



## Triple P - Positive Parenting Program: A population approach to promoting competent parenting

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### Abstract

Family conflict and poor parenting are generic risk factors associated with a wide variety of adverse developmental outcomes in children including increased risk for conduct problems, drug abuse, delinquency and academic underachievement. This paper makes the case for a multi-level population based approach to the development of parental competence. Evidence is reviewed showing that while parenting interventions based on social learning approaches are effective, they have significant limitations in achieving a level of population reach that will do enough to decrease the prevalence of dysfunctional parenting. A case is made for a contextual approach targeting the media, primary care services, schools, and worksites as basic institutions within the community which can potentially support the task of disseminating more widely evidence-based approaches to parenting intervention. Evidence is reviewed for the efficacy and effectiveness of the Triple P-Positive Parenting Program as a comprehensive, multilevel system of parenting and family intervention. The evidence reviewed shows significant effects across several trials on both child and parent mental health outcomes. Challenges in disseminating empirically supported interventions and possible future directions for family intervention research are discussed.

### Keywords

*Prevention, population, health, parent training, family intervention*

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### Introduction

There is widespread concern amongst parents about the behavioural and emotional problems of their children and youth. Australian prevalence surveys show between 14-18% of children and adolescents show significant behavioural and emotional problems (Sawyer, Arney, Baghurst et al., 2000; Zubrick, Silburn, Garton et al., 1995). The recent report *The mental health of young people in Australia: The child and adolescent component of the National survey of mental health and well-being* (Sawyer et al., 2000) found that 14% of children and adolescents in

Australia have mental health problems, with similar results to earlier surveys. The Queensland Health survey conducted in 1996 of 1218 parents revealed that 25% of parents reported that their child's behaviour was moderately to extremely difficult and 28% perceived that their eldest child, less than 12 years, had an emotional or behavioural problem in the last 6 months (Sanders, Tully, Baade et al., 1999).

Epidemiological studies indicate that family risk factors such as poor parenting, family conflict, and marital breakdown are powerful early

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predictors for the development and maintenance of behavioural and emotional problems in children and adolescents (eg. Cummings & Davies, 1994; Dryfoos, 1990; Robins & Price, 1991). Specifically, 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 and high levels of parenting stress), increase the risk that children develop major behavioural and emotional problems, including conduct problems, substance abuse, antisocial behaviour, and participation in delinquent activities (e.g., Coie, 1996; Loeber & Farrington, 1998; Patterson, 1982).

In contrast, supportive family relationships have been shown to be a significant predictor of positive adjustment in childhood and adolescence, and indirect evidence suggests that supportive family relationships are a protective factor for conduct problems and adolescent adjustment problems (Cauce, Reid, Landesman & Gonzales, 1990; Cohen & Wills, 1985; Collins, 2000; Wills, Vaccaro & McNamara, 1992).

### **The need for large scale parenting interventions**

Partly in response to this concern about children and the prevalence of various family risk factors in the community, greater attention is being given to the importance of better preparation for parents to undertake their role in raising children. Parents generally receive little preparation beyond the experience of having been parented themselves, with most learning on the job through trial and error. However, only a minority of parents participate in parent education programs and the more disadvantaged the parent the less likely they are to participate and the more likely they are to drop out (Sanders, Tully, et al., 1999).

The challenge is to develop intervention strategies at a population level that can enhance the competence and confidence of parents in raising their children. If this were to be achieved

it is argued that there would be a reduction in the prevalence of behavioural and emotional problems in children and adolescents.

A comprehensive population based strategy is required. This strategy needs to be designed to enhance parental competence, prevent dysfunctional parenting practices, promote better teamwork between partners and thereby reduce an important set of family risk factors associated with behavioural and emotional problems in children. In order for such a population approach to be effective several scientific and clinical criteria need to be met (Taylor, 1999):

*Knowledge of the prevalence and incidence of child outcomes being targeted.* A number of studies in the US, Canada, United Kingdom, New Zealand, Germany and Australia have established the prevalence rates of behavioural and emotional problems in children, showing that about 18% of children experience behavioural or emotional problems (eg. Zubrick et al., 1995). Parents themselves report a high level of concern about their child's behaviour and adjustment. For example, in a recent epidemiological survey of Queensland parents, when asked 'Do you consider your child to have a behavioural or emotional problem?' 28% said yes (Sanders, Tully et al., 1999), reflecting the high degree of parental concern about children.

*Knowledge of the prevalence and incidence of family risk factors.* Some studies which have established the incidence and prevalence of child behaviour problems have also examined parenting practices, disciplinary styles and marital conflict. For example, 70% of parents under the age of 12 years reported they smack their children at least occasionally, 3% reported hitting their child with an object other than their hand, and 25% of parents reported significant disagreements with partners about parenting issues (Sanders, Tully et al., 1999).

*Knowledge that changing specific family risk and protective factors leads to a reduction in the incidence and prevalence of the target problem.* An effective population level parenting strategy must make explicit the kinds of parenting practices that are considered harmful to children. The core constructs believed to underpin

competent parenting need to be articulated so that targets for intervention can be specified. The validity of any model of family intervention would be greatly strengthened if improvements in child functioning were shown to be directly related to the specific changes specified by the model, such as decreased dysfunctional and increased competent parenting variables. For example, there is now considerable evidence to support the proposition that teaching parents positive parenting and consistent disciplinary skills results in significant improvements in the majority of oppositional and disruptive behaviours in children, particularly young children, attesting to the importance of reducing coercive patterns of parent-child interaction (Patterson, 1982; Taylor & Biglan, 1998; Webster-Stratton & Hammond, 1997).

*Having effective family interventions.* A population perspective requires a range of effective family interventions to be available. Family interventions must also be subjected to comprehensive and systematic evaluation with rigorous scientific controls using either intrasubject replication designs or traditional, randomized, controlled clinical trials with sufficient statistical power to detect meaningful differences between intervention and control conditions. To be effective a family intervention strategy should demonstrate that short-term intervention gains maintain over time, are cost effective relative to no intervention, alternative interventions or usual community care, and are associated with high levels of consumer satisfaction and community acceptance. It is not sufficient just to demonstrate that a strategy results in improvements in family interaction based exclusively on parental reports, although this is a necessary first step. The mechanisms purported to underlie the improvements in family interaction must also be demonstrated to change and be responsible for the observed improvements.

*Family interventions must be culturally appropriate.* An effective population strategy should be tailored in such a way that it is accessible, relevant and respectful of the cultural values, beliefs, aspirations, traditions and identified needs of different ethnic groups. Factors such as family structure, roles and

responsibilities, predominant cultural beliefs and values, child raising practices and developmental issues, sexuality and gender roles may be culturally specific and need to be addressed. While there is much to learn about how to achieve this objective in a multicultural context, sensitively tailored parenting programs can be effective with a variety of cultural groups. It is important that the multicultural context within which assessment, intervention and research programs operate is made clear in evaluations. There is an ethical imperative to ensure that interventions designed to empower parents and children in the community's dominant culture are not at the expense of language and other competencies or values in the family's own culture.

*Interventions need to be widely available.* A key assumption of a population based approach is that parenting and other family intervention strategies should be widely accessible in the community. It is important that barriers to accessing parenting and other family intervention programs are reduced. Inflexible clinic hours may prevent working parents from participating in parenting programs. Families most in need of help with emotional and behavioural problems often do not have or seek access to support services. Families who are socially, economically or geographically disadvantaged are less likely to refer themselves for help. In addition, the family intervention services may be viewed as coercive and intrusive, rather than helpful. Use of the internet, CD rom based applications and media interventions all have the potential to increase the reach of interventions to hard to access groups, however such approaches require systematic evaluation.

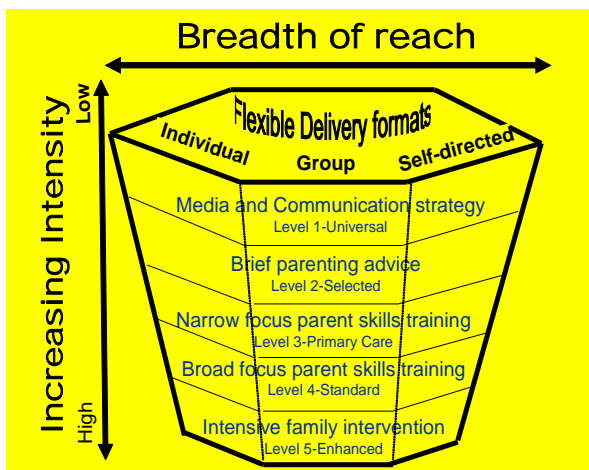
### **An ecological approach to supporting better parenting**

In order to achieve a significant improvement in parenting competence a population health perspective is needed. The concept of designing 'family friendly' environments to support and empower parents requires interventions that target social contexts that influence parents on a day to day basis including the mass media, primary health care services, child care and

school systems, religious organisations, worksites, and the political system.

In an effort to develop a contextually meaningful approach to supporting parents, the Triple P-Positive Parenting Program, a multi-level, preventively oriented, parenting and family support strategy has been developed by the author and his 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, confidence and teamwork of parents. The program has five levels of intervention on a tiered continuum of increasing strength (see Figure 1) for parents of children from birth to age 16.

The rationale for this tiered multilevel strategy is that there are differing levels of dysfunction and behavioural disturbance in children and that parents have differing needs and desires regarding the type, intensity and mode of assistance they require. The multilevel strategy is designed to maximize efficiency, contain costs, avoid waste and over servicing and to ensure the program has wide reach in the community. As the program is multidisciplinary it involves better utilisation of the existing professional workforce in the task of promoting competent parenting.



**Figure 1: The Triple P System of Parenting and Family Support**

The program targets four different developmental periods from infancy to preadolescence. 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 individual practitioners to determine the scope of the intervention given their own service priorities and funding. Alternatively the program can be delivered as a government funded service provided on a free to consumer basis.

### Theoretical basis of Triple P

Triple P is a form of behavioural family intervention based on social learning principles (eg. Patterson, 1982). Triple P aims to enhance family protective factors and to reduce risk factors associated with severe behavioural and emotional problems in preadolescent children. Specifically the program aims to: 1) enhance the knowledge, skills, confidence, self sufficiency and resourcefulness of parents of preadolescent children; 2) promote nurturing, safe, engaging, non-violent, and low conflict environments for children; 3) Promote children’s social, emotional, language, intellectual, and behavioural competencies through positive parenting practices. The program content draws on:

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 predicts 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 parenting practices.

2) *Research in child and family behaviour therapy and applied behaviour analysis* which has developed many useful behaviour change strategies, particularly research which focuses on rearranging antecedents of problem behaviour through designing more positive engaging environments for children (Risley, Clark & 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 heavily on work which traces the origins of social and intellectual competence to early parent-child relationships (eg., 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 and 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* which 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 (eg., Bandura, 1977; 1995). Parents' attributions are specifically targeted in the intervention by encouraging parents to identify alternative social interactional explanations for their child's behaviour.

5) *Research from the field of developmental psychopathology* that has identified specific risk and protective factors which 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 risk factors. As parental discord is a specific risk factor for many forms of child and adolescent psychopathology (Grych & Fincham, 1990; Rutter, 1985; Sanders & Markie-Dadds, 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 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 such as mood monitoring, challenging dysfunctional cognitions and attributions and teaching parents specific coping skills for high risk parenting situations.

6) *A population health perspective* to family intervention involves the explicit recognition of the role of the broader ecological context for human development (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 by validating and acknowledging publicly the importance and difficulties of parenting. It also involves actively seeking community involvement and support in the program by the engagement of key community stakeholders (eg. community leaders, businesses, schools and voluntary organisations).

### **Self regulation and parental competence**

The Triple P approach to promoting parental competence 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 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 routinized activity is impeded or when goal directedness is otherwise made salient (eg. the appearance of a challenge, the failure of habitual patterns; etc)...' (p25). This definition emphasises 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 their child's or their 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, to set goals for themselves, to choose specific parenting and child management techniques they wish to implement, and to 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 modeled and practiced. Parents receive feedback regarding their implementation of skills learned in a supportive context, using a self-regulatory framework (see Sanders & Dadds, 1993);

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 (eg. spouses' bad parenting or genes). This outcome is achieved by prompting parents to identify causes or explanations for their child's or their own behaviour.

Encouraging parents to become more self sufficient does not mean that parent's own social support networks are unimportant (partners, extended family, friends, child care supports). However, the broader ecological context within which a family lives can not be ignored (poverty, dangerous neighbourhoods, community, ethnicity, culture). It is hypothesised that the more self-sufficient parents become the more likely they are to seek appropriate support when they need it, to advocate for children, become involved in their child's schooling, and to protect children from harm (eg. 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 developmental and mental health outcomes in children. These core principles translate into a range of specific parenting skills, which are outlined in Table 1.

**Table 1: 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>
Monitoring children's behaviour	Spending quality time	Giving descriptive praise	Setting developmentally appropriate goals	Establishing ground rules	Planning and advanced preparation	Setting practice tasks	Catching unhelpful thoughts	Improving personal communication habits
Monitoring own behaviour	Talking with children	Giving non-verbal attention	Setting a good example	Using directed discussion	Discussing ground rules for specific situations	Self-evaluation of strengths and weaknesses	Relaxation and stress management	Giving and receiving constructive feedback
	Showing affection	Providing engaging activities	Using incidental teaching	Using planned ignoring	Selecting engaging activities	Setting personal goals for change	Developing personal coping statements	Having casual conversations
			Using Ask, Say, Do	Giving clear, calm instructions	Providing incentives		Challenging unhelpful thoughts	Supporting each other when problem behaviour occurs
			Using behaviour charts	Using logical consequences	Providing consequences		Developing coping plans for high risk situations	Problem solving
				Using quiet time	Providing consequences			Improving relationship happiness
				Using time-out	Holding follow-up discussions			

## Core features of Triple P

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

*Targets meaningful social contexts for parents.* Triple P aims to make parenting support available in a variety of different contexts that are part of the everyday lives of parents. These include using the media, primary health care services, child care, school and work settings as a delivery and access point for parents.

*Developmentally-sensitive information.* The information resources used in parent and practitioner materials have been designed to be developmentally sensitive to the changing needs and competencies of children as they mature from birth through to adolescence.

*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 independently manage a problem. Triple P aims to provide the minimally sufficient level of support parents require to do their job. For example, parents seeking advice on a specific topic (eg. tantrums) can 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 Levels 1 or 2 of Triple P would constitute a sufficient intervention.

*Flexible tailoring.* A number of different programs of varying intensity have been developed ranging from brief 1-2 session consultations with a primary care provider to more intensive interventions that target additional family risk factors, such as marital 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.

## Principles of effective program development and implementation

### *Principle 1: Use the media more effectively*

One way to disseminate effective parenting interventions more widely is by using the mass media. The mass media play an important role in providing health information for the general public (Egger, Donovan & Spark, 1993). The goals of a media strategy include normalising the process of participating in parenting programs, destigmatising the idea of getting assistance to address parenting issues, increasing the receptivity of parents to specific messages about parenting and to promote self sufficiency in parents. A comprehensive media strategy can include television, radio, print and internet based strategies.

Of all the media strategies, television has the greatest potential as television acts as the primary vehicle for mass media in today's society. Television has been shown to have the capacity to influence awareness and to change attitudes, beliefs and behaviours, making it potentially one of the most powerful educational resources available at the present time (Hofstetter, Schultze & Mulvihill, 1992; Zimmerman, 1996). For example, evidence from the public health field has shown that televised media strategies can successfully increase community awareness of the risk and protective factors impacting upon health and well-being, promote health preserving behaviours such as abstaining from drinking alcohol when driving, and be instrumental in modifying potentially harmful behaviours such as cigarette smoking, poor diet and lack of exercise (Biglan, 1995; Sorenson, Emmons, Hunt & Johnston, 1998). Although the mass media have been used widely in the health promotion field, little is known about resulting effectiveness in the field of family intervention. There are several potential advantages of using media strategies, such as television, as an information source for parenting and family issues. Television has a pervasive influence on modern families: adults watch approximately three hours of television per day

(Neilson, 1997); 47% of adults rate television as the best medium for accurate and reliable news; 61.8% choose to obtain news and information from television; and 79.6% report it to be the most influential advertising source (Federation of Australian Commercial Television Stations, 1995).

A televised parent education program has the advantage of being able to be accessed in the privacy of the home by a large proportion of the population, some of whom, such as parents living in rural and remote locations, may otherwise be difficult to reach. It may also assist parents to recognise early warning signs of behavioural and emotional problems in children and encourage them to seek professional advice early when a minimal level of intervention may be sufficient to address recent onset, discrete child behaviour problems (Sanders & Markie-Dadds, 1997). Moreover, a televised parent education program could promote and increase community awareness of effective parenting strategies and understanding of the role family relationships play in the health and well-being of young children (Sanders, 1999). Media interventions of this type have the capacity to create a social milieu that is supportive of parent education and family change (Flay, 1987) which can be used to counter alarmist, sensationalised or parent blaming messages (Sanders, 1999). An added advantage of a televised parent education program is that any behavioural change achieved by watching the program is likely to be attributed to one's own efforts (Flay 1987), thus increasing parents' feelings of personal competence.

To be most effective as a mechanism of behaviour change, rather than operating purely as a strategy for raising public awareness, it has been argued that a media intervention needs to not only provide information about the problem behaviour but also provide practical advice about how to deal with it effectively (Andrews, McLeese & Curran, 1995; Flay & Burton, 1990; Owen, Bauman, Booth, Oldenburg & Magnus, 1995). For example, Parloto, Green and Fishman (1992) found that efforts to teach mothers about the general principles of nutrition were less successful in changing infant feeding patterns than programs that pinpointed food-related

behaviours and gave specific skills-based information, such as teaching mothers how to adequately prepare their infant's food. Similarly, for the mass media to be a successful vehicle for the promotion of effective parenting skills and the modification of parental behaviour, information about functional strategies for promoting competence in children and for dealing with problem behaviour need to be provided. Behaviour change then requires parents to adopt a self-regulatory approach that involves self-monitoring, self-identification of personal strengths and weaknesses and personal goal setting (Halford, Sanders & Behrens, 1994; Webster-Stratton, 1992).

A Universal Triple P health promotion strategy was recently developed to include a media campaign on parenting based around a television series, *Families*, which was shown in prime time on a commercial television network in New Zealand. The 13, 30-minute episode series was in an 'infotainment' style to ensure the widest reach possible for Triple P. Such programs are very popular and according to ratings data, frequently attract around 20-35% of the viewing audience (Neilson, 1997). The series used an entertaining format to provide practical information and advice to parents on a variety of common behavioural and developmental problems in children as well as other parenting issues. The main segments were: a feature story, which presented brief discussions on a number of family issues (e.g. school involvement and the role of fathers); a segment in which a celebrity family discussed a range of issues about their family; family health care tips; animal care and integrating a pet into family life; interesting facts about the current state of families in society; and a Triple P segment.

A 5-7 minute Triple P segment each week enabled parents to complete a 13-session Triple P intervention at home. The Triple P segments provided brief examples of the causes of child behaviour problems from a social learning perspective, provided information on how to monitor child behaviour, and presented clear guidelines for using a range of parenting strategies designed to encourage desirable behaviour in children (e.g. descriptive praise, positive attention), prevent problems from

occurring (e.g. providing engaging activities), and manage difficult behaviour (e.g. rule setting, directed discussion, planned ignoring, and the provision of clear instructions backed up by logical consequences, quiet time or time-out). These strategies were integrated into parenting plans for common problems (e.g. whining, disobedience, aggression and temper tantrums), for promoting children's development (e.g. encouraging creativity and involvement in sport, and helping with homework), and for managing developmental issues (e.g. cooperative play, sleeping difficulties and eating difficulties). In addition, each Triple P segment presented a modeled demonstration of suggested strategies.

A cross promotional strategy used radio and the print media to prompt parents to watch the program and inform them of how to contact a Triple P telephone information line for more information about parenting. The *Families* fact sheets (specifically designed parenting tip sheets providing a written version of the information from the Triple P segment) were also available by writing to a Triple P Centre, calling the Triple P information line, or through a retail chain store.

To evaluate whether this form of media intervention could significantly impact on family functioning, Sanders, Montgomery and Brechman-Toussaint (2000) randomly assigned mothers with children aged between two and eight years either to a media intervention or control group. Mothers in the intervention group were given the television series, in the format of videos and tip sheets. These mothers watched two episodes of the series (in their own home) each week, at a time convenient to them, and read the relevant tip sheets. Mothers in the control group received no intervention for six weeks. As predicted, mothers in the media condition reported significant reductions in child behaviour problems post-treatment in comparison to the control group. Reductions occurred in both the intensity of problem behaviour and the number of problems that mothers were experiencing with their child. The percentage of children from the control condition falling in the clinical range for problem behaviour did not change from pre- to post-intervention, yet there was a significant decrease

in the percentage of children from the media condition who fell in the clinical range — from 46% prior to the intervention (over twice the national average) to 14% remaining in the clinical range following the intervention. Mothers in the media condition also reported an increased sense of competence and satisfaction in their parenting abilities relative to mothers in the control group. Anecdotally, many mothers reported that the realisation they were doing some things 'the right way' was one of the most salient outcomes of the program. A strong trend was also indicated for mothers in the media condition to demonstrate a reduction in dysfunctional parenting styles (e.g. laxness, overly harsh discipline, nagging) relative to the mothers in the waitlist condition. All intervention effects evident at post assessment were maintained at 4-6 months follow up.

Although the up-front costs of establishing a media-based intervention program such as *Families* is substantial, the reach may be wide and the long term benefits to individuals and the community may far outweigh these initial costs.

As Triple P has been disseminated more widely in the community, different kinds of media activities have been used to promote the program in the community. These activities have included the broadcast of Triple P positive parenting tips (approximately 60 seconds each) on community radio stations, a weekly newspaper column on positive parenting, editorial and feature articles on the program, 15-30-second television commercials promoting the five key principles of positive parenting (a safe engaging environment, a positive learning environment, assertive discipline, reasonable expectations, and taking care of ourselves as parents), positive parenting inserts in school newsletters, public lectures and presentations, news and current affairs stories on network television. These treatments have generally tracked one or more children through the intervention and have promoted strong public interest in the program.

These activities provide examples of ways in which the media can be used to promote program awareness, which in turn can create demand for evidence-based programs. Our experience has been that it is important to

develop appropriate referral networks and back-up services for more intensive interventions when required. For some families this is the only participation they will have in a parenting program. Hence, designing a media campaign to ensure that messages are thematically consistent, culturally appropriate, and practical is critical to ensure that messages are acceptable and have a positive impact. This level of intervention may be particularly useful for parents who have sufficient personal resources (i.e. motivation, literacy skills, commitment, time and support) to implement suggested strategies with only brief parenting advice. However, a media strategy is unlikely to be effective on its own for parents who have a child with a severe behavioural disorder or where a parent has few of the resources listed above, is depressed, in a conflictual relationship or suffering from major psychopathology. In these instances a more intensive form of intervention is indicated.

***Principle 2: Enhance the capacity of primary care services to support parents***

The last decade has seen an increasing emphasis on treating mental health problems at the primary care level (Giel, Koeter & Ormel, 1990). The family doctor or child health nurse is often the first point of contact for parents experiencing behavioural difficulties with their young children. A large number of pediatric consultations deal with parental concerns about their child's behaviour, development or school achievement (Christopherson, 1982; Oberklaid, Dworkin & Levine, 1979; Taylor & Biglan, 1998; Triggs & Perrin, 1989). Primary care professionals are well-positioned to provide parenting support and yet are commonly under-resourced and under-trained for the provision of effective mental health programs for children and families.

A recent parenting survey showed that doctors were the professionals most frequently consulted by caregivers of children with an emotional or behavioural problem (Sanders, Tully, et al., 1999). The Western Australian Child Health Survey reported that 65% of parents of children with behavioural and emotional problems consulted a doctor during a 6-month period.

Only 2% saw a mental health specialist (Zubrick, et al., 1995).

In a national U.S. survey of over 2000 parents with children under 3 years of age, Young, Davis, Schoen & Parker (1998) highlighted parents' concerns and the information they would like to receive from their pediatric physician or nurse. The majority of parents reported having a regular source of pediatric health care, which met their child's health needs, yet many were not satisfied with the help they received with regard to understanding their child's growth, development or care. Fewer than one quarter had talked with their pediatric clinician about discipline or promoting their child's development. Parents who had received this type of information were significantly more satisfied with their pediatric clinician than those who had not. A majority of parents (79%) reported a desire for more information from their pediatric clinician in at least one of six areas of child rearing (i.e. newborn care, sleep patterns, crying, toilet training, discipline, and encouraging early learning) and 53% wanted information in at least three areas. These data suggest that personalised advice, in the context of an ongoing supportive relationship, is the need being expressed by parents.

As they have regular contact with young families, primary care services can undertake several important tasks to promote children's mental health. Early detection of significant deviations from normal development and provision of advice to parents seeking information about developmental issues should become part of routine well-child care. Provision of brief behavioural counselling for child behaviour problems and increased access to early intervention on dysfunctional family interaction patterns could help to prevent later, more serious problems. Primary care service providers can perform a triage function for the appropriate referral of moderate to severe child behaviour problems to specialised services. This would help match intervention strength to individual family needs and ensure the limited funds available for specialist mental health services are directed where they are most needed. In the long term, widespread implementation of such preventive primary care

interventions could function to decrease the number of children requiring specialist health services. Through this type of primary care strategy, parenting support would become an integral part of family health care provision.

Two recent independent trials have assessed the impact of Triple P interventions in primary care settings. The first (Zubrick, Silburn, Teoh et al., 1997) examined the effectiveness of specialised training and implementation of a group format, intensive parenting skills training program (Markie-Dadds, Turner & Sanders, 1997; Turner, Markie-Dadds & Sanders, 1998) by primary care staff. The program was administered as a selective prevention demonstration project to reduce the prevalence of conduct problems at a population level. The target population was all parents of 3–4 year old children living in a metropolitan area with high socioeconomic disadvantage and high child abuse notification rates. The intervention was relatively brief — four 2-hour group sessions and four 15–30 minute individual telephone consultations. Groups were facilitated by community health nurses. Three in five eligible families attended the program and 85% of families completed at least 7 of the 8 program sessions. The program was successful in reducing dysfunctional parenting from twice the population average to general population levels and significantly reduced disruptive behaviour problems in the children of participating families. This trial has shown not only extremely high community support for parenting programs offered through primary care settings, it has demonstrated positive outcomes for parents and children.

The second (Sultana, Matthews, De Bortoli & Cann, 2000) involved a randomised controlled trial comparing two brief parenting interventions (Level 2 and 3 Triple P; Turner, Sanders, & Markie-Dadds, 1999) implemented by maternal and child health nurses, in comparison to a waitlist control condition. The study aimed to evaluate the impact of the Level 2 intervention (involving self-administration of written parenting advice following a 15 minute consultation) in comparison to the Level 3 intervention (involving four brief consultations supported by written and videotaped parenting

advice). Participants were 50 families of children aged between 18 months and 6 years with a recent onset, mild to moderate behaviour problem. Results showed the Level 3 intervention produced significant reductions in child behaviour problems and more appropriate discipline practices in comparison to the waitlist control condition. Moderate positive parent and child outcomes were achieved by families in the Level 2 intervention, however results did not differ significantly from the waitlist control condition. The Level 3 intervention proved superior to Level 2 on one measure of child behaviour problems (Parent Daily Report Checklist; Chamberlain & Reid, 1987), and in reducing conflict between parents over parenting. These results provide further support for the efficacy of primary care staff in offering brief, early parenting support, resulting in reduced child problem behaviour and improved parenting practices.

***Principle 3: Provide universal parenting programs targeting entire populations at developmentally sensitive transition points***

Triple P has also been used as a transitional program targeting the parents of children in their first year of school. McTaggart and Sanders (2003, this issue) evaluated the effects of Triple P as a transition to primary school program. They randomly assigned 25 schools to receive either Group Triple P and an information campaign or to a control group. At the end of Grade 1 in Triple P schools there were fewer children reported by teachers to have behaviour programs and a significant increase in self report measures of parenting skills than in schools where parents had not participated in Group Triple P. A similar project using the adolescent version of Group Triple P is currently being trialled in four Queensland state high schools. The encouraging preliminary finding from these studies suggested that the school could be used as a community context to support the needs of parents.

***Principle 4: Develop tailored more intensive interventions for high risk parents and children***

There are always likely to be non responders to universal parenting programs. These parents may

require more intensive programs specifically tailored for their needs. An example of such comes from our work with parents at risk of child maltreatment. Sanders, Pidgeon, Gravestock, Brown, Connors and Young (in press) compared the effects of a standard Group Triple P program with an enhanced program, Pathways Triple P which provided targeted, additional attributional retraining and anger management for parents. These parents all reported significant anger management concerns. Results showed that the enhanced training resulted in additional benefits in terms of reduced dysfunctional attributions of their child's behaviour, but similar levels of improvement on measures of child behaviour. This finding shows that a targeted adjunctive intervention designed to specifically address specific risk factors that are frequently present in parents at risk of child maltreatment enhances overall treatment effects.

***Principle 5: Develop interventions to enable parents to manage work and family responsibilities***

Many parents report difficulties balancing work and family responsibilities, and due to their work commitments can find it difficult to access parenting programs. The development of parenting interventions as an employee assistance program may be useful to enable workers who are parents to more effectively balance work and home responsibilities. There is increasing evidence that family conflict contributes to work stress, low motivation, accidents at work, and low productivity. Conflict with children before and immediately after work is a source of considerable stress for many parents. We have recently developed and evaluated Triple P as a worksite intervention where the effects of the intervention are assessed at both the family and worksite level. Sanders and Martin (2003) found that working parents who had completed Workplace Triple P reported significantly higher levels of self efficacy in completing work assignments and lower occupational stress compared to a waitlist control group. Ultimately programs tailored to the needs of working parents and delivered at work may put flesh on 'family friendly'

employment policies increasingly advocated for within business organisations.

***Principle 6: Promote better teamwork in parenting***

There is increasing evidence that exposure to significant parental conflict is a risk factor for the development of behavioural problems in children. Marital conflict is also a risk factor for parents failing to implement parenting skills learnt in parent training programs. Dadds, Schwartz and Sanders (1987) developed a brief form of marital communication skills training for marital discordant couples with an oppositional child. A randomised controlled trial evaluating this intervention found that providing Partner Support Training reduced the risk of relapse after successful parent training in these families.

***Principle 7: Help parents manage their own emotional distress***

Although parenting interventions can reduce parental distress, when parenting problems are complicated by more serious mental health problems tailored interventions to address the mental health problem may be required. Many treatments for adult depression ignore the interpersonal and family context of parental distress. Sanders and McFarland (2000) showed that an integrated parenting and brief cognitive intervention targeting parenting situations was effective in alleviating both parents' depression and children's conduct problems to a greater degree than standard individual parent training alone. This finding points to the potential for parenting interventions to contribute to the treatment of adult psychopathology.

***Principle 8: Develop appropriate evidence based interventions for culturally and linguistically diverse groups***

In a multicultural society any universal parenting intervention needs to be responsive to the parenting needs of culturally and linguistically diverse groups. We have recently developed and trialled a version of Group Triple P developed specifically for Indigenous Australian parents. In a randomised controlled trial Turner and Sanders (in prep) found that after participating in

Indigenous Triple P parents reported significantly lower levels of behavioural and emotional problems in their children, increased parental self efficacy and lower levels of parental distress. These positive findings and similar results with other ethnic groups indicate that core principles of positive parenting are applicable in many different cultural contexts when the programs are made culturally relevant.

***Principle 9: Develop effective systems of dissemination and quality assurance***

Many evidence based programs (e.g. parent management training) have little impact on children's health and well being because they are not properly disseminated. The design of effective systems of dissemination to avoid the problem of programs becoming reified and static needs to be configured to accommodate an evolving evidence base, that requires meaningful partnerships between program developers, evaluators, and agencies, and services that use the program.

***Principle 10: Be aware of the political context***

Parenting interventions occur within a sociopolitical context. Family intervention researchers need to hone their skills of political advocacy, so that more resources go to funding the dissemination of evidence based parenting and family intervention programs. One concern is that many governments do not see parenting interventions as part of main stream clinical services delivered through health or mental health services. Rather parenting interventions are often funded through the welfare sector with non government organisations being funded to deliver parenting programs. These funding mechanisms often occur with minimal accountability requirements and little insistence that evidence based parenting interventions be used. Insufficient systematic effort is devoted to providing adequate professional training to practitioners to deliver parenting intervention.

**Conclusion**

Raising competent, well adjusted children is a community responsibility. Parenting and family interventions based on social learning theory are

a powerful and underutilised resource. Empirically supported parenting and family intervention strategies arguably should be the centrepiece of public health efforts to prevent family and relationship distress and child mental health problems. While it is undoubtedly true that healthy families lead to healthy, well adjusted children, in order to achieve this ideal, family practitioners need to break away from a traditional delivery paradigm and adopt a far more contextual perspective in understanding and ameliorating parenting and other family difficulties in the community. Parenting interventions are amongst the most powerful and cost-effective tools available to promote better mental health. As a community we must invest further in promoting the well being of our children through supporting evidence based parenting interventions.

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