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# Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence

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This paper outlines the theoretical, empirical and clinical foundations of a unique parenting and family support strategy designed to reduce the prevalence of behavioural and emotional problems in children and adolescents. The program known as the Triple P-Positive Parenting Program is a multi-level system of family intervention, which provides five levels of intervention of increasing strength. These interventions include a universal population-level media strategy targeting all parents, two levels of brief primary care consultations targeting mild behaviour problems and two more intensive parent training and family intervention programs for children at risk for more severe behavioural problems. The program aims to determine the minimally sufficient intervention a parent requires in order to deflect a child away from a trajectory towards more serious problems. The self-regulation of parental skill is a central construct in the program. The program uses flexible delivery modalities (including individual face-to-face, group, telephone-assisted and self-directed programs) to tailor the strength and format of the intervention to the requirements of individual families. Its multi-disciplinary, preventive and community-wide focus gives the program wide reach, permitting the targeting of destigmatised access points through primary care services for families who are reluctant to participate in parenting skills programs. The available empirical evidence supporting the efficacy of the program and its implications for research on dissemination are discussed.

The quality of family life is fundamental to the wellbeing of children. Family relationships in general and the parent-child relationship in particular have a pervasive influence on the psychological, physical, social and economic wellbeing of children. Many significant mental health, social and economic problems are linked to disturbances in family functioning and the breakdown of family relationships (Chamberlain & Patterson, 1995; Patterson, 1982; Sanders & Duncan, 1995). Epidemiological studies indicate that family risk factors such as poor parenting, family conflict and marriage breakdown strongly influence children's development (e.g., Cummings & Davies, 1994; Dryfoos, 1990; Robins, 1991). Specifically, a lack of a warm positive relationship with parents; insecure attachment; harsh, inflexible, rigid or inconsistent discipline practices; inadequate supervision of and involvement with children; marital conflict and breakdown; and parental psychopathology (particularly maternal depression) increase the risk that children will develop major behavioural and emotional problems, including substance abuse, antisocial behaviour and juvenile crime (e.g., Coie, 1996; Loeber & Farrington, 1998).

Although family relationships are important, parents generally receive little preparation beyond the experience of having been parented themselves; with most learning on the job, through trial and error (Risley, Clark, & Cataldo, 1976; Sanders et al., 2000). The demands of parenthood are further complicated when parents do not have access to extended family support networks (e.g., grandparents or trusted family friends) for advice on child rearing, do not have partners, or experience the stress of separation, divorce or repartnering (Lawton & Sanders, 1994; Sanders, Nicholson, & Floyd, 1997).

This paper describes the conceptual and empirical foundations of the program's comprehensive model of parenting and family support, which aims to better equip parents in their child rearing role. The program's unique features, derivative programs and issues involved in the effective dissemination of the system are discussed and directions for future research are highlighted.

## WHAT IS THE TRIPLE P – POSITIVE PARENTING PROGRAM?

The Triple P-Positive Parenting Program is a multi-level, preventively-oriented parenting and family support strategy developed by the authors and colleagues at The University of Queensland in Brisbane, Australia. The program aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength (see Table 1) for parents of children and adolescents from birth to age 16. Figure 1 depicts the differing levels of intensity and reach of the Triple P system. Level 1, a universal parent information strategy, provides all interested parents with access to useful information about parenting through a coordinated promotional campaign using print and electronic media as well as user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies. This level of intervention aims to increase community awareness of parenting resources and the receptivity of parents to participating in programs, and to create a sense of optimism by depicting solutions to common behavioural and developmental concerns. Level 2 is a brief, one to two-session primary health care

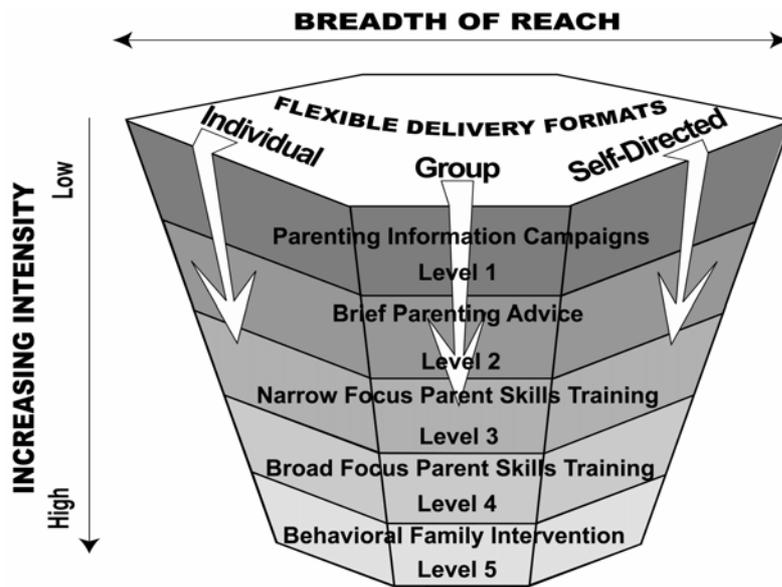
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**Table 1. The Triple P Model of Parenting and Family Support**

<b>Level of Intervention</b>	<b>Target Population</b>	<b>Intervention Methods</b>	<b>Practitioners</b>
<b>LEVEL 1</b> Media-based parent information campaign  <b>Universal Triple P</b>	All parents interested in information about promoting their child's development	Anticipatory well child care involving the provision of brief information on how to solve developmental and minor behaviour problems. May involve self-directed resources, brief consultation, group presentations, mass media strategies, and telephone referral services	Parent support and/or health promotion (e.g., parent aide volunteers linked to agencies routinely providing Triple P services)
<b>LEVEL 2</b> Brief selective intervention  <b>Selected Triple P</b> <b>Selected Teen Triple P</b>	Parents with a specific concern/s about their child's behaviour or development	Provision of specific advice for a discrete child problem behaviour. May be self-directed or involve telephone or face-to-face clinician contact or group sessions	Parent support during routine well-child health care (e.g., child and community health, education, allied health and childcare staff)
<b>LEVEL 3</b> Narrow focus parent training  <b>Primary Care Triple P</b> <b>Primary Care Teen Triple P</b>	Parents with a specific concern/s about their child's behaviour or development who require consultations or active skills training	Brief therapy program (1 to 4 clinic sessions) combining advice, rehearsal and self-evaluation to teach parents to manage a discrete child problem behaviour. May involve telephone or face-to-face clinician contact or group sessions	As for Level 2
<b>LEVEL 4</b> Broad focus parent training  <b>Standard Triple P</b> <b>Group Triple P</b> <b>Group Teen Triple P</b> <b>Self-Directed Triple P</b>	Parents wanting intensive training in positive parenting skills - typically parents of children with more severe behaviour problems	Intensive program focussing on parent-child interaction and the application of parenting skills to a broad range of target behaviours. Includes generalisation enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions	Intensive parenting interventions (e.g., mental health and welfare staff and other allied health professionals who regularly consult with parents about child behaviour)
<b>Stepping Stones Triple P</b>	Families of preschool children with disabilities who have or are at risk of developing behavioural or emotional disorders	A parallel 10-session individually tailored program with a focus on disabilities. Sessions typically last 60–90 minutes (with the exception of 3 home practice sessions which last 40 minutes)	As above
<b>LEVEL 5</b> Behavioural family intervention modules  <b>Enhanced Triple P</b>	Parents of children with concurrent child behaviour problems and family dysfunction such as parental depression or stress or conflict between partners	Intensive individually tailored program with modules including home visits to enhance parenting skills, mood management strategies and stress coping skills, and partner support skills. May involve telephone or face-to-face clinician contact or group sessions	Intensive family intervention work (e.g., mental health and welfare staff)
<b>Pathways Triple P</b>	Parents at risk of maltreating their children. Targets anger management problems and other factors associated with abuse	Modules include attribution retraining and anger management	As above



**Figure 1. The Triple P Model of Graded Reach and Intensity of Parenting and Family Support Services**

intervention providing early anticipatory developmental guidance to parents of children with mild behaviour difficulties or developmental issues. Level 3, a four-session intervention, targets children with mild to moderate behaviour difficulties and includes active skills training for parents. Level 4 is an intensive eight to ten-session individual, group or self-directed parent training program for children with more severe behavioural difficulties. Level 5 is an enhanced behavioural family intervention program for families where child behaviour problems persist or where parenting difficulties are complicated by other sources of family distress (e.g., marital conflict, parental depression or high levels of stress).

The rationale for this multi-level strategy is that there are differing levels of dysfunction and behavioural disturbance in children, and parents have different needs and preferences regarding the type, intensity and mode of assistance they may require. This tiered approach is designed to maximise efficiency, contain costs, avoid waste and over servicing, and to ensure the program has wide reach in the community. Also, the multi-disciplinary nature of the program involves the better utilisation of the existing professional workforce in the task of promoting competent parenting.

The program targets five different developmental periods: infants, toddlers, preschoolers, primary schoolers and teenagers. 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). This flexibility enables practitioners to determine the scope of the intervention within their own service priorities and funding.

### THEORETICAL BASIS OF TRIPLE P

Triple P is a form of behavioural family intervention based on social learning principles (e.g., Patterson, 1982). This approach to the treatment and prevention of childhood disorders has the strongest empirical support of any intervention with children, particularly those with conduct problems (see Kazdin, 1987; Sanders, 1996; Taylor & Biglan, 1998; Webster-Stratton & Hammond, 1997). Triple P aims to enhance family protective factors and to reduce risk factors associated with severe behavioural and emotional problems in children and adolescents. Specifically the program aims to: 1) enhance the knowledge, skills, confidence, self-sufficiency and resourcefulness of parents; 2) promote nurturing, safe, engaging, non-violent and low conflict environments for children; and 3) promote children's social, emotional, language, intellectual and behavioural competencies through positive parenting practices.

The program content draws on the following:

1. Social learning models of parent-child interaction that highlight the reciprocal and bidirectional nature of parent-child interactions (e.g., Patterson, 1982). This model identifies learning mechanisms, which maintain coercive and dysfunctional patterns of family interaction and predict future antisocial behaviour in children (Patterson, Reid, & Dishion, 1992). As a consequence, the program specifically teaches parents positive child management skills as an alternative to coercive, inadequate or ineffective parenting practices.
2. Research in child and family behaviour therapy and applied behaviour analysis, which has developed many useful behaviour change strategies, particularly research that focuses on rearranging antecedents of problem behaviour through designing more positive engaging

environments for children (Risley, Clarke, & Cataldo, 1976; Sanders, 1992, 1996).

3. Developmental research on parenting in everyday contexts. The program targets children's competencies in naturally occurring everyday contexts, drawing on work that traces the origins of social and intellectual competence to early parent-child relationships (e.g., Hart & Risley, 1995; White, 1990). Children's risk of developing severe behavioural and emotional problems is reduced by teaching parents to use naturally occurring daily interactions to teach children language, social skills, developmental competencies and problem solving skills in an emotionally supportive context. Particular emphasis is placed on using child-initiated interactions as a context for the use of incidental teaching (Hart & Risley, 1975). Children are at greater risk for adverse developmental outcomes, including behavioural problems, if they fail to acquire core language competencies and impulse control during early childhood (Hart & Risley, 1995).
4. Social information processing models that highlight the important role of parental cognitions such as attributions, expectancies and beliefs as factors which contribute to parental self-efficacy, decision making and behavioural intentions (e.g., Bandura, 1977, 1995). Parents' attributions are specifically targeted in the intervention by encouraging parents to identify alternative social interactional explanations for their child's and their own behaviour.
5. Research from the field of developmental psychopathology that has identified specific risk and protective factors that are linked to adverse developmental outcomes in children (e.g., Emery, 1982; Grych & Fincham, 1990; Hart & Risley, 1995; Rutter, 1985). Specifically, the risk factors of poor parent management practices, marital family conflict and parental distress are targeted. As parental discord is a specific risk factor for many forms of child and adolescent psychopathology (Grych & Fincham, 1990; Rutter, 1985; Sanders et al., 1997), the program fosters collaboration and teamwork between carers in raising children. Improving couples' communication is an important vehicle to reduce marital conflict over child rearing issues, and to reduce the personal distress of parents and children in conflictual relationships (Sanders, Markie-Dadds & Turner, 1998). Triple P also targets the distressing emotional reactions of parents including depression, anger, anxiety and high levels of stress, especially with the parenting role (Sanders, Markie-Dadds, & Turner, 1999). Distress can be alleviated through parents developing better parenting skills, which reduces feelings of helplessness, depression and stress. Enhanced levels of the intervention use cognitive behaviour therapy techniques of mood monitoring, challenging dysfunctional cognitions and attributions and by teaching parents specific coping skills for high-risk parenting situations.
6. A population health perspective to family intervention that involves the explicit recognition of the role of the broader ecological context for human development (e.g., Biglan, 1995; Mrazek & Haggerty, 1994; National Institute of Mental Health, 1998). As pointed out by Biglan (1995), the reduction of antisocial behaviour in children requires the community context for parenting to change. Triple P's media and promotional strategy as part of a larger system of intervention aims to change this broader ecological

context of parenting. It does this by normalising parenting experiences, particularly the process of participating in parent education, by breaking down parents' sense of social isolation, increasing social and emotional support from others in the community, and validating and acknowledging publicly the importance and difficulties of parenting. It also involves actively seeking community involvement and support in the program through the engagement of key community stakeholders (e.g., community leaders, businesses, schools and voluntary organisations).

## TOWARDS A MODEL OF PARENTAL COMPETENCE

The educative approach to promoting parental competence in Triple P views the development of a parent's capacity for self-regulation as a central skill. This involves teaching parents skills that enable them to become independent problem solvers. Karoly (1993) defined self regulation as follows:

*Self-regulation refers to those processes, internal and or transactional, that enable an individual to guide his/her goal directed activities over time and across changing circumstances (contexts). Regulation implies modulation of thought, affect, behaviour, and attention via deliberate or automated use of specific mechanisms and supportive metaskills. The processes of self-regulation are initiated when routinised activity is impeded or when goal directedness is otherwise made salient (e.g., the appearance of a challenge, the failure of habitual patterns; etc) (p.25).*

This definition emphasizes that self-regulatory processes are embedded in a social context that not only provides opportunities and limitations for individual self-directedness, but implies a dynamic reciprocal interchange between the internal and external determinants of human motivation. From a therapeutic perspective, self-regulation is a process whereby individuals are taught skills to modify their own behaviour. These skills include how to select developmentally appropriate goals, monitor a child's or the parent's own behaviour, choose an appropriate method of intervention for a particular problem, implement the solution, self-monitor their implementation of solutions via checklists relating to the areas of concern, and to identify strengths or limitations in their performance and set future goals for action.

This self-regulatory framework is operationalised to include:

1. Self-sufficiency: As a parenting program is time limited, parents need to become independent problem solvers so they trust their own judgment and become less reliant on others in carrying out basic parenting responsibilities. Self-sufficient parents have the resilience, resourcefulness, knowledge and skills to parent with confidence;
2. Parental self-efficacy: This refers to a parent's belief that they can overcome or solve a parenting or child management problem. Parents with high self-efficacy have more positive expectations about the possibility of change;
3. Self-management: The tools or skills that parents use to become more self-sufficient include self-monitoring, self-determination of performance goals and standards, self-evaluation against some performance criterion, and self-selection of change strategies. As each parent is responsible for the way they choose to raise their children, parents select which aspects of their own and

their child's behaviour they wish to work on, set goals for themselves, choose specific parenting and child management techniques they wish to implement, and self-evaluate their success with their chosen goals against self-determined criteria. Triple P aims to help parents make informed decisions by sharing knowledge and skills derived from contemporary research into effective child rearing practices. An active skills training process is incorporated into Triple P to enable skills to be modelled and practised. Parents receive feedback regarding their implementation of skills learned in a supportive context, using a self-regulatory framework (see Sanders, Markie-Dadds & Turner, 2000).

4. **Personal agency:** Here the parent increasingly attributes changes or improvements in their situation to their own or their child's efforts rather than to chance, age, maturational factors or other uncontrollable events (e.g., partner's bad parenting or genes). This outcome is achieved by prompting parents to identify potentially modifiable causes or explanations for their child's or their own behaviour.

Encouraging parents to become self-sufficient means that parents become more connected to social support networks (e.g., partner, extended family, friends and child care supports). However, the broader ecological context within which a family lives can not be ignored (e.g. poverty, dangerous neighbourhood, community, ethnicity and culture). It is hypothesized that the more self-sufficient parents become, the more likely they are to be resilient in coping with adversity, seek appropriate support when they need it, advocate for children, become involved in their child's schooling, and protect children from harm (e.g., by managing conflict with partners, and creating a secure, low-conflict environment).

## PRINCIPLES OF POSITIVE PARENTING

Five core positive parenting principles form the basis of the program. These principles address specific risk and protective factors known to predict positive developmental and mental health outcomes in children. These core principles translate into a range of specific parenting skills, which are outlined in Table 2.

### Ensuring a 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 & Salanda, 1996; Wesch & Lutzker, 1991). It is also relevant to older children and adolescents who need adequate supervision and monitoring in an appropriate developmental context (Dishion & McMahon, 1998; Forehand, Miller, Dutra, & Watts Chance, 1997). Triple P draws on the work of Risley and his colleagues who have articulated how the design of living environments can promote engagement and skill development of dependent persons from infancy to the elderly (Risley, Clark, & Cataldo, 1976).

### Creating a positive learning environment

This involves educating parents in their role as their child's first teacher. The program specifically targets how parents can respond positively and constructively to child-initiated interactions (e.g., requests for help, information, advice, attention) through incidental teaching to assist children to

learn to solve problems for themselves. Incidental teaching involves parents being receptive to child-initiated interactions when children attempt to communicate with their parents. The procedure has been used extensively in the teaching of language, social skills and social problem solving (e.g., Hart & Risley, 1975, 1995). A related technique known as Ask, Say, Do involves teaching parents to break down complex skills into discrete steps and to teach children the skill sequentially (in a forward fashion) through the use of a graded series of prompts from the least to the most intrusive.

### Using assertive discipline

Specific child management strategies are taught that are alternatives to coercive and ineffective discipline practices (such as shouting, threatening or using physical punishment). A range of behaviour change procedures are demonstrated to parents including: selecting ground rules for specific situations; discussing rules with children; giving clear, calm, age appropriate instructions and requests; logical consequences; quiet time (non-exclusionary time out); time out; and planned ignoring. Parents are taught to use these skills in the home as well as in community settings (e.g., getting ready to go out, having visitors, and going shopping) to promote the generalisation of parenting skills to diverse parenting situations (for more detail see Sanders & Dadds, 1993).

### Having realistic expectations

This involves exploring with parents their expectations, assumptions and beliefs about the causes of children's behaviour, and choosing goals that are developmentally appropriate for the child and realistic for the parent. There is evidence that parents who are at risk of abusing their children are more likely to have unrealistic expectations of children's capabilities (Azar & Rohrbeck, 1986). Developmentally appropriate expectations are taught in the context of parents' specific expectations concerning difficult and prosocial behaviours rather than through the more traditional 'ages and stages' approach to teaching about child development.

### Taking care of oneself as a parent

Parenting is affected by a range of factors that impact on a parent's self-esteem and sense of wellbeing. 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 wellbeing and by teaching parents practical parenting skills that all carers of a child are able to implement. In more intensive levels of intervention (Level 5), couples are also taught effective communication skills. In this level of intervention, parents are also encouraged to explore how their own emotional state affects their parenting and consequently their child's behaviour. Parents develop specific coping strategies for managing difficult emotions including depression, anger, anxiety and high levels of parenting stress.

## DISTINGUISHING FEATURES OF TRIPLE P

There are several other distinctive features of Triple P as a family intervention which are discussed below.

### Principle of program sufficiency

This concept refers to the notion that parents differ in the strength of intervention they may require to enable them to

**Table 2. Core Parenting Skills**

<b>Observation skills</b>	<b>Parent-child relationship enhancement skills</b>	<b>Encouraging desirable behaviour</b>	<b>Teaching new skills and behaviours</b>	<b>Managing misbehaviour</b>	<b>Preventing problems in high-risk situations</b>	<b>Self-regulation skills</b>	<b>Mood management and coping skills</b>	<b>Partner support and communication skills</b>
<ul style="list-style-type: none"> <li>• Monitoring children's behaviour</li> <li>• Monitoring own behaviour</li> </ul>	<ul style="list-style-type: none"> <li>• Spending quality time</li> <li>• Talking with children</li> <li>• Showing affection</li> </ul>	<ul style="list-style-type: none"> <li>• Giving descriptive praise</li> <li>• Giving non-verbal attention</li> <li>• Providing engaging activities</li> </ul>	<ul style="list-style-type: none"> <li>• Setting developmentally appropriate goals</li> <li>• Setting a good example</li> <li>• Using incidental teaching</li> <li>• Using Ask, Say, Do</li> <li>• Using behaviour charts</li> </ul>	<ul style="list-style-type: none"> <li>• Establishing ground rules</li> <li>• Using directed discussion</li> <li>• Using planned ignoring</li> <li>• Giving clear, calm instructions</li> <li>• Using logical consequences</li> <li>• Using quiet time</li> <li>• Using time-out</li> </ul>	<ul style="list-style-type: none"> <li>• Planning and advanced preparation</li> <li>• Discussing ground rules for specific situations</li> <li>• Selecting engaging activities</li> <li>• Providing incentives</li> <li>• Providing consequences</li> <li>• Holding follow up discussions</li> </ul>	<ul style="list-style-type: none"> <li>• Setting practice tasks</li> <li>• Self-evaluation of strengths and weaknesses</li> <li>• Setting personal goals for change</li> </ul>	<ul style="list-style-type: none"> <li>• Catching unhelpful thoughts</li> <li>• Relaxation and stress management</li> <li>• Developing personal coping statements</li> <li>• Challenging unhelpful thoughts</li> <li>• Developing coping plans for high-risk situations</li> </ul>	<ul style="list-style-type: none"> <li>• Improving personal communication habits</li> <li>• Giving and receiving constructive feedback</li> <li>• Having casual conversations</li> <li>• Supporting each other when problem behaviour occurs</li> <li>• Problem solving</li> <li>• Improving relationship happiness</li> </ul>

independently manage a problem. Triple P aims to provide the minimally sufficient level of support parents require. For example, parents seeking advice on a specific topic (e.g., tantrums) receive clear, high quality, behaviourally specific advice in the form of a parenting tip sheet on how to manage or prevent a specific problem. For such a parent Triple P Levels 1 or 2 would constitute a sufficient intervention.

**Flexible tailoring to identified risk and protective factors**

The program enables parents to receive parenting support in the most cost-effective way possible. Within this context a number of different programs of varying intensity have been developed. For example, Level 5 provides intervention for additional family risk factors, such as relationship conflict, mood disturbance and high levels of stress.

**Varied delivery modalities**

Several of the levels of intervention in Triple P can be delivered in a variety of formats, including individual face-to-face, group, telephone-assisted or self-directed programs or a combination. This flexibility enables parents to participate in ways that suit their individual circumstances and allows participation from families in rural and remote areas who typically have less access to professional services.

**Wide potential reach**

Triple P is designed to be implemented as an entire integrated system at a population level. However, the multi-level nature of the program enables various combinations of the intervention levels and modalities within levels to be used flexibly as either universal, selective or indicated

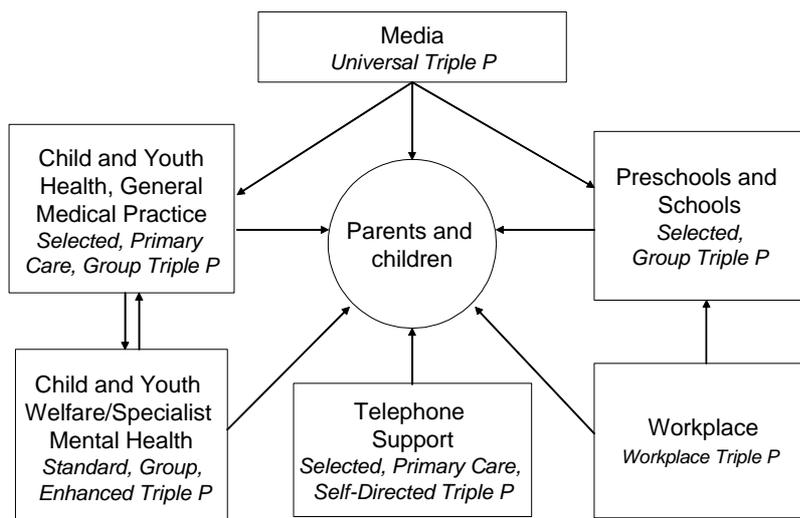
prevention strategies depending on local priorities, staffing and budget constraints. Some communities using Triple P will use the entire multi-level system, while other may focus on getting Primary Care or Group Triple P implemented at a population level, while seeking funding support for the other levels of intervention.

**A multi-disciplinary approach**

Many different professional groups provide support and advice to parents. Triple P was developed as a professional resource that can be used by a range of helping professionals. These professionals include community nurses, family doctors, pediatricians, teachers, social workers, psychologists, psychiatrists and police officers to name a few. At a community level, rigid professional boundaries are discouraged and an emphasis put on providing training and support to a variety of professionals to become more effective in their parent consultation skills.

**A contextual approach**

Triple P adopts a system-contextual or ecological perspective in supporting parents. This involves targeting various social contexts that parents already access often for other reasons (e.g., enrolling a child at school) and developing tailored delivery of Triple P to enable easier access for parents. For example, Workplace Triple P delivers interventions within the work setting as an employee assistance strategy for working parents. The specific social contexts targeted include the media, workplaces, day care, preschool and school settings, primary health care services, telephone counselling services and mental health services. Figure 2 diagrammatically represents various contexts that provide potential destigmatised access points for parents to receive parenting support.



**Figure 2. Ecological Model of Intervention**

## LEVELS OF INTERVENTION

### LEVEL 1: Universal Triple P

A universal prevention strategy targets an entire population (e.g., national, local community, neighbourhood or school) with a program aimed at preventing inadequate or dysfunctional parenting (Mrazek & Haggerty, 1994). Several authors have noted that the media have been underutilised by family intervention researchers (e.g., Biglan, 1992). Evidence from the public health field shows that media strategies can be effective in increasing community awareness of health issues and have been instrumental in modifying potentially harmful behaviour such as cigarette smoking, lack of exercise and poor diet (Biglan, 1995; Soreson, Emmons, Hunt, & Johnson, 1998).

Universal Triple P aims to use health promotion and social marketing strategies to: 1) promote the use of positive parenting practices in the community; 2) increase the receptivity of parents to participating in the program; 3) increase favourable community attitudes towards the program and parenting in general; 4) destigmatise and normalise the process of seeking help for children with behaviour problems; 5) increase the visibility and reach of the program; and 6) counter alarmist, sensationalised or parent-blaming messages in the media.

A Triple P promotional campaign is coordinated locally by a Triple P coordinator. Program coordinators use a media resource kit, which currently consists of the following elements.

- A 30-second television commercial promoting the program for broadcast as a community service announcement (CSA).
- A 30-second radio commercial announcing the program.
- A series of forty, 60-second audio sound capsules on positive parenting.
- 52 newspaper columns on Triple P dealing with common parenting issues and topics of general interest to parents.
- Self-directed information resources in the form of positive parenting tip sheets and a series of videos for parents, which depict how to apply behaviour management advice to common behaviour and developmental problems.
- Printed advertising materials (e.g., posters, brochures, business cards, coffee mugs, positive parenting tee shirts, fridge magnets).
- A series of press releases and sample letters to editors of local television, radio, newspapers and community leaders requesting their support and involvement with the program.
- A program coordinator's guide to the use of the media kit.

To illustrate such an approach, a media campaign on parenting based around a television series (*Families*) which was shown on a commercial television network in New Zealand is discussed below. The centrepiece of this media campaign was thirteen, 30-minute episodes of an 'infotainment' style television series, *Families*. This program was shown at prime time (7.30pm) on a Wednesday evening on the TV 3 commercial television network in October-December, 1995. The program was funded by New Zealand on Air and private business donations (Tindall Foundation).

The infotainment format ensured the widest reach possible for Triple P. Such programs are very popular in both Australia and New Zealand and according to ratings data, frequently attract around 20–35% of the viewing audience (Neilson, 1998). The series used an entertaining

format to provide practical information and advice to parents on how to tackle a wide variety of common behavioural and developmental problems in children (e.g., sleep problems, tantrums, whining, aggression) and other parenting issues. A 5 to 7-minute Triple P segment each week enabled parents to complete a 13 session Triple P program in their own home through the medium of television. A cross promotional strategy using radio and the print media was also used to prompt parents to watch the show and inform them of how to contact a Triple P information line for more information about parenting. *Families* fact sheets that were specifically designed parenting tip sheets were also available through writing to a Triple P Centre, calling a Triple P information line, or through a retail chain.

A carefully planned media campaign has the potential to reach a broad cross section of the population and to mobilise community support for the initiative. Hence, it is important to engage key stakeholders before outreach commences to mobilise community support in advance. The primary target group for a campaign are the parents and carers of children who may benefit from advice on parenting. However, media messages are also seen or heard by professionals, politicians and their advisers and at various levels of government, voluntary organisations, as well as non-parent members of the public. These groups may be able to support other program levels through referral, facilitating funding or donations.

For some families it is the only participation they will have in the program. Hence, designing the media campaign to ensure that messages are thematically consistent and culturally appropriate is critical to ensure that messages are acceptable. This level of intervention may be particularly useful for parents who have sufficient personal resources (e.g., motivation, literacy skills, commitment, time and support) to implement suggested strategies with no additional support other than a parenting tip sheet on the topic. However, a media strategy is unlikely to be effective on its own for parents of children with a severe behavioural disorder or where the parent is depressed, maritally distressed or suffering from major psychopathology. In these instances a more intensive form of intervention may be needed.

### LEVEL 2: Selected Triple P

Selective prevention programs refer to strategies that target specific subgroups of the general population that are believed to be at greater risk than others for developing a problem. The aim is to deter the onset of significant behavioural problems. The individual risk status of the parent is not specifically assessed in advance, but they may be targeted because they belong to a subgroup who are generally believed to be at risk (e.g., all parents of toddlers).

Level 2 is a selective intervention delivered through primary care services. These are services and programs that typically have wide reach because a significant proportion of parents take their children to them and are therefore more readily accessible to parents than traditional mental health services. They may include maternal and child health services, general practitioners and family doctors, day care centres, kindergartens and schools. These services are well positioned to provide brief preventively oriented parenting programs because parents see primary care practitioners as credible sources of information about children and are not

associated with the stigma often attached to seeking specialist mental health services.

For example, general medical practitioners are frequently asked by parents for advice regarding their children's behaviour (Christopherson, 1982; Triggs & Perrin, 1989). Family doctors are the most likely source of professional assistance sought by parents of children with behavioural and emotional problems and are seen by parents as credible sources of advice for a wide range of health risk behaviours (Sanders & Markie-Dadds, 1997). However, primary care providers are typically not well trained in providing behaviour management advice, hence adequate training is essential. The Triple P professional training program for general practitioners, child health nurses and other primary care providers is designed to improve early detection and management of child behaviour problems, and to develop closer links with community-based mental health professionals and other specialist family services, including appropriate referral mechanisms.

Selected Triple P is a brief one or two-session intervention (usually 20-minutes in total), for parents with specific concerns about their child's behaviour or development. A series of parenting tip sheets are used to provide basic information to parents on the prevention and management of common problems in each of five age groups: infants (Markie-Dadds, Turner, & Sanders, 1997); toddlers (Turner, Markie-Dadds, & Sanders, 1996); preschoolers (Turner, Sanders, & Markie-Dadds, 1996); and primary school-aged children (Sanders, Turner, & Markie-Dadds, 1996) and teenagers (Sanders & Ralph, 2001). Four videotape programs complement the tip sheets for use in brief primary care consultations. All materials are written in plain English, and checked to ensure the material is understandable at a grade 6 reading level, is gender sensitive, and avoids technical language and colloquial expressions, which might constitute barriers for parents from non-English-speaking backgrounds. Each tip sheet suggests effective, practical ways of preventing or solving common child management and developmental problems. Information is provided within a brief consultation format, which clarifies the presenting problem, explains the materials and tailors them to the family's needs. Families are invited to return for further help if they have any difficulties.

This level of intervention is designed for the management of discrete child problem behaviours that are not complicated by other major behaviour management difficulties or family dysfunction. With Level 2 interventions, the emphasis is on the management of specific child behaviour rather than developing a broad range of child management skills. Key indicators for a Level 2 intervention include: 1) the parent is seeking information, hence the motivational context is good; 2) the problem behaviour is relatively discrete; 3) the problem behaviour is of mild to moderate severity; 4) the problem behaviour has a recent onset; 5) the parents and/or child are not suffering from major psychopathology; 6) the family situation is reasonably stable; and 7) the family has successfully completed other

levels of intervention and is returning for a booster session.

### LEVEL 3: Primary Care Triple P

This is a more intensive selective prevention strategy targeting parents who have mild and relatively discrete concerns about their child's behaviour or development (e.g., toilet training, tantrums, sleep disturbance). Level 3 is a three to four 20-minute session program that incorporates active skills training and the selective use of parenting tip sheets covering common developmental and behavioural problems. It also builds in generalisation enhancement strategies for teaching parents how to apply knowledge and skills gained to non-targeted behaviours and other siblings.

The first session clarifies the history and nature of the presenting problem (through interview and direct observation), negotiates goals for the intervention and sets up a baseline monitoring system for tracking the occurrence of problem behaviours.

Session 2 reviews the initial problem to determine whether it is still current; discusses the results of the baseline monitoring, including the parent's perceptions of the child's behaviour; shares conclusions with the parent about the nature of the problem (i.e. the diagnostic formulation) and its possible etiology; and negotiates a parenting plan (using a tip sheet or designing a planned activities routine). This plan may involve the introduction of specific positive parenting strategies through discussion, modelling or presentation of segments from *Every Parent's Survival Guide* video. This session also involves identifying and countering any obstacles to implementation of the new routine by developing a personal coping plan with each parent. The parents then implement the program.

Session 3 involves monitoring the family's progress and discussing any implementation problems, and may involve the introduction of additional parenting strategies. The aim is to refine the parents' implementation of the routine as required and provide encouragement for their efforts.

Session 4 involves a progress review, trouble shooting for any difficulties the parent may be experiencing, positive feedback and encouragement, and termination of contact. If no positive results are achieved after several weeks, the family may be referred to a higher level of intervention.

As in Level 2, this level of intervention is appropriate for the management of discrete child problem behaviours that are not complicated by other major behaviour management difficulties or 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. Children do not generally meet diagnostic criteria for a clinical disorder such as oppositional defiant disorder, conduct disorder or ADHD, but there may be subclinical levels of problem behaviour.

### LEVEL 4: Standard Triple P / Group Triple P / Self-Directed Triple P

This indicated preventive intervention targets high-risk individuals who are identified as having detectable problems, but who do not yet meet diagnostic criteria for a behavioural disorder. It should be noted that this level of intervention can target individual children at risk or an entire population to identify individual children at risk. For example, a group version of the program may be offered universally in low-income areas, with the goal of identifying

and engaging parents of children with severe disruptive and aggressive behaviour. Parents are taught a variety of child management skills including providing brief contingent attention following desirable behaviour, how to arrange engaging activities in high-risk situations, and how to use clear calm instructions, logical consequences for misbehaviour, planned ignoring, quiet time (non exclusionary time-out), and time out. Parents are trained to apply these skills both at home and in the community. Specific strategies such as planned activities training are used to promote the generalisation and maintenance of parenting skills across settings and over time (Sanders & Dadds, 1982). As in Level 3, this level of intervention combines the provision of information with active skills training and support. However, it teaches parents to apply parenting skills to a broad range of target behaviours in both home and community settings with the target child and siblings. There are several different delivery formats available at this level of intervention.

#### *Standard Triple P*

This 10-session program incorporates sessions on causes of children's behaviour problems, strategies for encouraging children's development, and strategies for managing misbehaviour. Active skills training methods include modelling, rehearsal, feedback, and homework tasks. Segments from *Every Parent's Survival Guide* video may be used to demonstrate positive parenting skills. Several generalisation enhancement strategies are incorporated (e.g., training with sufficient exemplars, training loosely — varying the stimulus condition for training) to promote the transfer of parenting skills across settings, siblings and time. Home visits or clinic observation sessions are also conducted in which parents self-select goals to practise, are observed interacting with their child and implementing parenting skills, and subsequently receive feedback from the practitioner. Further clinic sessions then cover how to identify high-risk parenting situations and develop planned activity routines. Finally, maintenance and relapse issues are covered. Sessions last up to 90-minutes each (with the exception of home visits, which should last 40–60 minutes each).

#### *Group Triple P*

Group Triple P is an eight-session program, ideally conducted in groups of 10–12 parents. It employs an active skills training process to help parents acquire new knowledge and skills. The program consists of four 2-hour group sessions, which provide opportunities for parents to learn through observation, discussion, practise and feedback. Segments from *Every Parent's Survival Guide* video are used to demonstrate positive parenting skills. These skills are then practised in small groups. Parents receive constructive feedback about their use of skills in an emotionally supportive context. Between sessions, parents complete homework tasks to consolidate their learning from the group sessions. Following the group sessions, three 15- to 30-minute follow-up telephone sessions provide additional support to parents as they put into practice what they have learned in the group sessions. The final session covering skill generalisation and maintenance may be offered as a group session and celebration, or as a telephone session, depending on available resources. Although delivery of the program in a group setting may mean parents receive less individual attention, there are several benefits of group

participation for parents. These benefits include support, friendship and constructive feedback from other parents as well as opportunities for parents to normalise their parenting experience through peer interactions.

#### *Self-Directed Triple P*

In this self-directed delivery mode, detailed information is provided in a parenting workbook, *Every Parent's Self-Help Workbook* (Markie-Dadds, Sanders & Turner, 1999) which outlines a 10-week self-help program for parents. Each weekly session contains a series of set readings and suggested homework tasks for parents to complete. This format was originally designed as an information-only control group for clinical trials. However, positive reports from families have shown this program to be a powerful intervention in its own right (Markie-Dadds & Sanders, in preparation).

Some parents require and seek more support in managing their children than simply having access to information. Hence, the self-help program may be augmented by weekly 15 to 30-minute telephone consultations. This consultation model aims to provide brief, minimal support to parents as a means of keeping them focused and motivated while they work through the program and assists in tailoring the program to the specific needs of the family. Rather than introducing new strategies, these consultations direct parents to those sections of the written materials, which may be appropriate to their current situation.

Level 4 intervention is indicated if the child has multiple behaviour problems in a variety of settings and there are clear deficits in parenting skills. If the parent wishes to have individual assistance and can commit to attending a 10 session program the Standard Triple P program is appropriate. Group Triple P is appropriate as a universal (available to all parents) or selective (available to targeted groups of parents) prevention parenting support strategy, however, it is particularly useful as an early intervention strategy for parents of children with current behaviour problems. Self-Directed Triple P is ideal for families where access to clinical services is poor (e.g., families in rural or remote areas). It is most likely to be successful with families who are motivated to work through the program on their own and where literacy or language difficulties are not present. Possible obstacles to consider include major family adversity and the presence of parental or child psychopathology. In these cases, a Level 4 intervention may be begun, with careful monitoring of the family's progress. A Level 5 intervention may be required following Level 4, and in some cases Level 5 components may be introduced concurrently.

#### **LEVEL 5: Enhanced Triple P**

This indicated level of intervention is for families with additional risk factors that have not changed as a result of participation in a lower level of intervention. It extends the focus of intervention to include marital communication, mood management and stress coping skills for parents. Usually at this level of intervention children have quite severe behaviour problems, which are complicated by additional family adversity factors.

Following participation in a Level 4 program, families requesting or deemed to be in need of further assistance are invited to participate in this individually tailored program (Enhanced Triple P). The first session is a review and

feedback session in which parents' progress is reviewed, goals are elicited and a treatment plan negotiated. Three enhanced individual therapy modules may then be offered to families individually or in combination: Practice, Coping Skills and Partner Support. Each module is ideally conducted in a maximum of three sessions lasting up to 90-minutes each (with the exception of home visits, which should last 40–60 minutes each). Within each additional module, the components to be covered with each family are determined on the basis of clinical judgement and needs identified by the family (i.e. certain exercises may be omitted if parents have demonstrated competency in the target area).

All sessions employ an active skills training process to help parents acquire new knowledge and skills. Parents are actively involved throughout the program with opportunities to learn through observation, discussion, practice and feedback. Parents receive constructive feedback about their use of skills in an emotionally supportive context. Between sessions, parents complete homework tasks to consolidate their learning. Following completion of the individually tailored modules, a final session is conducted which aims to promote maintenance of treatment gains by enhancing parents' self-management skills and thus reduce parents' reliance on the clinician.

The first module, Practice, consists of up to three sessions often conducted in the family's home. These sessions give parents opportunities to practise and receive personalised feedback on their application of the positive parenting strategies introduced in Level 4 Triple P. This process allows the parents and clinician to work together to identify and overcome obstacles and refine their implementation of these strategies. These sessions are largely self-directed, with parents setting their own goals, evaluating their own performance and setting their own homework tasks.

The second module, Coping Skills, is designed for parents experiencing personal adjustment difficulties that interfere with their parenting ability. Difficulties may include stress, anxiety, depression or anger. The module includes up to three sessions to help identify dysfunctional thinking patterns and introduce parents to personal coping skills such as relaxation, coping statements based on stress inoculation training (Meichenbaum, 1974), challenging unhelpful thoughts (Beck, Rush, Shaw, & Emery, 1979), and developing coping plans.

The third module, Partner Support (based on Dadds, Schwartz, & Sanders, 1987), is designed for two-parent families with relationship adjustment or communication difficulties. The module consists of up to three sessions, which introduce parents to a variety of skills to enhance their teamwork as parenting partners. It helps partners improve their communication, increase consistency in their use of positive parenting strategies, and provide support for each other's parenting efforts. Parents may be taught positive ways of listening and speaking to one another, sharing information and keeping up to date about family matters, supporting each other when problems occur, and solving problems.

Several additional Level 5 modules are currently being developed and trialled. These include specific modules for changing dysfunctional attributions, improving home safety, modifying disturbances in attachment relationships, and strategies to reduce the burden of care of parents of children with disabilities. When complete, these additional modules will comprise a comprehensive range of additional resources

for practitioners to allow tailoring to the specific risk factors that require additional intervention.

This level of Triple P is designed as an indicated prevention strategy. It is designed for families who are experiencing ongoing child behaviour difficulties after completing Level 4 Triple P, or who may have additional family adversity factors such as parental adjustment difficulties and partner support difficulties that do not resolve during Level 4 interventions.

## EVALUATION

The evaluation of Triple P needs to be viewed in the broader context of research into the effects of behavioural family intervention (BFI). There have been several recent comprehensive reviews that have documented the efficacy of BFI as an approach to helping children and their families (Lochman, 1990; McMahon, in press; Sanders, 1996, 1998; Taylor & Biglan, 1998). This literature will not be revisited here in detail. There is clear evidence that BFI can benefit children with disruptive behaviour disorders, particularly children with oppositional defiant disorders (ODD) and their parents (Forehand & Long, 1988; Webster-Stratton, 1994). The empirical basis of BFI is strengthened by evidence that the approach can be successfully applied to many other clinical problems and disorders including attention-deficit/hyperactivity disorder (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992), persistent feeding difficulties (Turner, Sanders, & Wall, 1994), pain syndromes (Sanders, Shepherd, Clegghorn, & Woolford, 1994), anxiety disorders (Barrett, Dadds, & Rapee, 1996), autism and developmental disabilities (Schreibman, Kaneko, & Koegel, 1991), achievement problems, habit disorders as well as everyday problems of normal children (see Sanders, 1996; Taylor & Biglan, 1998 for reviews of this literature).

Treatment outcome studies often report large effect sizes (Serketich & Dumas, 1996), with good maintenance of treatment gains (Forehand & Long, 1988). Treatment effects have been shown to generalise to school settings (McNeil, Eyberg, Eisenstadt, Necomb, & Funderbunk, 1991) and to various community settings (Sanders & Glynn, 1981). Furthermore, parents participating in these programs are generally satisfied consumers (Webster-Stratton, 1989).

### Development of the core intervention

Research into the system of behavioural family intervention that has become known as Triple P began in 1977 with the first findings published in the early 1980s (e.g., Sanders & Glynn, 1981). Since that time, the intervention methods used in Triple P have been subjected to a series of controlled evaluations using both intra-subject replication designs and traditional randomised control group designs. Early studies (e.g., Sanders, & Christensen, 1985; Sanders & Dadds, 1982; Sanders & Glynn, 1981) demonstrated that parents could be trained to implement behaviour change and positive parenting strategies in the home and many parents applied these strategies in out of home situations in the community and to other non-targeted situations in the home.

However, not all parents generalised their skills to high-risk situations after initial active skills training. These high-risk situations for lack of generalisation are often characterised by competing demands, time constraints or by placing parents under stress in a social evaluative context (e.g., shopping). For these parents, the addition of self-management skills such as planning ahead, goal setting,

self-monitoring, selecting specific behaviour change strategies in advance and planning engaging activities to keep children busy were effective in teaching parents to generalise their skills (Sanders & Dadds, 1982; Sanders & Glynn, 1981). Children receiving both the basic parenting skills training and planned activities training showed significantly lower levels of disruptive and oppositional behaviour following intervention. After training, parents showed increases in positive parent-child interaction and reduced levels of negativity. A later study showed that the same intervention methods were also effective with oppositional children who were mildly intellectually disabled (Sanders & Plant, 1989). This research established the core program as a 10-session individual intervention known as a Standard Triple P.

### Randomised efficacy trials

Following this initial research, a series of controlled outcome studies sought to improve the outcomes of standard parent training by systematically targeting other family risk factors such as marital discord and parental depression. Marital conflict has been shown to be a risk factor for the development of antisocial behaviour in children, particularly boys (Emery, 1982). Dadds, Schwartz and Sanders (1987) evaluated a brief, four session marital communication (partner support training) intervention to complement parenting skills training. This intervention involved teaching couples to support rather than to undermine or criticise each other. It also taught couples problem solving skills to resolve disagreements about parenting. In a controlled evaluation of this combined intervention, the provision of partner support training significantly improved outcome on both child and parent observational measures for families with marital discord, but not for parents without marital discord. This finding suggested that when child management problems are complicated by marital conflict, better longer term (6-month) outcomes for both child and parent are likely when marital communication is specifically targeted.

Another study sought to assess the effects of parent training with clinically depressed parents of oppositional children. Sanders and McFarland (2000) randomly assigned 47 mothers who met diagnostic criteria for either major depression or dysthymia to either a standard BFI condition or to an enhanced BFI condition. The enhanced condition provided additional treatment components that specifically targeted the mothers' depression, including mood monitoring, cognitive restructuring, and cognitive coping skills. Both the standard and the enhanced condition produced significant reductions in children's aversive behaviour and in mothers' mood at post-intervention. However, at 6-month follow-up more families in the enhanced condition (53%) compared to standard BFI (13%) experienced concurrent clinically reliable reductions in both maternal depression and child disruptive behaviour. These findings suggest that Triple P can be a viable treatment option for clinically depressed mothers.

A recent large scale randomised controlled trial compared the efficacy of three different variants of the Triple P intervention for a large sample of disruptive 3-year olds (Sanders, Markie-Dadds, Tully, & Bor, 2000). The parents of 305 preschoolers were considered to be high-risk for conduct problems on the basis of elevated rates of disruptive behaviour, high levels of parenting conflict, maternal depression, single parenthood status, or low

socioeconomic status. Parents were randomly assigned to either Standard Triple P (ST), Self-Directed Triple P (SD), Enhanced Triple P (EN) or to a waitlist control (WL) condition. The enhanced condition combined the partner support and coping skills interventions described previously to form a comprehensive adjunctive intervention for high-risk families. At post-intervention, the two therapist assisted conditions (ST and EN) produced similar improvements and were associated with significantly lower levels of observed and parent-reported disruptive child behaviour, lower levels of dysfunctional parenting, greater parental competence, and higher consumer satisfaction than self-directed or WL conditions. However, by 1-year follow-up children in all three Triple P variants had achieved similar levels of clinically reliable change in their disruptive behaviour. Parents in the therapist-assisted conditions however, were more satisfied in their parenting roles than parents in the SD condition.

This study showed, with a large sample of parents, that more is not always better than less. The provision of a generic enhanced family intervention should be reserved for those families who fail to make adequate improvement after standard BFI and who still have elevated scores on measures of adult psychosocial adjustment. It also raised the interesting possibility that self-directed program variants could be effective for some families. This issue has been examined more closely in a series of studies on self-directed interventions.

### Effects of self-directed variants

Not all parents are able to attend regular therapy sessions. This is a particular issue for parents living in rural and remote areas that are typically not well served with mental health facilities. Hence, the authors developed and evaluated a variant of the program, which could be used as a self-directed intervention with weekly telephone contact. Connell, Sanders and Markie-Dadds (1997) randomly allocated 24 families living in rural areas to either a self-directed program which combined self-help materials and back up telephone consultation or a waitlist control group. All families had a child aged between 2 and 5 years who were at risk for the development of disruptive behaviour problems. Telephone calls occurred once weekly for 10 weeks and ranged from 5 to 30 minutes (mean = 20 minutes). The calls prompted parents to use the self-help materials which included a copy of *Every Parent: A Positive Approach to Children's Behaviour* (Sanders, 1992a) and *Every Parent's Workbook* (Sanders, Lynch, & Markie-Dadds, 1994).

Following intervention, families in the enhanced self-directed condition showed significantly lower levels of disruptive child behaviour, lower levels of coercive parent behaviour, greater parenting competence and reduced levels of depression and stress when compared to families in the waitlist condition. At post-intervention, 100% of children in the waitlist group and 33% of children in the intervention condition were in the clinical range for disruptive behaviour. There was a high level of parent satisfaction with the intervention for both mothers and fathers (Connell, Sanders, & Markie-Dadds, 1997). These findings demonstrated that a brief, largely self-directed version of Triple P can be effective with families that traditionally have had little access to mental health services.

Two other studies examined the effectiveness of the self-directed variants of Triple P for parents of preschool-aged children with oppositional behaviour problems.

Markie-Dadds and Sanders (in preparation) randomly assigned 64 parents with a child aged between 2- and 5-years to either the self-directed program or to a waitlist control group. All parents were concerned about their child's behaviour. Parents in the self-directed condition received a copy of the same parenting materials as used in Connell et al., (1997), and completed the program at home over a 10-week period. At post-intervention, parents in the self-directed program used less coercive parenting practices than parents in the waitlist group. Children in the self-directed condition were rated by their parents as having a significantly lower level of disruptive behaviour than children in the control group at post-intervention. Improvements obtained in the self-directed group were maintained over a 6-month follow-up period. Mothers in the self-directed condition reported significantly lower levels of problem behaviour at both post-intervention and at 6-months follow-up compared to the waitlist control group.

Markie-Dadds and Sanders (in preparation) compared the effects of three intervention conditions: written information alone (standard self-directed), written information plus telephone counselling (enhanced self-directed) and waitlist control group. Forty-five families with a child aged between 2- and 5-years who were at risk for the development of behavioural problems participated in the program. Results indicated that the combined self-directed and telephone backup condition produced more positive outcomes for parents and children in comparison with both the standard self-directed program and waitlist group, on measures of child disruptive behaviour.

These findings show that while the standard self-directed program was effective with some families its effects could be enhanced by the provision of brief telephone calls using a self-regulatory framework which encouraged parents to take control of the learning process.

### Evaluation of Group Triple P

Continuing concern about mental health costs has led to the search for more cost-efficient ways of delivering family interventions within a population level prevention framework. Several studies have shown that parent training administered in groups could be successful (e.g., Cunningham, 1996). The group version of Triple P (Turner, Markie-Dadds, & Sanders, 1997) was first evaluated in a large-scale population trial involving 1673 families in East Perth, Western Australia. Preliminary data from this trial showed that parents in the geographical catchment area which received the intervention reported significantly greater reductions on measures of child disruptive behaviour than parents in the non-intervention comparison group (Williams, Silburn, Zubrick, & Sanders, 1997). Prior to intervention 42% of children had levels of disruptive behaviour in the clinical range. Following participation in Group Triple P, the level of children's disruptive behaviour had reduced by half to 20%. Participation in the group program also resulted in significant reductions in dysfunctional parenting practices, marital conflict, parental stress and depression, as well as significant improvements in marital satisfaction.

The robustness of these findings is being tested in three further large-scale population replication trials in Sydney, Braunschweig in Germany, and Brisbane in Queensland.

### Effects of the media

Evidence that parents can benefit from self-help variants of Triple P raised the further possibility that the mass media could be used to teach parenting skills. Research by Webster-Stratton (1994) had previously shown that video-modelling could be effective in teaching parenting skills to parents of conduct problem children. However, no studies have specifically examined the impact on parent-child interaction of a universal popular television series as a medium for parent training.

We have recently completed a study evaluating the *Families* television series as an intervention for parents of young children. This 13-episode series included a weekly segment on Triple P. Fifty-six parents of preschool-aged children were randomly assigned either to a TV viewing condition or to a no intervention control group (Sanders, Montgomery, & Brechman-Toussaint, 2000). All 13 episodes were viewed through the medium of videotapes over a 6-week period rather than live to air, as the program was not shown in Australia when it originally went to air in New Zealand. Hence, the outcome data from this study reflects the effects of a media intervention under relatively ideal conditions of viewing (i.e. parents watched all episodes, and back up Triple P fact sheets were provided for each episode). Only parents in the TV viewing condition reported a significant reduction in disruptive behaviours, an increase in parenting confidence, a decrease in dysfunctional parenting practices, and high overall levels of consumer satisfaction with the program.

These findings showed that a media intervention could affect changes in parenting practices and therefore children's behaviour. Such findings are consistent with other research by Webster-Stratton (1994) that has demonstrated the benefits of showing parents videotape models of parenting skills as an intervention with oppositional children.

### Effects of primary care interventions

At the time of writing, two randomised controlled trials are in progress involving primary care nurses in the implementation of either Level 2 or Level 3 interventions, as well as one study evaluating the effectiveness of training general medical practitioners to provide Triple P Levels 2 and 3 consultation advice to parents. Although there have been no controlled evaluations of Level 3 interventions there have been several brief intervention studies targeting discrete problems such as sleep disturbance, feeding difficulties, and habit disorders which have used similar interventions in a brief consultation format (Christensen & Sanders, 1987; Dadds, Sanders, & Bor, 1984; Sanders, Bor, & Dadds, 1984). The trials in progress described in the previous section when completed will provide a clearer basis for determining who responds to which level of intervention.

### Other related family intervention research

Although the BFI methods used in Triple P have been applied primarily with children with conduct problems, several other projects have used similar family intervention methods with other problems. For example, Lawton and Sanders (1994) described the adaptation of BFI for parents living in step-families. Nicholson and Sanders (1999) randomly assigned 42 step-families to either therapist directed BFI, self-directed BFI or to a waitlist condition. There were no differences between the therapist and the

**Table 3. Behavioural Family Intervention Outcomes from Group Design Studies in the Triple P Research Series**

Authors	Method / Population	Sample Size (attrition at post)	Age Range (yrs)	Measures	Outcomes
Sanders and Christensen (1985)	RCT comparing Child Management Training (without Planned Activities Training) and Standard Triple P. Parents of children with oppositional behaviour	20 (CMT nil) (ST nil)	2–7	Child disruptive behaviour and parent-child interaction	Both interventions were associated with significant reductions in observed child disruptive behaviour and mother aversive behaviour and increased use of targeted parenting strategies in all observation settings. Results were maintained at 3-month follow-up. At follow-up, rates of disruptive child behaviour were not significantly different from a group of non-problem controls.
Christensen and Sanders (1987)	RCT comparing Habit Reversal, Differential Reinforcement of Other Behaviour and a waitlist control. Children with thumb-sucking behaviour and their parents	30 (HR nil) (DRO nil) (WL nil)	4–9	Child thumbsucking and disruptive behaviour	Both interventions effectively reduced thumb-sucking in a training setting and two generalisation settings, and intervention effects were maintained at 3-month follow-up. No changes were observed in the WL controls. However, both interventions were associated with some temporary increases in disruptive child behaviour and elimination rates were low.
Dadds, Schwartz and Sanders (1987)	Group design with crossed factors of marital type and intervention type, evaluating Standard Triple P and Standard Triple P with a partner support module. Parents of children with oppositional defiant disorder or conduct disorder (split according to relationship discord)	24 (ST nil) (ST+PS nil)	2–5	Child disruptive behaviour, parent-child interaction, and relationship satisfaction	All groups showed a significant improvement on observed and parent-reported disruptive child behaviour, and observed mother implementation of targeted strategies and aversive parenting. A relapse effect was found for parents with relationship discord who received only the standard program without partner support training. The partner support training added little to the maintenance of change for parents without relationship distress, however it produced gains over Standard Triple P for the discordant group. There was an increase in marital satisfaction for all parents following intervention, although by follow-up this had relapsed for mothers and fathers in the distressed group who did not receive partner support training.
Sanders, Rebgetz, Morrison, Bor, Gordon, Dadds and Shepherd (1989)	RCT comparing Cognitive Behavioural Family Intervention and a waitlist control. Children with recurrent abdominal pain and their parents	16 (Int nil) (WL nil)	6–12	Child pain intensity, adjustment, parent-child interaction, and parent and teacher observations of pain behaviour	The intervention group reduced their self-reported levels of pain and mother observed pain behaviour quickly, with significant decreases occurring in phase 2 of the intervention (working directly with the child on coping strategies). Both groups had improved significantly on pain measures by 3-month follow-up. However, intervention group effects also generalised to the school setting, and a significantly larger proportion were completely pain free by follow-up. Both groups also showed decreases in parent-reported disruptive behaviour, which maintained at follow-up. No effects were found for observed mother or child behaviour, although baseline levels of observed disruptive child behaviour approximated those of a normal comparison group.
Sanders, Shepherd, Cleghorn and Woolford (1994)	RCT comparing Cognitive Behavioural Family Intervention and Standard Pediatric Care. Children with recurrent abdominal pain and their parents	44 (Int 11%)	7–14	Child pain intensity, adjustment, and parent observations of pain behaviour	Both intervention conditions resulted in significant improvements on measures of pain intensity and pain behaviour, which maintained at 6- and 12-month follow-up. Children receiving BFI had higher rates of complete elimination of pain, lower levels of relapse at follow-up assessments and lower levels of interference with usual activities due to pain. Significant improvements on measures of child adjustment were found for both conditions, which maintained at both follow-up assessments.

Turner, Sanders and Wall (1994)	RCT comparing Behavioural Parent Training and Standard Dietary Education. Parents of children with persistent feeding problems	21 (BPT nil) (SDE 11%)	1–5	Child dietary intake, anthropometrics, mealtime behaviour, disruptive behaviour, parent-child mealtime interaction, parenting confidence, and parental adjustment	Children in both intervention conditions showed significant improvements on observed and home mealtime behaviour. There was a significant increase in observed positive mother-child interaction at mealtimes in the Behavioural Parent Training group only. Results were maintained at 3-month follow-up. At follow-up, children in both conditions also showed a significant increase in the variety of foods eaten. No changes were observed on measures of children's weight or height for age, or measures of child or parent adjustment.
Connell, Sanders and Markie-Dadds (1997)	RCT comparing Enhanced Triple P (for stepfamilies), Enhanced Self-Directed Triple P and a waitlist control. Parents and stepparents of children with oppositional defiant disorder or conduct disorder	60 (EN 36%) (SD 43%) (WL 6%)	7–12	Child disruptive behaviour and adjustment (depression, anxiety, self-esteem), and parenting conflict	No differences were found between the therapist-directed and self-directed programs. Children in the intervention groups showed significant reductions in parent reported disruptive child behaviour (with smaller changes for the waitlist group on one measure only). Significant reductions in parenting conflict were reported by parents and stepparents in the intervention conditions only. All children showed reductions in anxiety and increases in self-esteem.
Sanders, Markie-Dadds, Tully and Bor (2000)	RCT comparing Standard Triple P, Self-Directed Triple P, Enhanced Triple P and a waitlist control. Parents of children with clinically elevated disruptive behaviour, and at least one family adversity factor (e.g. low income, maternal depression, relationship conflict, single parent)	305 (ST 17%) (SD 19%) (EN 24%) (WL 8%)	3	Child disruptive behaviour, parent-child interaction, parenting style and confidence, parental adjustment, parenting conflict and relationship satisfaction	Children in the three intervention conditions showed greater improvement on mother-reported disruptive behaviour than the WL control, however only those in the Enhanced Triple P and Standard Triple P conditions showed significant improvement on observed disruptive child behaviour and father reports. Parents in the two practitioner assisted programs also showed significant reduction in dysfunctional parenting strategies (self-report) for both parents. No intervention effects were found for observed mother negative behaviour toward the child or for parent adjustment, conflict or relationship satisfaction. Mothers in all three intervention conditions reported greater parenting confidence than controls. At 1-year follow-up, children receiving Self-Directed Triple P had made further improvements on observed disruptive behaviour and all intervention groups were comparable on measures of child behaviour and parenting style.
Sanders and McFarland (2000)	RCT comparing Standard Triple P and Enhanced Triple P. Parents of children with oppositional defiant disorder or conduct disorder, and mothers with major depression	47 (ST 21%) (EN 13%)	3–9	Child disruptive behaviour, parent-child interaction, parenting confidence and parental adjustment	Both interventions were effective in reducing observed and parent reported disruptive child behaviour, as well as mothers' and fathers' depression. Both interventions also significantly increased parental confidence. Intervention results were maintained at 6-month follow-up, with more mothers in the Enhanced Triple P intervention experiencing concurrent clinically reliable reductions in disruptive child behaviour and maternal depression.
Sanders, Montgomery and Brechman-Toussaint (2000)	RCT comparing Triple P television segments (12 episodes) and a waitlist control. Parents reporting concerns about disruptive child behaviour	56 (Int nil) (WL nil)	2–8	Child disruptive behaviour, parenting style and confidence, parental adjustment and parenting conflict	Mothers in the television intervention condition reported significantly lower levels of disruptive child behaviour and higher levels of parenting confidence than controls following intervention. No changes were found on parenting strategies, conflict or parental adjustment. Results for the intervention group were maintained at 6-month follow-up.

Authors	Method / Population	Sample Size (attrition at post)	Age Range (yrs)	Measures	Outcomes
Bor, Sanders and Markie-Dadds (2002)	RCT comparing Standard Triple P, Enhanced Triple P and a waitlist control. Parents of children with co-morbid significantly elevated disruptive behaviour and attention problems	87 (ST 28%) (EN 42%) (WL 16%)	3	Child disruptive behaviour, parent-child interaction, parenting style and confidence, parental adjustment, parenting conflict and relationship satisfaction.	Both intervention programs were associated with significantly lower parent-reported child behaviour problems and dysfunctional parenting and significantly greater parenting confidence than the WL condition. Enhanced Triple P was also associated with significantly less observed disruptive child behaviour than the WL condition. Results were maintained at 1-year follow-up. Both interventions produced significant reductions in children's co-morbid disruptive behaviour and attention problems.
Hoath and Sanders (2002)	RCT comparing Enhanced Group Triple P (targeting ADHD characteristics) and a waitlist control. Parents of children with clinically diagnosed ADHD	21 (GR-ADHD 10%) (WL nil)	5-9	Child disruptive behaviour and attention problems, parenting style, parental adjustment, parenting conflict and relationship satisfaction.	Parents in the intervention condition reported significant reductions in intensity of disruptive child behaviour and aversive parenting practices, and increases in parental self-efficacy in comparison to controls. There was also a high level of parental satisfaction with the intervention. No condition effect was found for parent or teacher reports of child inattention, teacher reports of disruptive behaviour, or for parental adjustment, parenting conflict or relationship satisfaction. Post-intervention gains in child behaviour and parenting practices were maintained at 3-month follow up.
Ireland, Sanders and Markie-Dadds (2003)	RCT comparing Group Triple P and Group Triple P with a partner support module. Couples with concerns about disruptive child behaviour and concurrent clinically elevated marital conflict	44 (GR 14%) (GR+PS 22%)	2-5	Child disruptive behaviour, parenting style, parental adjustment, parenting conflict, relationship satisfaction, and communication	Both interventions were associated with significant improvements in parent-reported disruptive child behaviour, dysfunctional parenting strategies, parenting conflict, relationship satisfaction and communication. Treatment effects were generally maintained at 3-month follow up. For some measures, Group Triple P effects were achieved by follow-up rather than post assessment. No differences were found on parent adjustment measures.
Leung, Sanders, Leung, Mak, and Lau (2003)	RCT comparing Group Triple P and a waitlist control. Chinese parents reporting concerns about disruptive child behaviour.	91 (GR 28%) (WL 20%)	3-7	Child disruptive behaviour, parenting style and confidence, parenting conflict and relationship satisfaction.	Parents in the intervention condition reported significantly lower levels of disruptive child behaviour, dysfunctional parenting and parenting conflict, and higher levels of parenting efficacy and satisfaction, and relationship satisfaction at post-assessment than those in the waitlist condition.
Martin and Sanders (2003)	RCT comparing Group Triple P designed for workplace delivery and a waitlist control. Working parents of children with clinically elevated disruptive behaviour, with significant distress balancing work and home demands.	39 (GR-WP 30%) (WL 31%)	2-9	Child disruptive behaviour, parenting style and confidence, parental adjustment, social support, work stress and efficacy and job satisfaction.	Parents in the intervention condition reported significantly lower levels of disruptive child behaviour and dysfunctional parenting, and higher levels of parenting efficacy and work efficacy at post-assessment than those in the waitlist condition. No condition effect was found for parental adjustment, social support, work stress or job satisfaction. Results maintained at 4-month follow-up, with further improvements evident on parenting, parental adjustment and work stress.
Sanders, Pidgeon, Gravestock, Connors, Brown and Young	RCT comparing Group Triple P and Group Triple P with an attribution retraining and anger management module. Parents notified for child	98 (GR 8%) (GR+AM 16%)	2-7	Risk of maltreatment, parenting style and confidence, parental adjustment and parenting conflict, and	Parents in both intervention conditions showed significant improvements across all risk indicators, as well as parenting style and confidence, parental adjustment and parenting conflict, and child disruptive behaviour. Parents in the enhanced condition showed greater improvements than those in Group Triple P on potential for child abuse and unrealistic expectations. No other

(2003)	abuse or neglect, or concerned about their anger or harming their child.			child disruptive behaviour.	condition differences were found. Results maintained at 6-month follow-up, with further improvements for the Group Triple P condition on unrealistic expectations.
Markie-Dadds and Sanders (in prep)	RCT comparing Self-Directed Triple P and a waitlist control. Parents of children with clinically elevated disruptive behaviour	63 (SD 28%) (WL 23%)	2–5	Child disruptive behaviour, parenting style and confidence, parental adjustment, and parenting conflict	Self-Directed Triple P was associated with significantly lower levels of disruptive child behaviour and dysfunctional parenting strategies, and significantly higher parenting confidence in comparison to WL controls. No differences were found on parent adjustment measures. Intervention results were maintained at 6-month follow-up, with the exception of parenting confidence, which had decreased significantly from post.
Markie-Dadds and Sanders (in prep)	RCT comparing Self-Directed Triple P, Self-Directed Triple P with telephone sessions, and a waitlist control. Parents of children with clinically elevated problem behaviour living in rural areas	41 (SD nil) (SD+T 7%) (WL nil)	2–6	Child disruptive behaviour, parenting style and confidence, parental adjustment, and parenting conflict	Both interventions were associated with significantly lower levels of mother-reported disruptive child behaviour in comparison to WL controls, with the telephone-assisted group significantly more improved than the standard group. Significantly less dysfunctional parenting (laxness) and higher parental confidence were evident in the telephone-assisted group in comparison to SD and WL. No differences were found on measures of parent adjustment or parenting conflict. Results for the telephone-assisted condition were generally maintained at 6-month follow-up.
McTaggart and Sanders (in prep)	RCT comparing Universal Triple P and Group Triple P delivered in schools with waitlist control schools. Parents of children in Year 1 (teacher reports also obtained).	985 teacher reports (71% of pop'n)* 423 parents (30% of pop'n)*	5–6	Teacher reports of child behaviour, parent reports of child behaviour, parenting style and confidence, parental adjustment and relationship satisfaction.	In intervention schools, teachers reported significant decreases in disruptive child behaviour which maintained at 6-month follow-up, while control school teachers reported increases in disruptive behaviour at post-test. Parents attending the groups reported higher levels of disruptive child behaviour at pre-test than parents receiving the Universal intervention, however no condition effect was found at post-test or 6-month follow-up (a time effect was found for the group participants by follow-up). Significant and reliable change was found for parents in the Group Triple P condition on parenting style (laxness and verbosity) and efficacy in comparison to Universal intervention (newsletters) and the waitlist control condition. No effect was found for parental adjustment or relationship satisfaction.
Ralph and Sanders (in prep)	Non-random matched sample design comparing Group Teen Triple P in one high school with a wait-list control school. Parents of first year high school children	67 (GR 30%) (WL nil)	12–13	Teen behavioural strengths and difficulties, parent-teen conflict, parenting style, conflict and relationship satisfaction, and parental adjustment	Analyses of parent self-report data collected before and after the groups revealed significant improvements in parenting efficacy and style, reductions in conflict between parent and teenager, and reductions in parental anxiety, depression and stress. Parents in the group intervention condition reported significantly more positive experiences and fewer problem behaviours at 12-month follow-up relative to matched parents in the wait-list condition.
Sanders, Turner and Wall (in prep)	RCT comparing Behavioural Parent Training, Nutrition Education and a waitlist control. Parents of children with persistent feeding problems	56 (BPT 16%) (NE 4%) (WL nil)	1–7	Child dietary intake, anthropometrics, mealtime behaviour, disruptive behaviour, and parent-child mealtime interaction, and parental perception of the child's eating problem	Children in the BPT group showed significant increases in weight for age and height for age and decreases in some observed problem mealtime behaviours in comparison to the NE and waitlist conditions. Children in both intervention conditions showed a significant increase in the variety of foods eaten and significant decreases in mothers' ratings of the severity of the child's eating problem. All children increased their energy intake over time. No changes were found for mothers' mealtime behaviour or child general adjustment. At 6-month follow-up, children in the BPT condition maintained their significant increase in weight for age, and mothers reported significant decreases in disruptive mealtime behaviour at home.

Authors	Method / Population	Sample Size (attrition at post)	Age Range (yrs)	Measures	Outcomes
Sultana, Matthews, De Bortoli and Cann (in prep)	RCT comparing Selected Triple P, Primary Care Triple P and a waitlist control. Parents with concerns about discrete child behaviour problems	50 (SE nil) (PC nil) (WL 38%)	1–5	Child disruptive behaviour, parenting style, and parental adjustment	Parents in the Primary Care Triple P condition reported significantly fewer child behaviour problems and dysfunctional parenting strategies than the WL controls. Moderate positive changes in child and parent behaviour were found for Selected Triple P, however these did not differ significantly from controls. No differences were found on parent adjustment measures. Results for the intervention groups were maintained at 4-month follow-up.
Turner and Sanders (in prep)	RCT comparing Primary Care Triple P and a waitlist control. Parents of children with discrete child behaviour problems or developmental concerns	30 (PC 19%) (WL 14%)	2–5	Child disruptive behaviour, parenting style, parental adjustment, parenting conflict and relationship satisfaction.	In comparison to the waitlist condition, families receiving the intervention showed a significant reduction in targeted child behaviour problem/s according to monitoring and mother-report. Mothers receiving the intervention also reported significantly reduced dysfunctional parenting practices, greater satisfaction with their parenting role, and decreased anxiety and stress following the intervention in comparison to waitlist mothers. No group differences were found for observed parent-child interaction. However, rates of observed disruptive child behaviour and aversive parent behaviour were low from the outset. Consumer satisfaction with the program was high, and intervention gains were primarily maintained at 6-month follow-up.
Zubrick, Northey, Silburn, Williams, Blair, Robertson, and Sanders (in prep)	Non-random two-group concurrent prospective observation design evaluating Group Triple P in one high-risk health region with a comparable region as control. All parents of children in the age-range	1,615 (GR 11%) (CON 4%)	3–4	Child disruptive behaviour, parenting style, parental adjustment, parenting conflict and relationship satisfaction	Intervention group parents had significantly higher pre-intervention levels of dysfunctional parenting strategies, which decreased significantly following intervention and although slightly increased, remained lower at 12- and 24-month follow-up than control parents who showed a gradual decline in dysfunctional parenting over time. Children in the intervention group showed significant decreases in parent-reported disruptive child behaviour following intervention, which maintained at 12- and 24-month follow-up. Two years following intervention, there was a 37% decrease in prevalence of child behaviour problems in the intervention region. Although poorer than controls at pre, parental adjustment (depression, anxiety and stress) and marital adjustment also improved significantly for intervention families. This was maintained at 12- but not 24-month follow up. The same pattern was found for parenting conflict.

**Note.**  
RCT = randomised controlled trial; CMT = Child Management Training or Standard Triple P (Level 4) without Planned Activities Training; ST = Standard Triple P (Level 4); HR = Habit Reversal; DRO = Differential Reinforcement of Other Behaviour; WL = Waitlist; PS = Level 5 Partner Support Module; Int = Intervention as detailed; CMT = Child Management Training or Standard Triple P (Level 4) without Planned Activities Training; PAT = Planned Activities Training; Con = Control; BPT = Behavioural Parent Training (re mealtime management); SDE = Standard Dietary Education; EN = Enhanced Triple P (Level 5); SD = Self-Directed Triple P (Level 4); GR-ADHD = Group Triple P targeting attention-deficit hyperactivity disorder symptoms; GR = Group Triple P (Level 4); GR+PS = Group Triple P plus Level 5 Partner Support Module in group format; SD = Self-Directed Triple P (Level 4); SD+T = Self-Directed Triple P plus telephone consultations; SE = Selected Triple P (Level 2); PC = Primary Care Triple P (Level 3); NE = Nutrition Education; GR+AM = Group Triple P plus Attribution Retraining and Anger Management Module;

\*Indicates participation rate not attrition.

self-directed BFI conditions on measures of child problem behaviour. Compared to control families, families receiving BFI reported significantly greater reductions from pre- to post-intervention in couple conflict over parenting, and were more likely to show clinically significant and statistically reliable change on a range of family and child measures.

Another series of studies has focused on the application of BFI methods to children with recurrent abdominal pain (Sanders, Shepherd, Cleghorn, & Woolford, 1994), and persistent feeding difficulties (Turner, Sanders, & Wall, 1994). It is beyond the scope of this paper to review this work, other than to highlight the versatility of a family intervention model that can be applied to a diverse range of clinical problems.

The major research findings from group trials in the Triple P system to date are detailed in Table 3. In summary, this research shows that when parents change problematic parenting practices, children experience fewer problems, are more cooperative, get on better with other children, and are better behaved at school. Parents have greater confidence in their parenting ability, have more positive attitudes toward their children, are less reliant on potentially abusive parenting practices, and are less depressed and stressed by their parenting role. The interested reader is referred to Sanders (1999) for a thorough review of the empirical basis of Triple P.

Inspection of Table 3 shows the progression of the evidence base from efficacy trials to effectiveness trials and, finally, to studies examining the dissemination of the program. The approach to evaluation to date has been to evaluate each level of intervention and different delivery modalities within levels. These outcome studies have included both efficacy trials conducted within a University clinical research setting (e.g., Sanders & McFarland, 2000) and effectiveness trials conducted within regular health services in the community (e.g., Zubrick et al., 2002).

Evaluation of the program for parents of teenagers is currently focused on the effectiveness of parenting groups aimed at reducing difficulties encountered at the transition to high school. An effectiveness trial evaluating the full implementation of the multilevel system with tracking of population level outcomes will be the ultimate test of the benefits of the population approach advocated. Such an evaluation trial is being planned at time of writing. Our current research activity also includes studies evaluating the efficacy our approach to the dissemination of Triple P into regular clinical services.

### SUMMARY

There is now encouraging evidence that Triple P is an effective parenting strategy according to the following criteria:

1. **Replicability of findings:** There has been a consistent finding across many studies which shows that parenting skills training used in Triple P produces predictable decreases in child behaviour problems, which have typically been maintained over time. Furthermore, several studies show that these improvements in child behaviour are also paralleled by improvements in parents', particularly mothers', adjustment. The primary treatment effects on child and family functioning have been replicated several times in different studies involving different research teams.

2. **Clinically meaningful outcomes for families:** Clinically meaningful and statistically reliable outcomes for both children and their parents have been demonstrated for the standard, self-directed, telephone-assisted, group and enhanced BFI interventions.
3. **Effectiveness of different levels of intervention:** The proposition that parenting skills programs at differing levels of intensity can be effective has been supported. Further evidence on the effects of brief and universal interventions is being documented in ongoing studies.
4. **Consumer acceptability:** Participation in Triple P as either an individual or group intervention is typically associated with high levels of consumer acceptance and satisfaction.
5. **Effectiveness with a range of family types:** The program has been successfully used for several different family types including two-parent families, single parents, step-families, maternally depressed families, maritally discordant families, and families with a child with an intellectual disability.

### PRINCIPLES OF EFFECTIVE PARENT CONSULTATION

Reports of clinical trials documenting the effects of parenting and family intervention programs often mask the complexity of the therapeutic process issues involved in successful family intervention. In addition to relevant theoretical and conceptual knowledge on family relationships, psychopathology, life long human development, principles and techniques of behaviour, and attitude and cognitive change, practitioners must be interpersonally skilled. They require well-developed communication skills, with advanced level training in the theory and principles of family intervention. In this section, several principles that optimise the effectiveness of parenting interventions are proposed.

#### **Parenting interventions should empower families**

Interventions should aim to enhance individual competency and the family's ability as a whole to solve problems for themselves. In most (but not all) instances, families will have a lesser need for support over time.

#### **Parenting interventions should build on existing strengths**

Successful interventions build on the existing competencies of family members. It is assumed that individuals are capable of becoming active problem solvers, even though their previous attempts to resolve problems may not have been successful. This may be due to lack of necessary knowledge, skills, or motivation.

#### **The therapeutic relationship is an important part of effective family intervention**

Regardless of theoretical orientation, most family intervention experts agree that the therapeutic relationship between the clinician and relevant family members is critical to successful long-term outcomes (Patterson & Chamberlain, 1994; Sanders & Lawton, 1993). Clinical skills such as rapport building, effective interviewing and communication skills, session structuring, and the development of empathic, caring relationships with family members are important to all forms of family intervention. Such skills are particularly important in face to face programs, but are also important in models of counselling that involve brief or minimal contact, including telephone

counselling or correspondence programs. Consequently, mental health professionals undertaking family intervention work need advanced level training and supervision in both the science and the clinical practice of family intervention.

### **The goals of intervention should address known risk variables**

Family interventions vary according to the focus or goals of the intervention. Interventions that have proven most successful address variables that are known to increase the risk of individual psychopathology. Some interventions focus heavily on behavioural change (e.g., Forehand & McMahon, 1981), whereas others concentrate on cognitive, affective, and attitude change as well (e.g., Sanders & Dadds, 1993; Webster-Stratton, 1994). The focus of the intervention depends greatly on the theoretical underpinnings and assumptions of the approach. However, a common goal in most effective forms of family intervention is to improve family communication, problems solving, conflict resolution, or parenting skills.

### **Intervention services should be designed to facilitate access**

It is essential that interventions are delivered in ways that increase access to services. Professional practices can sometimes restrict access to services. For example, inflexible clinic hours during 9am - 5pm may be a barrier to working parents' participation in family intervention programs. Family intervention consultations may take place in many different settings, such as in clinics or hospitals, family homes, kindergartens, preschools, schools, and worksites. The type of setting selected should vary depending on the goals of the intervention and the needs of the target group. Practitioners must become more flexible to allow better tailoring of services.

### **Family intervention programs should be timed developmentally to optimise impact**

The developmental timing of the intervention refers to the age and developmental level of the target group. Family intervention methods have been used across the life span including pre-birth, infancy, toddlerhood, middle childhood, adolescence, early adulthood, middle adulthood, and late adulthood. Developmentally targeted family interventions for particular problems may have a greater impact than if delivered at another time in the life cycle. For example, premarital counselling may be more effective in reducing subsequent relationship breakdown than a marriage enrichment program delivered after marital distress has already developed.

### **Parenting and family interventions can complement and enhance other interventions**

Family intervention can be an effective intervention in its own right for a variety of clinical problems. However, for other problems such as schizophrenia, bipolar disorder, depression, and learning difficulties, family intervention can be successfully combined with other interventions such as drug therapy, individual therapy, social and community survival skills training, classroom management, and academic instruction. Family intervention can complement other interventions for individuals by increasing compliance with medication, and by ensuring the cooperation and support of family members. Family intervention should be an integral component of comprehensive mental health services for all disorders.

### **Parenting interventions should be gender sensitive**

Family interventions have the potential to promote more equitable gender relationships within the family. Intervention programs may directly or indirectly promote inequitable relationships between marital partners by inadvertently promoting traditional gender stereotypes and power relationships that increase dependency and restrict the choices of women. Consequently, family intervention programs should promote gender equality.

### **Theories underlying family interventions should be scientifically validated**

Family interventions should be based on coherent and explicit theoretical principles that allow key assumptions to be tested. This extends beyond demonstrating that an intervention works, although that may be an important first step. It involves showing that the mechanisms purported to underlie improvement (specific family interaction processes) actually change and are responsible for the observed improvement, rather than other non-specific factors.

### **Parenting interventions should be culturally appropriate**

Family intervention programs should be tailored in such a way as to respect and not undermine the cultural values, aspirations, traditions and needs of different ethnic groups. There is much to learn about how to achieve this objective. However, there is increasing evidence from other countries that sensitively tailored family interventions can be effective with minority cultures (Myers et al., 1992).

### **Parenting interventions should be both child- and parent-centered**

Behavioural family interventions are sometimes criticised as being too adult centered with too great an emphasis on controlling children and compliance. Triple P seeks a balanced approach aiming to be both child- and parent-centered in approach by helping parents identify the skills and competencies their children need to learn and develop in a healthy manner (e.g., language skills, emotional self-regulation, independence and problem solving skills). Skills such as learning to be cooperative with others, and learning to be respectful of parental authority are not inherently adult-centred. For example, children with high levels of non-compliant behaviour often experience significant adjustment problems and difficulties at home, school and with peers. Valuing children's opinions, treating children respectfully, and respecting children's rights to a safe environment are quite consistent with promoting parental self-efficacy.

## **DISSEMINATION TO PROFESSIONALS**

Clinical researchers often lament the lack of uptake of empirically supported interventions by practitioners (Backer, Lieberman, & Kuehnel, 1986; Biglan, 1995; Fixsen & Blase, 1993). The effective dissemination of empirically supported interventions is of major importance to all prevention researchers, policy advisers and organisations involved in the provision of mental health and family intervention services. Obstacles to the utilisation of empirically supported interventions include the lack of reinforcement for clinical researchers to engage in dissemination activities, particularly when academic promotion depends on grants and publication rate. There are also significant practical obstacles to conducting controlled research into

dissemination itself including a lack of reliable and valid measures of practitioner uptake or resistance, and concerns regarding randomisation of practitioners or services to different conditions of dissemination. Some practitioners have also been critical of randomised clinical trial methodology which are portrayed as having little relevance, and because of the highly restrictive selection criteria which are typically used in trials, the elimination of comorbidity, the use of student therapists, and the reliance on manualised treatments which necessarily limit the extent of flexible tailoring that many practitioners value.

Notwithstanding these concerns, we have developed a nationally coordinated system of Triple P training and accreditation for practitioners in health, education and social welfare. This system is designed to promote program use, program fidelity and to support practitioners' use of the program through a national practitioner network. This network provides trained practitioners with access to consultation support and research updates on the scientific basis of the program. Other support services include a biannual newsletter (Triple P news), data management and scoring software, a media promotional kit to support the use of the program, a Triple P web site, and program consultation and evaluation advice. A National Scientific and Professional Advisory Committee advises on policy matters and helps to determine research priorities.

### DERIVATIVE PROGRAMS

Following the development of the core system for parents of children from birth to age 12, a number of derivative programs have also been developed to address the needs of parents of children with special needs. These include the following programs: the Pathways Positive Parenting Program (a version for parents at risk for child maltreatment); the Stepping Stones Positive Parenting Program (a version for parents of children with disabilities); Workplace Triple P (a version delivered through workplaces as an employee assistance strategy); Lifestyle Triple P (a version for parents of obese and overweight children); Teen Triple P (a version for parents of teenagers); and Indigenous Triple P (a version for Aboriginal parents). Each of these derivative programs is being subject to clinical trialling and evaluation to develop its own evidence base.

### CONCLUSIONS

The task of supporting parents is usefully conceived of as a process that begins with pregnancy and continues until children leave home and become fully independent adults. Parenting support needs to be viewed on a continuum whereby the informational needs of parents change as a function of the parents' experience and the child's developmental level. The strength or intensity of the intervention families require also may change as a function of life transitions (separation, divorce, repartnering, illness, loss, trauma and financial hardship). A universal parenthood program requires greater flexibility in how parenting programs are offered to parents. As the next generation of parenting programs evolve a strong commitment to the promotion of empirically supported parenting practices is required. Little progress is likely until parenthood preparation is seen as a shared community responsibility.

The future development of Triple P will rest in part on the program's capacity to evolve in the light of new evidence concerning the strengths and limitations of the

model. Although Triple P has evolved as a comprehensive multi-level system of parenting and family support, which has been widely adopted in Australia the work is far from complete. Adaptations of the core program into different languages and the development of culturally appropriate versions for minorities such as indigenous parents and immigrant groups is required. A prospect of developing a comprehensive, high quality, empirically supported, multi-level, preventively-oriented, universal, freely accessible parenting support strategy remains the fundamental goal of Triple P. In order to achieve this ideal, research is required to identify responders to different delivery modalities, and to determine how to engage and maintain in intervention families which traditionally have been less likely to participate in parenting skills programs (fathers, indigenous parents). Parenting programs that are truly universal must also examine the parenting and family support needs of children with special needs such as children with disabilities, chronic or terminal illness, or those who have suffered neurological damage as a result of injuries.

Finally, tiered multi-level models of intervention such as Triple P have potential applications in many other areas of intervention research with children. For example, similar tiered strategies could be usefully employed in training programs for teachers in classroom management skills. As the range of alternative program delivery modalities increases families will have a wider range of choices in terms of how to access parenting support at different points in time. Continuing research is needed to determine the types of families and child problems that respond to the different levels of intervention, either alone or in combination with other interventions.

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