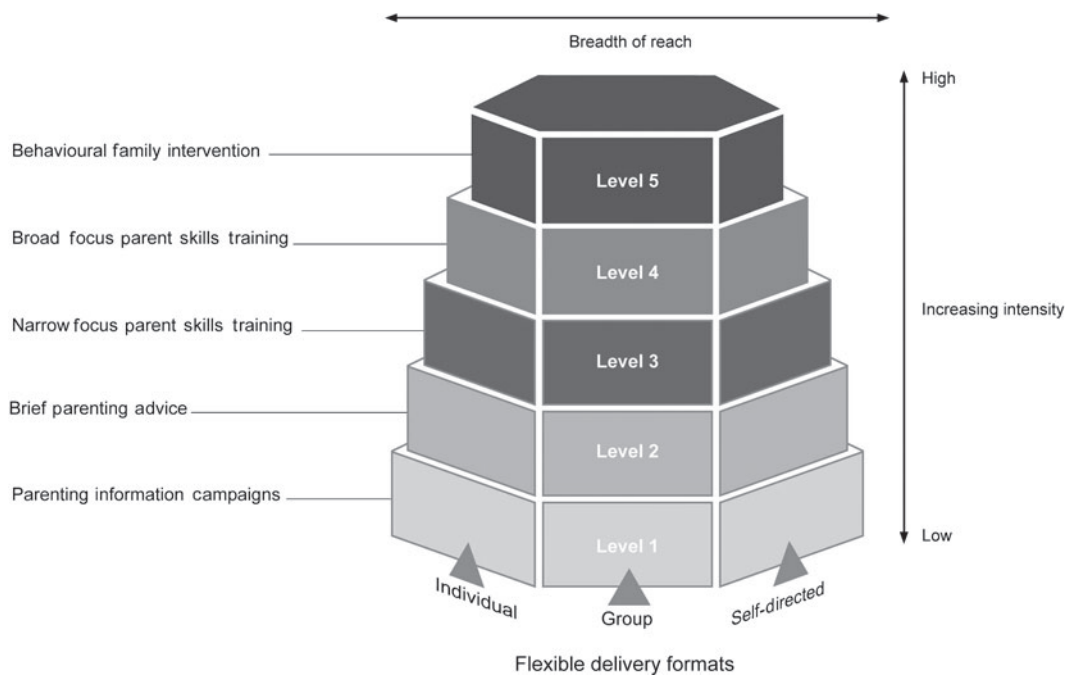


Figure 1

The Triple P model of graded reach and intensity of parenting and family support services.

The rationale for this multilevel strategy is that there are differing levels of dysfunction and behavioral disturbance in children and adolescents, and parents have different needs and preferences regarding the type, intensity, and mode of assistance they may require. The multilevel strategy utilizes the principle of the “minimally sufficient” effective intervention as a guiding principle to serve the needs of parents. As presented in **Figure 1**, the system enables practitioners to determine the scope of the intervention and is designed to maximize efficiency, contain costs, avoid waste and overservicing, and ensure the program has wide reach in the community.

The Triple P system has a range of evidence-based tailored variants and flexible delivery options that target different groups of high risk or vulnerable parents (e.g., parents of children with a disability; abusive, depressed, or maritally discordant parents). The multidisciplinary nature of the program involves the utilization of the existing professional workforce in the task of

promoting competent parenting. **Table 1** summarizes the key features of the Triple P multilevel model.

Universal Triple P (Level 1). The Universal facet of the Triple P intervention involves the implementation of media and informational strategies pertaining to positive parenting. These strategies are intended to destigmatize parenting and family support, to make effective parenting strategies readily accessible to all parents, and to facilitate help-seeking and self-regulation by parents who need higher-intensity intervention. Universal Triple P includes the use of radio, local newspapers, newsletters at schools, mass mailings to family households, presence at community events, and Web site information.

Selected Triple P (Level 2). The Selected Triple P program has utility for many parents and is intended to normalize parenting interventions. There are two delivery formats for

Table 1 The Triple P-Positive Parenting Program system of parenting and family support^a

Level of intervention	Intensity	Program variant	Target population	Modes of delivery	Intervention methods used
Level 1					
Media and communication strategy on positive parenting	Very low intensity	<i>Stay Positive</i>	All parents and members of the community interested in information about parenting to promote children's development and prevent or manage common social, behavioral, and emotional problems	Web site to promote engagement. May also include television programming, public advertising, radio spots, newspaper and magazine editorials	Coordinated media and promotional campaign to raise awareness of parent issues, destigmatize and encourage participation in parenting programs. Involves electronic and print media
Level 2					
Brief parenting interventions	Low intensity	<i>Selected Triple P</i> <i>Selected Teen Triple P</i> <i>Selected Stepping Stones Triple P</i>	Parents interested in general parenting information and advice or with specific concerns about their child's development or behavior	Series of 90-minute stand-alone large group parenting seminars or one or two brief individual face-to-face or telephone consultations (up to 20 minutes)	Parenting information promoting healthy development or advice for a specific developmental issue or minor behavior problem (e.g., bedtime difficulty)
Level 3					
Narrow focus parenting programs	Low to moderate intensity	<i>Primary Care Triple P</i> <i>Primary Care Teen Triple P</i> <i>Primary Care Stepping Stones Triple P</i>	Parents with specific concerns as above who require brief consultations and active skills training	Brief program (about 80 minutes) over three to four individual face-to-face or telephone sessions	Combination of advice, rehearsal, and self-evaluation to teach parents to manage discrete child problems
		<i>Triple P Discussion Groups</i>		or series of two-hour stand-alone group sessions dealing with common topics (e.g., disobedience, hassle-free shopping)	
Level 4					
Broad focus parenting programs	Moderate to high intensity	<i>Standard Triple P Group Triple P</i> <i>Self-Directed Triple P</i> <i>Standard Teen Triple P</i> <i>Group Teen Triple P</i> <i>Self-Directed Teen Triple P</i> <i>Online Triple P</i> <i>Baby Triple P</i>	Parents wanting intensive training in positive parenting skills	Intensive program (about 10 hours) with delivery options including 10 60-minute individual sessions; or five two-hour group sessions with three brief telephone or home visit sessions; or 10 self-directed workbook modules (with or without telephone sessions); or eight interactive online modules	Broad focus sessions on improving parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies

(Continued)



Table 1 (Continued)

Level of intervention	Intensity	Program variant	Target population	Modes of delivery	Intervention methods used
		<i>Standard Stepping Stones Triple P</i> <i>Group Stepping Stones Triple P</i> <i>Self-Directed Stepping Stones Triple P</i>	Parents of children with disabilities who have, or who are at risk of developing, behavioral or emotional problems	Targeted program involving 10 60- to 90-minute individual sessions or two-hour group sessions	Parallel program with a focus on parenting children with disabilities
Level 5					
Intensive family interventions	High intensity	<i>Enhanced Triple P</i>	Parents of children with behavior problems and concurrent family dysfunction such as parental depression or stress, or conflict between partners	Adjunct individually tailored program with up to eight individual 60-minute sessions (may include home visits)	Modules include practice sessions to enhance parenting, mood management and stress-coping skills, and partner support skills
		<i>Pathways Triple P</i>	Parents at risk of maltreating their children. Targets anger management problems and other factors associated with abuse	Adjunct program with three 60-minute individual sessions or two-hour group sessions	Modules include attribution retraining and anger management
		<i>Lifestyle Triple P</i>	Parents of overweight or obese children. Targets healthy eating and increasing activity levels as well as general child behavior	Intensive 14-session group program (including telephone consultations)	Program focuses on nutrition, healthy lifestyle, and general parenting strategies
		<i>Family Transitions Triple P</i>	Parents going through separation or divorce	Intensive 12-session group program (including telephone consultations)	Program focuses on coping skills, conflict management, general parenting strategies, and developing a healthy coparenting relationship

^aOnly program variants that have been trialed and are available for dissemination are included.

Selected Triple P: (a) brief and flexible consultation with individual parents and (b) parenting seminars with large groups of parents. The brief and flexible consultation format involves one to two consultation contacts (20 minutes each) and is designed for parents with relatively minor and fairly discrete problem behaviors that do not require more intensive levels of intervention. However, this is also a useful and nonthreat-

ening strategy to help parents begin to address their own parenting behaviors but in the context of their asking for information or assistance about their child's behavior. The intervention can be provided in the context of childcare, daycare, and preschool settings, and in other settings where parents may have routine contact with service providers and other professionals who regularly assist families. Selected Triple P



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can be viewed as a form of anticipatory development guidance. The parenting seminar format of Selected Triple P, called the Triple P Seminar Series, involves three 90-minute sessions designed for delivery to large groups of parents. The seminar series includes specific seminars on the following topics: The Power of Positive Parenting; Raising Confident, Competent Children; and Raising Resilient Children. The three seminars are independent of each other so that parents can attend any or all of them and still benefit. Seminars are used to promote awareness of Triple P and as brief and informative sessions for any parent. Each seminar includes a presentation, a question-and-answer period, and distribution of a parenting tip sheet, and practitioners are available at the end of the session to deal with individual inquiries and requests for further assistance.

Primary Care Triple P (Level 3). Primary Care Triple P, like Selected Triple P, is appropriate for the management of discrete child problem behaviors that are not complicated by other major behavior management difficulties or significant family dysfunction. The key difference is that provision of advice and information alone is supported by active skills training for those parents who require it to implement the recommended parenting strategies. This program level is especially appropriate for parents of infants, toddlers, and preschoolers with respect to common child behavior problems and parenting challenges. Level Three involves a series of four brief (20-minute) consultations that incorporate active skills training and the selective use of parenting tip sheets covering common developmental and behavioral problems of preadolescent children. This brief and flexible consultation modality also builds in generalization enhancement strategies for teaching parents how to apply knowledge and skills gained to nontargeted behaviors and other children in the family. Primary Care Triple P can be administered in either individual or group settings, and there are also tailored variants for parents of children and adolescents

with a disability (Primary Care Stepping Stones, Primary Care Teen Steeping Stones).

Standard Triple P (Level 4). The Level 4 program benefits children and adolescents who have detectable problems but who may or may not yet meet diagnostic criteria for a behavioral disorder, and parents who are struggling with parenting challenges. Parents learn a variety of child management skills, in either a group or individual setting, and how to apply these skills both at home and in the community. Level 4 combines the provision of information with active skills training and support, as well as teaching parents to apply skills to a broad range of target behaviors with the target child and siblings. There are also variants of Level 4 Triple P for first-time parents undertaking the transition to parenthood (Baby Triple P) and parents of a child with a developmental disability (Stepping Stones Triple P).

Enhanced Triple P (Level 5). Enhanced Triple P is an optional augmentation of Standard (Level 4) Triple P for families with additional risk factors that might need to be addressed through the intervention. Many families can receive sufficient benefit from Standard Triple P without extending programming with Enhanced Triple P. Enhanced Triple P includes optional intervention modules on partner communication, mood management and stress coping skills for parents, and additional practice sessions addressing parent-child issues. There are several variants of Level 5 Triple P including Family Transitions Triple P (for parents undergoing separation or divorce), Lifestyle Triple P (for parents of overweight or obese children), and Pathways Triple P (for parents at risk of child abuse).

Principles of Positive Parenting

Triple P seeks to help parents increase their confidence, skills, and knowledge about raising children; to be more positive in their daily interactions with children; to be less coercive,

depressed, stressed, or anxious; to have less conflict with partners over parenting issues; and to have lower levels of stress and conflict in managing work and family responsibilities (Sanders 2008). The program targets children at five different developmental periods: infant, toddler, preschooler, primary schooler, and teenager. Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) or quite narrow (targeting only high-risk children). Triple P seeks to target modifiable family risk and protective factors causally implicated in the onset, exacerbation, or maintenance of adverse child development outcomes.

To achieve this, five core principles of positive parenting form the basis of the program. These were selected from the developmental literature to directly address specific risk and protective factors known to predict positive developmental and mental health outcomes in children. **Table 2** shows how these principles are operationalized into a range of specific parenting skills.

Safe and engaging environment. Children of all ages need a safe, supervised, and therefore protective environment that provides opportunities for them to explore, experiment, and play. This principle is essential to promote healthy development and to prevent accidents and injuries in the home (Peterson & Saldana 1996, Risley et al. 1976).

Positive learning environment. Although this principle involves educating parents in their role as their child's first teacher, the program specifically teaches parents to respond positively and constructively to child-initiated interactions (e.g., requests for help, information, advice, and attention) through incidental teaching and other techniques that assist children to learn to solve problems for themselves.

Assertive discipline. Triple P teaches parents specific child management and behavior change strategies that are alternatives to

coercive and ineffective discipline practices (such as shouting, threatening, or using physical punishment). These strategies include selecting ground rules for specific situations; discussing rules with children; giving clear, calm, age-appropriate instructions and requests; presenting logical consequences; using quiet time (nonexclusionary timeout) and timeout; and using planned ignoring.

Realistic expectations. This principle involves exploring with parents their expectations, assumptions, and beliefs about the causes of children's behavior and choosing goals that are developmentally appropriate for the child and realistic for the parent. Parents who are at risk of abusing their child are more likely to have unrealistic expectations of children's capabilities (Azar & Rohrbeck 1986).

Parental self-care. Parenting is influenced by a range of factors that affect a parent's self-esteem and sense of well-being. All levels of Triple P specifically address this issue by encouraging parents to view parenting as part of a larger context of personal self-care, resourcefulness, and well-being and by teaching practical parenting skills that both parents are able to implement.

Application of Triple P's principles teaches parents to encourage their child's social and language skills, emotional self-regulation, independence, and problem-solving ability. It is hypothesized that attainment of these skills promotes family harmony, reduces parent-child conflict, fosters successful peer relationships, and prepares children to be successful at school. To achieve these child outcomes, parents are taught a variety of child management skills, including monitoring problem child behavior; providing brief contingent attention for appropriate behavior; arranging engaging activities in high-risk parenting situations; using directed discussion and planned ignoring for minor problem behavior; giving clear, calm instructions; and backing up

Self-regulation:

a process whereby parents are taught skills of personal change to modify their own behavior and become independent problem solvers





Table 2 Core parenting skills introduced in Triple P-Positive Parenting Program

Parent-child relationship enhancement skills	Encouraging desirable behavior	Teaching new skills and behaviors	Managing misbehavior	Anticipating and planning	Self-regulation skills	Mood and coping skills	Partner support skills
Partner support skills	Giving descriptive praise	Setting a good example	Establishing ground rules	Planning and advanced preparation	Monitoring children's behavior	Catching unhelpful thoughts	Improving personal communication habits
Talking with children	Giving nonverbal attention	Using incidental teaching	Using directed discussion	Discussing ground rules for specific situations	Monitoring own behavior	Relaxation and stress management	Giving and receiving constructive feedback
Showing affection	Providing engaging activities	Using ask, say, do	Using planned ignoring	Selecting engaging activities	Setting developmentally appropriate goals	Developing personal coping statements	Having casual conversations
		Using behavior charts	Giving clear, calm instructions	Providing incentives	Setting practice tasks	Challenging unhelpful thoughts	Supporting each other when problem behavior occurs
			Using logical consequences	Providing consequences	Self-evaluation of strengths and weaknesses	Developing coping plans for high-risk situations	Problem solving
			Using quiet time	Holding follow-up discussions	Setting personal goals for change		Improving relationship happiness
			Using timeout				

instructions with logical consequences, quiet time (nonexclusionary timeout), and timeout.

Parents learn to apply these skills both at home and in the community. Specific strategies such as planned activities training are used to promote the generalization and maintenance of parenting skills across siblings and settings and over time. Triple P interventions combine the provision of quality parenting information with active skills training and support. At each level of intervention, active skills training methods are used to promote skill acquisition. For example, in Universal Triple P, media strategies are used that involve the realistic depiction of possible solutions to commonly encountered parenting situations (e.g., bedtime problems). These potential solutions can be illustrated through various mediums, including television programs, community service announcements, “talkback” radio, newspaper columns, and advertising. The messages are optimistic and promote the idea that even the most difficult parenting problems are solvable and/or preventable. In more intensive levels of intervention (e.g., Levels 3, 4, and 5), information is supplemented by the use of active skills training methods that include modeling, rehearsal, feedback, and between-session practice tasks.

Triple P Evidence Base

We elected to use a narrative account of how the system evolved to describe the accumulated evidence evaluating Triple P rather than attempt another meta-analysis or systematic review. Such meta-analyses and reviews have been conducted by others on several occasions, and readers are referred to these papers to directly review this evidence (de Graaf et al. 2008a,b; Nowak & Heinrichs 2008; Thomas & Zimmer-Gembeck 2007). However, it is important to note that no review has included all available studies because evidence continues to be produced, and some trials were published before the program was named. Additionally, analyses of the evidence typically exclude single-subject experiments using observational methods, tend to blend treatment and prevention studies, and

have focused primarily on children with conduct problems rather than on the full range of problems studied. Notwithstanding these limitations, all meta-analyses have concluded that Triple P has a positive effect on children’s behavior and adjustment, with evidence being strongest in the toddler, preschool, and elementary school age groups. Effect sizes described across these analyses have ranged from small to large positive effects for Triple P, with a large range. Such variability in effect sizes is not surprising in light of the fact that Triple P is a system of parenting intervention that contains multiple levels of varying intensity that include both prevention and treatment interventions.

Other independent analyses prepared by several policy advising groups have concluded that the evidence has justified Triple P’s inclusion on many evidence-based lists for well-established or promising interventions. These have included the National Institute of Clinical Excellence guidelines for the treatment of conduct disorder (NICE 2006); the World Health Organization’s recommended programs for global violence reduction (WHO 2009), the United Nations’ Task force on family based treatment for prevention of substance abuse (UNODC 2009), Blueprints for Violence Prevention (<http://www.colorado.edu/cspv/blueprints>), the California Clearing House for Evidence-Based Social Work (<http://www.cebc4cw.org>), and the National Academy for Parenting Research (<http://www.parentingresearch.org.uk>). There are also independent replications of various Triple P interventions across several countries and cultures (e.g., Gallart & Matthey 2005, Hartung & Hahlweg 2011, Heinrichs & Jensen-Doss 2011, Moharreri et al. 2008).

BUILDING A PUBLIC HEALTH APPROACH TO PARENTING SUPPORT

The starting point for Triple P was as a home-delivered program targeting parents of disruptive preschool children (Sanders & Glynn 1981) as part of this author’s PhD in psychology at



the University of Queensland. The first evaluation study was conducted between February and October in 1978. A series of single-subject experiments using interrupted time series designs established the efficacy of the program on independently observed measures of child disruptive behavior and parenting. Early evaluations used multiple-baseline across-subjects designs within the applied behavior analytic tradition (Baer et al. 1968). The foundational work, with mentoring advice from Professors Ted Glynn and Todd Risley, focused on a relatively understudied issue; namely, the extent to which parents, when trained to manage their children's behavior in one setting (home), would generalize their skills to other relevant settings, such as shopping trips (Sanders & James 1983). The work of early parent-training researchers, such as Patterson (1982) and Koegel et al. (1978), and programs using the Hanff Model of parent training including the Incredible Years (Webster-Stratton 1989), Parent-Child Interaction Therapy (Fernandez & Eyberg 2009), and Helping the Non-Compliant Child (Forehand & McMahon 1981), had shown that parents of children with conduct problems could be trained via active skills training to use positive parenting skills to change their children's disruptive behavior. However, it was unclear whether the coaching methods employed were successful in teaching parents to generalize their parenting skills across different settings, siblings, behaviors, and times (Sanders & James 1983, Stokes & Baer 1977).

Sanders & Glynn (1981) showed that teaching parents self-management and preemptive parenting skills in addition to positive parenting and contingency management skills increased the extent to which parents generalized changes in their parenting across different childcare settings. Sanders & Dadds (1982) tested the effects of building into a parenting program a procedure known as Planned Activities Training (PAT). PAT focused on anticipatory or preemptive parenting strategies rather than contingency management. Sanders & Christensen (1985) subsequently showed that the parent training methods used produced positive effects

across a range of different home settings (e.g., bedtime, mealtime).

Once the training methods for working with individual parents with disruptive children were developed, a series of studies examined the application of positive parenting methods with other clinical problems. During this period (1983–1990) the basic parenting intervention was tested with parents of children with a developmental disability who had high rates of challenging behavior. For example, Sanders & Plant (1989), using a multiple-baseline across-subjects design, demonstrated that the parenting intervention produced a sustained decrease in observed disruptive behavior in both a training setting, with therapist present, and in a generalization setting, where the therapist was absent. These early positive effects with parents of children with a disability were subsequently replicated and extended in randomized controlled trials (RCTs) in the past two decades (Plant & Sanders 2007, Roberts et al. 2006). Other applications included testing the effects with young children with habit disorders such as thumb sucking (Christensen & Sanders 1987), bedtime problems (Sanders et al. 1984), mealtime problems (Dadds et al. 1984), and with children with feeding disorders (Turner et al. 1994) recurrent abdominal pain (Sanders et al. 1990), and ADHD (Bor et al. 2002, Hoath & Sanders 2002).

In the mid 1980s, Dadds et al. (1987a,b) tested the effects with maritally discordant couples, examining whether combining a brief four-session partner support intervention (Partner Support Training) would enhance the effects of parent training. The findings showed that parents who were maritally discordant maintained improvements in their child's observed disruptive behavior and parenting, whereas couples receiving only individual parent training relapsed at six months follow-up. The partner support intervention made no difference to parents without marital problems.

Other studies subsequently explored the effects of providing adjunctive interventions in addition to parenting skills training, including the effects of increasing social support for

single parents (Dadds & McHugh 1992), partner support training for stepparents (Nicholson & Sanders 1999), and cognitive coping skills training for clinically depressed mothers (Sanders & McFarland 2000).

In Search of a Name

Between 1978 and 1993, the parenting interventions and methods forming the basis of Triple P did not have an official name and were variously referred to in scientific publications as behavioral parent training, behavioral family intervention, cognitive-behavioral family intervention, and occasionally parent management training. None of these descriptors were “parent friendly.” In 1993, when a name was needed for a large-scale project targeting the parents of 300 disruptive three-year-olds, the program became known as the Positive Parenting of Preschoolers Program. In 1994, to encompass a wider age range of children, “preschoolers” was removed, and the program simply became known locally as the Triple P-Positive Parenting Program. Triple P was first used in a scientific publication by Sanders & Markie-Dadds (1996), and in 2002 we began referring to the intervention model as the Triple P System to reflect the multilevel nature of the program and the increasing recognition of Triple P as a public health approach to parenting support (see Sanders et al. 2002).

Self-Regulation and the Adoption of a Public Health Framework

The realization that most parents who experience significant problems with their children receive no assistance, combined with the recognition that many more parents needed to complete parenting programs in order to make any significant impact on the social and emotional problems of children, prompted the developers of Triple P to adopt a public health approach to parenting support. Traditional clinical models of parent training primarily focus on the treatment of children and their parents with already well-established problems, leaving untreated

the majority of children who develop social, emotional, or behavioral problems and the majority of parents who have concerns about everyday parenting issues. Various epidemiological surveys show that most parents concerned about their children’s behavior or adjustment do not receive professional assistance for these problems, and when they do, they typically consult family doctors or teachers, who rarely have specialized training in parent consultation (see Dittman et al. 2011, Sanders et al. 2008b). A public health approach to increasing parenting support offers an alternative framework to the traditional clinical treatment model of parent training. This approach ensures that large numbers of parents who might benefit actually do participate to produce meaningful change at a whole-of-population level rather than individual improvement at an individual-case level (Prinz & Sanders 2007).

Within a public health framework, an approach to supporting parents is needed that protects and promotes parents’ fundamental rights to make decisions about how they raise their children rather than an approach that is judgmental, critical, or prescriptive. When parents are offered information and strategies that have been shown to work, they can make more informed choices about how to tackle their concerns about parenting. The principle of self-regulation has been a central construct in the design of the Triple P system from the beginning (Sanders & Glynn 1981). Self-regulation is a process whereby individuals are taught skills to change their own behavior and become independent problem solvers in a broader social environment that supports parenting and family relationships (Károly 1993, Sanders 2008, Sanders & Mazzucchelli 2011). The approach to self-regulation used in Triple P is derived from social-cognitive theory. According to Bandura (1986, 1999), the development of self-regulation is related to personal, environmental, and behavioral factors; these factors operate separately but are interdependent.

The rationale for focusing on self-regulation in parenting is compelling. First, the capacity for self-regulation is associated with various

Public health approach to parenting support:

an approach to parenting support that emphasizes the need to target parents at a whole-of-population level in order to achieve meaningful change in population-level indices of parent and child outcomes



positive life outcomes such as academic achievement, income, savings behavior, physical and mental health, better interpersonal relationships, and happiness (e.g., Aspinwall 1998, Duckworth & Seligman 2005, Fredrickson & Joiner 2002, Mischel et al. 1988, Moffitt et al. 2011, Shoda et al. 1990, Tangney et al. 2004, Tsukayama et al. 2010). Second, deficits in self-regulation are found in many personal and social problems and psychological disorders including aggression, anxiety, criminal behavior, depression, and impulse control problems such as binge eating and alcohol abuse (e.g., Avakame 1998, Baumeister et al. 1994, Moffitt et al. 2011, Tangney et al. 2004, Tremblay et al. 1995). Third, self-regulation is an important mechanism in the success of many psychological interventions including acceptance and commitment therapy (Hayes et al. 1999), behavioral activation therapy (Martell et al. 2001, 2010), dialectical behavior therapy (Linehan 1993), problem-solving therapy (Nezu 1986), self-control therapy (Rehm 1977), and in some positive psychology interventions (Kashdan & Rottenberg 2010, Mazzucchelli et al. 2010). Finally, deficits in self-regulation in early childhood predict adult health, economic, and social behavior (Moffitt et al. 2011).

Increasing the Reach of Parenting Programs

Group variants. To increase the reach of the intervention, a group variant known as Group Triple P was developed (Turner et al. 1998). Originally designed as a “light-touch,” low-intensity intervention for use as part of a large-scale universal prevention initiative, the eight-session program consisted of four two-hour group sessions and four brief telephone consultations. The initial demonstration of the effects of Group Triple P using a quasi-experimental design was the largest evaluation of a universal parenting intervention at the time, involving some 1,600 parents in the trial (see Zubrick et al. 1995). The study targeted parents drawn from two low-income catchment areas in Perth, Western Australia.

The 804 parents participating in Group Triple P reported significantly fewer conduct problems, less dysfunctional parenting, and lower levels of parental distress and marital conflict than parents in services-as-usual comparison communities at post intervention and at one and two years follow-up (Zubrick et al. 2005).

The beneficial effects of Group Triple P for children and parents have been replicated in several RCTs and service-based evaluations initially in Australia (e.g., Gallart & Matthey 2005) and then overseas. These include RCTs showing reduced problem behaviors and improved parenting with Australian Aboriginal parents (Turner et al. 2007), parents in Hong Kong (Leung et al. 2003), Germany (Cina et al. 2006), Switzerland (Bodenmann et al. 2008), Japan (Matsumoto et al. 2007), Iran (Tehrani-Doost et al. 2009), and in a range of nonexperimental service-based evaluations (Cann et al. 2003, Crisante 2003, Lindsay et al. 2010). The core group program has also been successfully used with adaptations with parents at risk of child maltreatment (Sanders et al. 2004, Wiggins et al. 2009), parents experiencing separation and divorce (Stallman & Sanders 2007), parents of gifted and talented children (Morawska & Sanders 2009), parents of children with feeding problems (Adamson et al. 2011), parents of children with ADHD (Bor et al. 2002, Hoath & Sanders 2002), parents of teenagers (Ralph & Sanders 2003), parents of multiples (Brown et al. 2011), parents of overweight and obese children (West et al. 2010), and highly stressed working parents (Sanders et al. 2011b).

Self-help and telephone-assisted variants.

To further improve access for parents, a self-help version of the 10-session individual program was developed (Connell et al. 1997). A series of RCTs showed that this 10-session self-help parenting program could be successfully delivered to parents in rural areas using a self-help workbook alone or in combination with a brief (10- to 30-minute) weekly telephone consultation (Connell et al. 1997). The efficacy of this self-help plus telephone-assisted intervention was subsequently replicated and

extended and shown to be effective when delivered by regular telephone counseling service for parents (Morawska & Sanders 2006a,b), with parents of disruptive preschoolers (Markie-Dadds & Sanders 2006a,b), and with parents of teenagers (Morawska et al. 2005, Stallman & Ralph 2007).

Using the mass media. A public health approach to parenting support requires an effective media and communication strategy to engage parents (Sanders & Prinz 2008). Mass media campaigns have been used to increase awareness to induce behavioral changes in prevention studies focusing on cancer, cigarette smoking, vaccinations, exercise, and cardiovascular risk (Borland et al. 1990, Flay 1987, McDivitt et al. 1997, Owen et al. 2006, Salonen et al. 1981).

In 1995, we began examining the effects of using different types of media interventions, particularly television programming, as a means to promote positive parenting on a larger scale. This work included the use of radio programs, newspaper columns, promotional and advertising materials, and the Internet. For example, Sanders et al. (2000) investigated the feasibility of using a television series on parenting to promote positive family outcomes. The *Families* series, originally aired at prime time on commercial television in New Zealand in 1995, was a 30-minute, 12-episode “infotainment”-style program. The program used an entertaining format to provide practical information and advice to parents on a variety of common behavioral and developmental problems in children as well as on other parenting issues. An RCT evaluation of the program (see Sanders et al. 2000) showed that mothers watching the series reported significant reductions in the number of child behavior problems posttreatment in comparison with the control group, and there was a significant decrease in the number of children who scored in the clinical range on a measure of disruptive behavior. Mothers in the media condition also reported an increased sense of competence and

satisfaction in their parenting abilities relative to mothers in the control group.

Sanders et al. (2008a) and Calam et al. (2008) evaluated a six-episode observational documentary television series, *Driving Mum and Dad Mad*, on ITV, the United Kingdom’s largest commercial network. This series depicted the experiences and emotional journey of five families with children with severe conduct problems as they participated in Group Triple P (an eight-session group program). The series attracted an average of 5.1 million viewers and 25% market share of the viewing audience in the United Kingdom, demonstrating the audience potential of a parenting series that is based on the actual experiences of real families undergoing the Triple P group intervention. All five participating on-air families made significant gains on all key indices of outcome. The evaluation showed that parents who watched the series reported improved self-efficacy and reduced conduct problems, parental distress, coercive parenting, and marital conflict over parenting.

Low-intensity seminar series. Our search to distill the core elements of interventions continued with the development and trialing of a large-group seminar series and additional small-group, stand-alone, topic-specific discussion groups for parents. A three-session seminar series on positive parenting was developed as a transition-to-school program (Sanders et al. 2008a) and was designed to be a cost-efficient universal program. Several evaluation studies showed positive intervention effects for the series, and it has been used extensively in large-scale rollouts of Triple P as a public health intervention (e.g., Sanders et al. 2008a, 2009). A variant has also been developed and trialed for parents with a developmental disability (Sofronoff et al. 2011).

Triple P for parents of children with a disability. In comparison to parents of typically developing children, parents of children with a developmental disability experience considerably more stress in raising their children, and their children are more likely to develop



mental health problems. Beginning in 1996 in collaboration with the Disabilities Services Commission in Western Australia, we commenced the development of a parallel system of parenting support known as Stepping Stones Triple P, modeled on the core multilevel system of Triple P, for parents of children with a disability (Roberts et al. 2006). A series of studies has evaluated each of the Stepping Stones program variants, including an intensive 10-session individual program, an eight-session group program, a self-help program, a brief primary care variant, and a two-session seminar series on positive parenting (Plant & Sanders 2007, Roberts et al. 2006).

Topic-specific parent discussion groups.

The final stage in the development of a group format involved the development of topic- and age-specific discussion groups for up to 20 parents at a time. Two RCTs have shown medium to large effect sizes on child outcome for discussion groups on disobedience, hassle-free shopping, bedtime, and fighting and aggression. Sustained intervention effects were obtained on in both trials (Joachim et al. 2010, Morawska et al. 2011).

Online parenting interventions. The development of a suite of online programs for parents is the most recent aspect of program development. Access to high-speed Internet connections has increased remarkably over the past five years, and this has fostered a proliferation of Web sites providing information on parenting. An Internet search using the term “positive parenting” yielded millions of hits. However, most Web sites on parenting, including government-sponsored sites, have never been evaluated to determine whether using the Web improves parenting skills. The challenge facing parenting researchers is to harness the utility of the online world—including social media—and transform it into an effective, evidence-based platform of parenting support.

Online Triple P offers parents a parent-controlled learning environment that is consistent with consumer preference (see

Metzler et al. 2011), improves the convenience and reach of the intervention, and reduces the cost of delivery to parents. The online parenting program included eight educational modules with interactive exercises and brief videos and was recently tested in a sample of 127 parents (Sanders et al. 2011a). Compared to a waitlist control group, Online Triple P was effective and was associated with large effect sizes on key variables (child behavior, dysfunctional parenting, parenting confidence, and parental anger) that were similar to those for in-person group delivery. Love et al. (2011) recently argued that Online Triple P could be further enhanced by combining it with a moderated social network for parents at risk of child maltreatment. The effects of such an intervention are currently under investigation.

PUTTING IT ALL TOGETHER: THE SIMULTANEOUS IMPLEMENTATION OF ALL LEVELS OF THE TRIPLE P SYSTEM

The approach to building a system of intervention involved developing and testing in isolation the different levels and variants of the program rather than integrating multiple levels at the outset. Such an approach is consistent with Collins and colleagues’ (2009) recently advocated model of building the components of an intervention prior to implementing a complex multicomponent system of intervention. The Triple P system now has a full spectrum of integrated, theoretically consistent, preventive and treatment interventions ranging from very light touch to intensive programs for more complex and difficult-to-treat behavioral and emotional problems. The goal was to ensure that each component of the intervention system worked and had an evidence base to justify inclusion in a public health model, with supporting evidence for every component. A demonstration that the simultaneous implementation of the multilevel system could produce population-level benefits was required.

Implementation of Triple P as a system involved targeting defined geographical catchment areas and tracking the population-level impact on indices of child well-being, maltreatment, and parenting. The simultaneous implementation of multiple levels allowed for synergies to develop and helped to create momentum for a parenting program in a community. To date, two large-scale population-level evaluations of the Triple P system have been published that have shown the feasibility and cost-effectiveness of this approach; several other evaluations are in progress in the United Kingdom, Canada, Sweden, Ireland, Australia, New Zealand, and Belgium.

Sanders et al. (2008b,c) described the implementation and evaluation of the Every Family project. Every Family targeted parents of all 4- to 7-year-old children in 20 geographical catchment areas in Australia. All parents in 10 geographic catchment areas could participate in various levels (depending on need and interest) of the multilevel Triple P suite of interventions. Interventions consisted of a media and communication strategy, parenting seminars, parenting groups, and individually administered programs. These parents were then compared to a sample of parents from the other 10 geographical catchment areas. The evaluation of population-level outcomes was through a household survey of parents using a structured computer-assisted telephone interview. Following a two-year intervention period, parents in the Triple P communities reported a greater reduction in behavioral and emotional problems in children and in coercive parenting and parental depression and stress, greater program awareness, and higher levels of exposure to Triple P than parents in comparison communities. These findings showed for the first time that population-level change in parenting practices and child mental health outcomes could be achieved through a public health model targeting parenting.

Prinz et al. (2009) took the approach to population-level implementation one step further using a cluster randomized design. Eighteen counties in the state of South Carolina

were randomly assigned to either the Triple P system or to care-as-usual control. Following intervention, the Triple P counties observed lower rates of founded cases of child maltreatment, hospitalizations and injuries due to maltreatment, and out-of-home placements due to maltreatment. This was the first time a public health parenting intervention has shown positive population-level effects on child maltreatment in a randomized design with county as the unit of random assignment.

ESSENTIAL CRITERIA FOR MAKING A PUBLIC HEALTH APPROACH TO PARENTING WORK

Much has been learned about how to implement a public health approach to increasing parenting support in communities. Detailed implementation guidelines have been developed and are being used in a number of replication studies around the world. These rollouts continue to refine our understanding of how best to implement large-scale psychological interventions. Several criteria need to be met for the approach to work.

Having Parenting Programs Available that Work

Parents prefer parenting programs that are supported by evidence that they actually work (e.g., Sanders et al. 2011c). However, parents vary greatly in the level and type of support they require or are prepared to participate in. Some parents are seeking basic advice on dealing with common parenting problems and issues (e.g., establishing bedtime routines), and yet others have more serious problems that require more intensive intervention over a longer period. This variation in need was behind the development of a range of Triple P delivery formats, variants, and levels of intensity. To ensure that the diverse needs of parents are addressed, a population-level parenting strategy requires different evidence-based interventions to be available.

Population-level change: the associated changes in parenting practice and child behavior and emotion resulting from the adoption and implementation of a public health approach to parenting support



Stay Positive: a media communication strategy aimed at engaging parents in positive parenting strategies in a nonstigmatized way

Having Evidence of Cost-Effectiveness

A public health approach to parenting support can be a very cost-effective approach to prevention. Foster et al. (2008) estimated that the infrastructure costs associated with the implementation of the Triple P system in the United States was \$12 per participant, a cost that could be recovered in a single year by as little as a 10% reduction in the rate of abuse and neglect. Aos et al. (2011) conducted a careful economic analysis of the costs and benefits of implementing the Triple P system using indices of improvement on rates of child maltreatment (out-of-home placements and rates of abuse and neglect). Their findings showed that for an estimated total intervention cost of \$137 per family if only 10% of parents received Triple P, there would be a positive benefit of \$1,237 per participant, with a benefit-to-cost ratio of \$9.22. The benefit-to-cost ratio is even higher when higher rates of participation are modeled. Other economic analyses of implementation of Triple P as a system have similarly shown the intervention to be highly cost-effective in the prevention of antisocial behavior (e.g., Mihalopoulos et al. 2007, 2011).

Ensuring Cultural Relevance and Acceptability

Public health interventions need to be acceptable to ethnically and socioeconomically diverse parents. RCTs, focus groups, and survey methods have been used to establish the acceptability and effectiveness of parenting strategies used in Triple P (e.g., praise, positive attention, quiet time, and timeout) with a diverse range of parents, including parents from Australia, the United States, New Zealand, Japan, Singapore, Hong Kong, Iran, Scotland, England, Ireland, Sweden, Belgium, the Netherlands, Germany, Turkey, Switzerland, South Africa, and Panama (e.g., Bodenmann et al. 2008, Matsumoto et al. 2010, Morawska et al. 2010). In this cultural acceptability work, it is important to access parents directly rather than to rely exclusively on the views of professionals serving minority

populations, who can seek to be “cultural gatekeepers,” holding views on cultural acceptability that differ from those of the parents (Morawska et al. 2011).

Apart from its cross-cultural robustness, Triple P has been shown to be effective with parents from all socioeconomic groups, including socioeconomically disadvantaged parents. McTaggart & Sanders (2007) showed that family income and education levels of parents did not moderate intervention effects of Group Triple P when delivered as a transition-to-school program. However, specific efforts are required to engage some lower-income minority parents, and fathers in general, because they are less likely to participate than are other parents, even though the interventions can be just as effective when they do participate (Leung et al. 2003, Turner et al. 2007).

Reducing Stigma Associated with Participation in Parenting Programs

When development-enhancing and life-course-altering parenting programs are restricted to a small minority of vulnerable parents with established serious problems (a common approach used in targeting parenting interventions), such programs can be viewed as something for struggling or “failed” parents with difficult children or for parents involved in the child protection, justice, or mental health systems. As an unfortunate result, parenting programs become associated with stigma. Hence, an effective engagement strategy is needed to ensure that all parents can participate in the interventions in a nonstigmatized way. To normalize parental engagement, a media and communication strategy is needed that is designed to complement and to be theoretically consistent with other types of parenting support. An example of such an approach is the Stay Positive communication strategy (see <http://www.triplep-staypositive.net>), which has been used in a number of large-scale population rollouts of Triple P. Active media outreach strategies include radio announcements, newspaper columns, editorials,

television features, and promotion of programs through the Internet. This approach aims to increase receptivity toward participating in Triple P and other family/child interventions, normalize the process of seeking help for children with behavioral and emotional problems, and increase the visibility and reach of various interventions.

Engaging Consumers in the Development of Evidence-Based Programs

The content of parenting programs and the processes of delivery benefit greatly from consumer input (Sanders & Kirby 2011). Parents have increasingly been used to provide insights at various stages of the development, implementation, and evaluation of Triple P. For example, Metzler et al. (2011) showed parents a prototypical episode of a television series based on Triple P that is being used in a clinical trial to ensure the footage was considered culturally acceptable and engaging to a mixed-race sample of U.S. parents (including Caucasian, Spanish-speaking, and African American parents). Parents overwhelmingly confirmed that the multicultural footage was acceptable to them.

Kirby & Sanders (2011) used focus groups with grandparents to identify parenting situations that grandparents found challenging (e.g., communicating about grandchild discipline with their own adult children). On the basis of work with these groups, Group Triple P has been modified to include a greater focus on conflict management and teamwork with birth parents, and a new variant of Triple P, Grandparent Triple P, is currently under development. We have also used consumer preference surveys to solicit parents' and practitioners' views on the cultural appropriateness and relevance of parenting procedures, materials (written and DVD), program features, and delivery methods (Morawska et al. 2010). In each of these studies, parents have viewed the program as highly culturally appropriate and useful.

Establishing Achievable Participation Targets

Careful attention needs to be given to ensuring that participation targets are set at the outset so that the necessary numbers of practitioners are trained who have the capacity, interest, and organizational support to implement the program with fidelity. The resources required to implement the program vary as a function of the costs of delivering the intervention (number of sessions required), the type of provider who delivers the program (e.g., nurses, psychologists, social workers, teachers, family support workers, doctors), and how active practitioners are after initial training. A limited number of very active practitioners who see hundreds of families a year would achieve far greater population reach than a large number of practitioners who use the intervention infrequently (Shapiro et al. 2011). Limiting training access to practitioners who are prepared to negotiate specific delivery targets helps to ensure greater program reach. Moderate program use by many providers in diverse delivery settings enables the spread of the program to a more diverse population of parents.

Having an Evaluation Plan and Tracking Population-Level Indicators

Reliably assessing the prevalence and incidence rates of child problems and parenting practices targeted by an intervention is a major challenge for all prevention interventions. Several different approaches have been used to assess population-level effects of Triple P. These include accessing aggregate archival data at a county or local government level to track rates over time of child abuse and neglect cases, hospitalizations and emergency room visits due to maltreatment, and out-of-home placements (Prinz & Sanders 2007). Household telephone surveys using random digit dialing have also been used (Sanders et al. 2007b). Population-level indices can also be complemented by service-based data concerning outcomes achieved by participating parents using



TPI: Triple P International

Dissemination: the process of taking evidence-based parenting interventions from the research laboratory and delivering them to parents in the community

standardized parent- or child-report instruments. Data linkage at the individual-case level across different administrative systems in health, education, and welfare sectors is particularly valuable and can enable a broader range of outcomes to be assessed at an individual-case level over time. There is a need for a range of brief, reliable, valid, and change-sensitive measures of parenting for use in public health interventions. Such measures need to be low cost; easy to use, score, and interpret; have low literacy demands; easy to translate into different languages; and have consistent response formats across different areas assessed.

CREATING A GLOBAL AND SUSTAINABLE SYSTEM OF DISSEMINATION

Several world bodies have recognized that positive parenting programs are essential to increase safe, stable, and nurturing relationships between children and their parents/carers if global violence is to be reduced. These groups include the World Health Organization's Violence Prevention Alliance (<http://www.who.int/violenceprevention>). The emerging field of implementation science is devoted to studying the implementation process associated with the successful translation of research findings into practice. Various models of sustainable program implementation have emerged and are being evaluated (Aarons et al. 2011; Fixsen et al. 2005; Sanders & Murphy-Brennan 2010a,b). Unfortunately, most of the discussion about implementation has focused on high-income countries (mostly English-speaking countries), where the majority of efficacy trials have been conducted. However, there is a great need to introduce culturally appropriate and effective parenting support to low- and middle-income countries in Sub-Saharan Africa, Central and South America, Central and Southeast Asia, the Middle East, and Eastern Europe, where high rates of child maltreatment, family violence, and substance abuse are common (UNODC 2009, WHO 2009). In order to achieve such levels of

implementation, parenting interventions must possess several important characteristics.

Capacity to Go to Scale

The capacity of an evidence-based program to be scaled up is crucial in a public health context. "Going to scale" means that program developers and disseminators (purveyors) have the relevant knowledge, experience, and resources to roll out programs on a large scale and the ability to respond to workforce training demands. When efforts to disseminate Triple P began in earnest in 1996, we could find no well-established exemplars of how to undertake the task. To enable the program to go to scale, a purveyor organization, Triple P International (TPI), was established to disseminate the program worldwide. Since the commencement of dissemination efforts in 1996, more than 62,000 practitioners have been trained across 23 countries to implement Triple P. This would not have been achieved without a dedicated dissemination organization with the necessary fiscal resources and expertise to manage the process.

Developing a System of Professional Training

Parents accessing parenting services expect programs to be delivered competently by professionals. Evidence-based programs achieve the best results when delivered with fidelity (Beidas & Kendall 2010), and practitioners with higher levels of competence produce better child outcomes; in contrast, incompetently delivered evidence-based programs may even be harmful (Henggeler 2011). Despite this, in many countries the workforce delivering advice and guidance to parents is a diverse multidisciplinary group of practitioners that is often undertrained, poorly supervised, and relatively poorly qualified. This is even more pronounced in poorer rural and remote communities in high-income countries, and in low- and middle-income countries.

A training and dissemination system was developed in 1996 in the Parenting and

Family Support Centre at the University of Queensland. However, our initial attempts to disseminate Triple P in Australia through this mechanism were short-lived. The core business of research-intensive universities is teaching and research, not disseminating intervention programs. From a university base we did not have the infrastructure, financial capacity, or the necessary business acumen to disseminate the program on a global scale in a sustainable manner. Such a task requires collaborators and partners outside the field of psychology to provide expertise in business, marketing, publishing, management of intellectually property matters, and international business.

After different options were explored, the research and development functions were consolidated within the university, while the training and dissemination functions were completely transferred to TPI, which became a one-stop shop to handle Triple P resource publications, video production and training, and program consultation and technical support.

One important aspect of this process was that the intellectual property involved in the Triple P system needed to be managed. On the advice of Uniquet, the University of Queensland's technology transfer company, all authors agreed to assign their intellectual property rights to the University of Queensland, which in turn (through Uniquet) licensed TPI, an independent company appointed to publish the program and to disseminate it worldwide. Without such an arrangement, Triple P would probably have remained in the cloisters of academia and would have made little impact.

Between 1996 and 1998, a standardized professional training program was developed for all levels of the Triple P system. This system of training was built on the successful training methods used in preparing therapists in clinical trials and in teaching clinical psychology students behavioral family intervention skills. The program adopted an active skills training approach that involved a combination of didactic input, video and live demonstration of core consultation skills, small-group exercises to practice skills, problem-solving exercises,

course readings, and competency-based assessment. This assessment included a written quiz and live or videotaped demonstrations by participants to show that they had mastered core competencies specific to the level of training undertaken. Triple P training was designed to be relatively brief to minimize disruption to staff schedules and to reduce the need for relief workers while staff undertook training. The training experience was structured to provide background reading, attendance at a one- to five-day training workshop (based on the level of intervention), and attendance at a one-day accreditation workshop eight to 12 weeks after initial training. Every training course is carefully evaluated, and feedback is elicited on the course content, quality of presentation, opportunities for active participation, and practitioners' overall consumer satisfaction. Practitioner feedback is incorporated into revisions of the training program. A range of professionals delivers Triple P interventions to parents. To be eligible to undertake Triple P training, participants must have professional training in psychology, medicine, nursing, social work, counseling, or other related field as well as some prior exposure to principles of child development and work with families.

Practitioner Accreditation

To successfully complete a Triple P training course and become an accredited provider involves attendance at a training course and completion of accreditation requirements, including a short-answer quiz addressing knowledge of theory, program content, and process issues involved in consulting with families. Since 1998, accreditation has been incorporated into the training process, and only practitioners who complete accreditation requirements can be considered properly trained to deliver the intervention. Follow-up studies of participants in Triple P training show that about 85% of practitioners who start training become accredited, and of those, about 90% implement Triple P (Seng et al. 2006).



Flexible Tailoring and Responsive Program Delivery

Many manualized evidence-based programs have been criticized as being rigid and inflexible. Mazzucchelli & Sanders (2010) argued that delivering a program with fidelity does not mean inflexible delivery and that there are high- and low-risk variations in content and process that can influence clinical outcomes. The training process encourages practitioners to work collaboratively with parents and to be responsive to client need and situational context while preserving the key or essential elements of the program. The needs of specific client populations can be met by adapting examples used to illustrate key teaching points and through customized homework. This type of tailoring preserves core concepts and procedures while it meets the idiosyncratic needs of particular parent groups (e.g., parents of twins or triplets or parents of children with special needs).

Ensuring Competent Trainers Are Used

Masters- or doctorate-level professionals (mainly clinical or educational psychologists) are used to train practitioners to implement professional training programs. Professionals invited to become trainers undergo an intensive two-week training program. After initial induction, trainers are provisionally accredited and can begin conducting training under supervision from TPI. To be considered fully trained, trainers have to complete a skills-based accreditation process. Trainers do not work independently and use standardized materials, which serves to ensure that program integrity is protected. Although many agencies favor a train-the-trainer model, such an approach can lead to substantial program drift and poorer client outcomes. Program disseminators can quickly lose control of the training process and, as a result, can find it harder to efficiently incorporate revisions and changes when ongoing research indicates they are required. Maintaining control over the initial training of

providers, although not without its challenges (when the demand for a program occurs in different cultural contexts), is achievable and helps to promote quality standards.

Tailoring Training Methods to Target Groups

Because Triple P training is delivered to a broad range of service providers, the delivery of courses must be customized to a certain extent to cater to the special characteristics of those undergoing training. This can be accomplished by ensuring that trainers are familiar with the local context, including where different providers work, their role in providing parenting support, their professional backgrounds, and their level of experience. A good trainer seeks to be flexible enough to cater to the experience and learning styles of the group while ensuring that essential content is properly covered. This tailoring can involve selection of relevant (to the audience) case examples and illustrations—drawing upon the knowledge, experience, and expertise of the group—and by bringing to the attention of the group the variant and invariant features of the program.

Maintaining Training Quality

The training organization must carefully manage and maintain the quality of the training process itself to minimize program drift at source. To prevent program drift, all trainers use standardized materials (including participant notes, training exercises, and training DVDs demonstrating core consultation skills) and adhere to a quality-assurance process; trainers become part of a trainer network, and maintenance of their accreditation is required. TPI manages all aspects of the training program, including the initial training, post-training support, and follow-up technical assistance.

Technical and Consultation Support

The Triple P team encourages organizations and practitioners to access ongoing back-up

consultative advice posttraining. Triple P staff members have ongoing email contact, teleconferences, and staff meetings as well as update days to address administrative issues (e.g., data management, performance indicators), logistical issues (e.g., avoidance of accreditation workshops due to anxiety, referral strategies), and clinical issues (e.g., dealing with specific populations, clinical process problems) identified by practitioners. These contacts actively engage agency staff in troubleshooting.

An online practitioner network has also been established to provide ongoing technical support to practitioners using Triple P (<http://www.triplep.org>). This network provides practitioners with downloadable clinical tools and resources (e.g., monitoring forms, public domain questionnaires, and session checklists), updates of new research findings, and practice tips and suggestions. An international practitioner network for accredited providers enables Triple P practitioners to keep up to date with the latest developments in the world of Triple P, including recent research findings and new programs being released.

Encouraging Reflective Practice Through Supervision

Practitioners who access supervision and workplace support posttraining are more likely to implement Triple P. A self-regulatory peer-assisted approach is the preferred method of supervision in the dissemination of Triple P (see Sanders & Murphy-Brennan 2010a, Sanders et al. 2002, Turner et al. 2011). The self-regulation approach to supervision is an alternative to more traditional, hierarchically based group or individual clinical supervision with an experienced, expert supervisor who provides mentoring, feedback, and advice. The self-regulation model utilizes the power and influence of the peer group to promote reciprocal learning outcomes for all participants in supervision groups. Under this model, peers become attuned to assessing the clinical skills of fellow practitioners and provide a motivational context to enable peer colleagues

to change their own behaviors, cognitions, and emotions so they become proficient in delivering interventions.

KEY CHALLENGES IN WORKFORCE DEVELOPMENT

The successful implementation of evidence-based interventions such as Triple P requires strong local leadership and the creation of an organizational climate that embraces evidence-based ways of working with clients (Aarons et al. 2009a; Fixsen et al. 2005, 2009; Turner et al. 2011). Many organizations pay lip service to installing evidence-based practices but fail to create an organizational climate or workforce development strategy that sustains effective program use. Some of the key challenges faced in training workforces to deliver Triple P and how they have been overcome are discussed below.

Quality of Organizational Leadership

The quality of organizational leadership influences innovation within practice settings. Line managers seeking to improve service quality through the use of evidence-based practices can encounter significant resistance from staff members, particularly if adoption of the practice has been a top-down process with little consultation with staff. When line managers prepare staff adequately to undertake training, trainees typically look forward to the experience, are motivated to learn, and are ready to participate. Additionally, the implementation of evidence-based practice within a workforce has been shown to affect staff emotional exhaustion and retention: Research indicates that evidence-based practices that have ongoing fidelity monitoring are likely to produce higher levels of staff retention and lower levels of emotional exhaustion (Aarons et al. 2009a,b).

The Triple P model of training has sought to promote better organizational support by providing manager briefings prior to the commencement of staff training. These briefings include an overview of the system of intervention,



Evidence-based parenting programs: prevention or treatment interventions supported by empirical evidence documenting significant change of targeted parent or child outcome variables

its evidence base, and the process of training to be undertaken by staff; how staff can be supported by managers through the training and accreditation process; how to set implementation targets; and how to support staff with ongoing delivery of the program. It is becoming increasingly evident that this kind of technical support is important in enabling organizations to become involved in programs such as Triple P. Managers attending these sessions report greater clarity in knowledge of program requirements, are more motivated to adopt the program, feel supported by the program disseminator (i.e., the training organization) in getting started, and are in a better position to support staff through the training, accreditation, and implementation phases.

Ensuring Adequate Infrastructure Support

The adoption of a public health approach to the provision of parenting services represents a significant shift in policy for many organizations. Organizations that provide services to parents and families typically receive funding to deliver treatment services to defined high-need client groups as opposed to delivering prevention programs to parents. Involvement in Triple P requires a significant reorientation of a workforce to prevention, early intervention, and mental health promotion.

In large-scale rollouts of Triple P, it is paramount to ensure that adequate funding and infrastructure are in place. For example, experience has shown that government departments or organizations may fund the initial training of their own staff and other agencies serving a population but then expect the local agencies to allocate funds from their own budgets to pay for implementation (e.g., to purchase necessary parent resources).

Taking a Long-Term View of Workforce Development

One downside of emphasizing brief, cost-effective training processes is that unrealistic

expectations of organizations can be created. For example, an assumption that external training consultants can equip a workforce to deliver vastly improved client outcomes through participation in a brief service training course may be unrealistic. A more defensible assumption is that the development of capacity to deliver programs will take time and that learning to be a better clinician will continue throughout a professional lifetime. It is important to undertake a thorough, detailed planning session in the adoption or engagement phase, prior to the commencement of staff training. This will allow for a smoother process within organizations in the implementation phase post accreditation.

GLOBAL DISSEMINATION OF TRIPLE P

There is a great need for evidence-based parenting programs to be disseminated internationally. The unfortunate reality is that only a handful of the wealthiest countries account for the vast majority of published RCTs on parent training (e.g., the United States, Australia, Canada, and, to a lesser extent, the United Kingdom). The Triple P system has generated considerable international interest and is one of a small number of evidence-based parenting interventions to have been successfully disseminated across countries and cultures. A number key challenges must be addressed to disseminate programs internationally.

Build a Local Evidence Base

Every country should aim to develop its own local evidence that the program works. We have collaborated with many local research institutions to identify interested and competent researchers to conduct evaluations of Triple P to help build a local evidence base. Not only is sustainability more likely with local evidence of impact, but strategic alliances also can be built to increase the total pool of researchers across countries contributing to the cumulative international evidence base on parenting programs. Triple P often begins in a new country with a

small-scale demonstration project to establish the feasibility and clinical utility of the intervention before it is implemented more widely (e.g., Leung et al. 2003). Such an approach ensures that the program is meeting local needs and fosters a spirit of openness and critical evaluation and builds local partnerships that are needed to sustain an intervention. In many countries, there are competent researchers but there is not a pool of well-established researchers with the necessary expertise to write grants, independently conduct RCTs of parenting evaluations, and publish outcomes in peer-reviewed journals. An international network of Triple P researchers has assisted with this capacity-building process.

Connect International Researchers

Triple P has benefited greatly from several important collaborations that have fostered international projects and promoted knowledge exchange regarding delivery of public health parenting interventions (e.g., Calam et al. 2008, Dittman et al. 2011, Heinrichs et al. 2005, Leung et al. 2003, Metzler et al. 2011, Prinz et al. 2009). A coordinated international research network for interested scientists has been established through the International Triple P Research Network (ITPRN). ITPRN facilitates communication about research activity around the world involving the Triple P system. The network has created a data repository for outcome studies. The Helping Families Change Conference, an international conference for researchers, practitioners, and policy makers, takes place in a different country annually. The conference is centered on Triple P research and practice and connects members of the ITPRN and the broader community for a series of focused discussions and presentations. It provides an opportunity for critical appraisal of research conducted on Triple P.

Tune in to Local Issues

Each country has its own unique policies, regulations, practices, and opportunities that

influence service priorities. These differences need to be acknowledged and understood. Usually this means listening carefully to how the issues of concern are framed and accessing relevant policy documents that provide insight into local issues. Identifying local opinion leaders is also critical, as they can become either advocates or critics depending on how they are engaged with the program.

IMPLICATIONS FOR POLICY AND PRACTICE

Parenting interventions have considerable scope to improve children's developmental outcomes for any mental health, physical health, or social problem for which potentially modifiable parenting and family variables in the onset, maintenance, exacerbation or relapse of the problem have been causally implicated.

Public Policy Advocacy for Parenting Programs

The quality of parenting that children receive can be affected by the broader social ecology of parenthood, including economic downturn, war, natural disaster, and the law. Prevention scientists should advocate for child- and family-friendly public policies and practices that promote the well-being of children and families. Such policies can include supporting bans on the use of corporal punishment in schools and homes, increasing access to high-quality and affordable child care, provision of universal health care, access to quality programs for early child development, limiting exposure of children to violent television and computer games, and restricting access to unhealthy school meals. Parenting programs are likely to work best when they occur in a socio-political climate that values children, that recognizes the importance of the parenting role, and that is prepared to invest in providing parenting support for a better future for children. Achieving this outcome requires a multilevel parenting support strategy that targets all parents.



Research, Policy, and Practice

In most high-income countries, the quality of parenting programs offered in a community rarely features in policy debates. Despite the fact that it is one of the most effective mental health interventions available for children and adolescents, the funding of parenting services has often been marginalized. For example, in Australia, parent training interventions were excluded from rebatable services provided by psychologists under Medicare when the Federal government introduced rebates for psychological services in 2006.

Nevertheless, impressive inroads have been made to improve access to evidence-based parenting programs in several countries, including Australia, the United Kingdom, the United States, New Zealand, Canada, Belgium, Norway, and The Netherlands. Although there are increasing demands that services use evidence-based programs, many parenting programs that lack a credible evidence base continue to receive government funding. At the core of the problem is that once programs are adopted by agencies, there is rarely a requirement that clinical outcomes are assessed when programs are delivered in everyday practice. Failure by funders to require agencies to report on clinical outcomes means that there is a lack of accountability. Until funders of services demand routine measurement of clinical outcomes, evidence-based practice will remain an elusive ideal that is not matched by the necessary actions of providers. Service providers could benchmark their outcomes against effect sizes achieved in clinical trials using the same intervention. Such data would provide valuable feedback to providers regardless of whether their outcomes match, exceed, or fall short of trial data.

FUTURE DIRECTIONS

Despite the weight of evidence indicating that parenting programs are among the most efficacious and cost-effective interventions available to promote the mental health and well-being of children and adolescents, the

majority of families who might benefit do not participate in parenting programs. The parenting intervention field faces several challenges, which, if addressed, could mean better outcomes for millions of children globally.

Parenting Across the Lifespan

Parenting is a task that continues through life and presents different challenges continuously along the way. However, parenting programs are typically focused on parents of young children and rely on the assumption that parenting has its greatest impact on infants, toddlers, and preschoolers because of the developmental plasticity of the infant brain in the early childhood years. Positive, warm, and supportive interactions with family members and critical, conflicted interaction patterns can have positive or detrimental effects regardless of the child's or parent's age.

A lifespan approach to parenting support, however, involves developing evidence-based programs that normalize and destigmatize parenthood preparation, from the early parenting of infants to the parenting of adult children to the great-grandparenting of great-grandchildren. Programmatic effects are needed to make culturally appropriate and effective parenting programs available throughout the lifespan of a parent.

Broadening Parenting Programs to Address Children's Health Problems

Parents influence many diverse aspects of children's lives, including a wide range of social, emotional, and behavioral problems, and parenting interventions have been developed for some of these problems. However, many more remain relatively unexplored. Parenting influences have been demonstrated to be related to children's physical health and well-being as reflected by inadequate nutrition, sedentary lifestyles, excessive computer and television screen exposure, and difficulty coping with chronic health problems such as asthma and diabetes or life-threatening conditions such as

cystic fibrosis and cancer. A number of trials are currently examining the effects of different variants of Triple P for specific health issues (e.g., asthma, eczema, and cerebral palsy), but many areas of parenting and children's health and development remain unexplored.

CONCLUSION

Over a 33-year period, Triple P has evolved into a whole-of-population parenting support strategy. The Triple P system adopted a public health approach to the delivery of universal parenting support with the goal of increasing parental self-efficacy, knowledge, and

competence in the use of skills that promote positive development in children and adolescents. This change in focus has enabled millions of children around the world to experience the benefits of positive parenting and family environments that promote healthy development; as a consequence, fewer children have developed behavioral and emotional problems or episodes of maltreatment. Triple P remains a work in progress, and there is much to learn. When parents are empowered with the tools for personal change that they require to parent their children positively, the resulting benefits for children, adolescents, parents, and the community at large are immense.

SUMMARY POINTS

1. The quality of parenting that children and adolescents receive has a major influence on their development, well-being, and life opportunities.
2. Of all the potentially modifiable influences that can be targeted through preventive interventions, none is more important than the quality of parenting that children experience.
3. Prevention interventions targeting parenting should be widely used to promote the development of healthy, well-adjusted children and adolescents.

FUTURE ISSUES

1. Parenting across the lifespan: Parenting is a task that continues through life and presents different challenges continuously along the way. The field of parenting intervention research has focused heavily on the parenting of young children. A lifespan approach to parenting support changes this focus and will lead to the development of evidence-based programs that normalize and destigmatize parenting interventions and increase support for parents.
2. Broadening parenting programs to address children's health problems: Although parenting interventions have been developed to address many child social, emotional, and behavioral problems, numerous problems remain relatively unexplored. Future parenting intervention research should aim to address known gaps in the literature and to further explore the ways in which parenting intervention can address child health issues.

DISCLOSURE STATEMENT

Matthew R. Sanders is the founder and lead author of the Triple P-Positive Parenting Program ("Triple P"). Triple P is owned by the University of Queensland. Dr. Sanders has no ownership in Triple P International.



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