A Public-Health Approach to Improving Parenting and Promoting Children's Well-Being

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Abstract

Randomized controlled trials and meta-analyses have demonstrated the efficacy of evidence-based parenting programs (EBPPs) to improve social, emotional, and behavioral outcomes for children. Although EBPPs are effective, their reach is limited, and many families that could benefit do not have an opportunity to participate. In this article, we argue for a paradigm shift—from traditional, highly targeted approaches of program delivery to a more inclusive public-health framework that blends universal and targeted elements. The Triple P—Positive Parenting Program is an EBPP that has applied a public health framework to increase parenting support in communities. The approach seeks to improve the reach of the program while increasing capacity to reduce the prevalence of children's social, emotional, and behavioural problems, as well as of child maltreatment.
Keywords—public health; Triple P; parenting; child development; prevention

Evidence-based parenting programs (EBPPs) are a recommended pathway to prevent and treat childhood social, emotional, and behavioral problems (United Nations Office on Drugs & Crime, 2009; World Health Organisation [WHO], 2009). EBPPs achieve this through enhancing the knowledge, skills, and confidence of parents (Sanders, 2012). Despite their success, most EBPPs focus narrowly on children of a certain age (e.g., preschoolers) or on one type of problem (e.g., early onset conduct problems), and reach relatively few parents (Prinz & Sanders, 2007).

In this article, we provide a rationale for a paradigm shift in the field of EBPPs, moving away from traditional, targeted approaches of program delivery to a public-health framework. We then discuss what is involved, provide initial evidence of effectiveness, and describe some of the challenges and criticisms of a public-health model for improving parenting support. Finally, we discuss the challenges involved in implementing the approach and the implications of adopting a public-health framework to support parents.

Why a public-health approach to parenting support is needed

Parenting has a pervasive impact on the development of children. Concerns about parenting are widespread and too many children are exposed to coercive family environments that harm children's development (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000; Odgers et al., 2012). Meta-analyses of parenting programs that are based on social learning theory and cognitive–behavioral principles have demonstrated that positive parenting programs can change children's behavior (McCart, Priester, Davies, & Azen, 2006; Menting, de Castro, & Matthys, 2013; Sanders, Kirby, Tellegen, & Day, 2014). Programs with the most empirical support include but are not limited to the Incredible Years Program (Webster-Stratton, 1998), Parent Management Training-Oregon Model (Forgatch & Patterson, 2005), Parent-Child Interaction Therapy (Fernandez & Eyberg, 2009), and the Triple P-Positive Parenting Program (Sanders, 2012). Traditional approaches to parent training involve working with individual families or small groups of parents; although effective, such programs reach relatively few parents and consequently are unlikely to reduce rates of serious child

development problems related to inadequate parenting (Prinz & Sanders, 2007). In a survey, 75% of parents who had a child with an emotional or behavioral problem had not participated in a parenting program (Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007). In addition, the worldwide rate of child behavioral problems is approximately 20% (WHO, 2005). Thus, the benefits derived from participating in EBPPs are largely unseen across communities (Prinz & Sanders, 2007). In response to the limited reach of parenting programs and the continuing prevalence of social, emotional, and behavioral problems in children, researchers in the field of parenting have advocated for a public-health approach to support parents.

What is involved in adopting a public-health model to support parents?

A public-health approach to parenting support has been defined as "an approach that emphasizes the targeting of parents at a whole-of-population level, utilizing a blend of universal and targeted interventions, to achieve meaningful change in population-level indices of child and parent outcomes" (Sanders et al., 2014, p. 339). The Triple P system (Sanders, 2012) is one of the most widely used and extensively evaluated models of parenting support. It is also one the few EBPPs designed specifically as a comprehensive public-health model. The Triple P system incorporates five levels of intervention on a tiered continuum of increasing strength and narrowing reach for parents of children from birth to age 16 (see Figure 1 for a description of Triple P and Table 1 for the program variants of Triple P). As a result, Triple P is a blended model of parenting support involving a mix of universal and targeted programs that adheres to the public health principle of proportionate universalism-which suggests that exclusive focus on delivering interventions to the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage (The Marmot Review, 2010).

Although chiefly based on cognitive–behavioral principles and social learning theory, Triple P is also informed by developmental research, social information-processing models, and developmental psychopathology (Sanders, 2012). Within this social interaction model, parent–child exchanges are seen as bidirectional, with parenting influencing children's behavior and children's behavior affecting parenting. The Triple P model of intervention is also informed by a self-regulation framework that seeks to build parental capacity. Self-regulated parents have a clear sense of purpose, knowing what skills, values, and behaviors they wish to instill in their children, in themselves, and in their community (Sanders & Mazzucchelli, 2012). When confronted with a challenge between their goals and actual behavior, self-regulated parents recognize quickly that they are behaving in a manner contrary to their valued outcome, try to identify why this is happening, and formulate a plan to correct the situation. They carry out and review the plan, and take further corrective action as needed. The adoption of a self-regulation approach is suited to a public-health framework, as it avoids parenting advice being perceived as prescriptive, since parents themselves ultimately decide on the goals, values, and priorities they wish to focus on in their interactions with their children.

Another distinguishing feature of Triple P is the public-health principle of minimal sufficiency, which refers to the selection of interventions aimed at achieving a meaningful clinical outcome in the most cost-effective and time-efficient manner. Consequently, Triple P blends low-intensity interventions that can engage many parents (e.g., mass media and parenting seminars) with more intensive group and individual programs for more complex cases. Moreover, the program is designed to be used flexibly as a multilevel system (i.e., Levels 1–5) with different delivery formats (e.g., group, online, over the phone) and a multidisciplinary workforce to deliver the intervention (e.g., psychologists, doctors, teachers). Within this multilevel system and minimally sufficient framework, parents' concerns, as well as practitioners' assessments (e.g., intake, questionnaires) and knowledge of the intervention system, determine which intervention the parent receives.

A public-health model enhances capacity to involve many more parents in an evidence-based parenting intervention than would otherwise be involved (Prinz & Sanders, 2007). While prenatal education classes are widely accepted and available (Gagnon & Sandall, 2007), accessing parent support beyond early infancy is still not the norm. Adopting a public-health model can help

destigmatize the process of seeking support for parenting assistance so it becomes more socially acceptable to participate (Sanders, 2012). Widening a program's reach increases a community's capacity to reduce rates of social, emotional, and behavioural problems in children as well as child maltreatment.

Does it work?

Although a public-health approach to parenting support is relatively new, in the case of Triple P, the intervention is built on more than 30 years of program development and evaluation. A meta-analysis of Triple P (Sanders et al., 2014) looked at 101 studies (including 62 randomized controlled trials) conducted over 33 years involving more than 16,000 families. Studies were included in the analyses if they reported a Triple P evaluation, reported child or parent outcomes, and provided sufficient original data. In these analyses, significant moderate effect sizes were identified for children's social, emotional, and behavioural outcomes (d = 0.473), parenting practices (d = 0.578), and parenting satisfaction and efficacy (d = 0.519). Significant small to moderate effects were also found for the distal outcomes of parental adjustment (d = 0.340) and parental relationship (d = 0.225). Significant positive effect sizes were found for each level of the Triple P system for children's social, emotional, and behavioral outcomes, although greater effect sizes were found for the more intense interventions (Levels 4 and 5). These results support the effectiveness of light-touch interventions (Levels 1, 2, and 3) as affecting key parenting outcomes independently. Significant moderate to large effects were also found for various delivery modalities, including group, individual, phone, and online delivery.

The meta-analysis (Sanders et al., 2014) is comprehensive, including more studies than any other meta-analysis (e.g., Nowak & Heinrichs, 2008; Wilson et al., 2012). By doing so, it permitted a wider range of moderator variables to be examined, including length of follow-up, level of intervention (i.e., Levels 1–5), and study approach (i.e., universal, targeted, treatment). These variables, which are important when adopting a public health approach, have not been examined sufficiently in past meta-analyses because of a lack of available studies or a focus on a single outcome (Wilson et al., 2012).

Targeting entire communities can be effective in changing population-level indices of children's social, emotional, and behavioral problems. The approach, which involves targeting a geographically defined community and introducing the intervention model, has been carried out in four large-scale evaluations. Using a quasi-experimental design, one study (Sanders et al., 2008) demonstrated that geographical catchment areas that received the Triple P system of parenting support (e.g., media campaign and Levels 2–5 of the Triple P system) reduced psychosocial problems in 4- to 7-year-olds compared to children in catchment areas receiving usual services.

Another study (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009) extended these findings by using a place randomization design. In this study, after 2½ years, counties randomly assigned to the Triple P intervention had lower rates of child maltreatment on many indices (including hospitalizations and injuries due to child maltreatment, out-of-home placements, and number of founded cases of child maltreatment) compared with counties that did not take part in the program.

Two additional studies investigated the effects of Triple P as a public-health intervention. In one (Sarkadi, Sampaio, Kelly, & Feldman, in press), preschools delivering the Triple P system in the form of large group seminars (Level 2) with brief individual primary-care consultations (Level 3) reported significantly greater health gains (12%) than preschools without the program (3%). In the other (Fives, Pursell, Heary, Nic Gabhainn, & Canavan, 2014), counties that received the Triple P system in the form of a media campaign (Level 1), seminars (Level 2), discussion groups (Level 2), and Group Triple P (an 8-week group program that includes five 2-hr group sessions and three individual phone consultations; Level 4) showed approximately 30% fewer total child difficulties 2 years later than counties that did not receive the program.

Based on two economic analyses of the Triple P system, the approach can be cost effective. In one of the analyses (Aos et al., 2014), every $1 invested in the Triple P system (i.e., implementation of Levels 1–5) yielded a $9 return in terms of reduced costs of children in the welfare system. In the other (Foster, Prinz, Sanders, & Shapiro, 2008), the infrastructure costs associated with implementing

the Triple P system (i.e., Levels 1–5) in the United States (Prinz et al., 2009) was $12 per participant, a cost that could be recovered in a year by as little as a 10% reduction in the rate of abuse and neglect. Although these savings are striking, it is unclear who absorbs the cost of delivering EBPPs, such as Triple P, to the community. Federal and state governments can choose to direct investment in these programs as part of their social-welfare and mental-health policies. However, in an environment of intense competition for public funds and resources, sustained investment in EBPPs is ultimately a matter of priority, which points to the importance of continued advocacy by researchers, agencies, and consumers for investment in prevention programs.

Criticisms and areas for development

While evidence for adopting a public-health model for parenting support is emerging, research supporting the approach is in its infancy. Moreover, studies have raised criticisms and pointed to areas that need improvement.

Concerns about the social gradient of health inequalities

In one study (Fives et al., 2014), lower income families and children with behavior problems were more likely to participate in a Triple P and benefited more than higher income parents. A public-health approach that carefully applies the principle of proportionate universalism is one way of ensuring that the most needy families with the most to gain are targeted for recruitment to encourage participation.

Lack of reliable measures to document population-level effects

Several studies have used household surveys to measure population- level effects of parenting interventions (e.g., Sanders et al., 2008); we need brief, reliable measures that are sensitive to change to document programs' effect on children and parents. A range of measures can assess population-level interventions (as summarized by Metzler, Sanders, & Rusby, 2012), including linked archival administrative data such as child hospitalizations and out-of-home placements. However, moving toward public-health databases that record indices related to parenting and make such data accessible to researchers requires further discussion and investment between government stakeholders and researchers.

State intrusion into families

Most parents are interested in and willing to devote time to learning practical parenting skills that will help them raise their children (Sanders, Haslam, Calam, Southwell, & Stallman, 2011). When participation is voluntary, the approach is nonprescriptive, allowing parents to make informed decisions about how they wish to raise their children, and parents are more likely to embrace the notion of enhancing parental support. However, we need to continue to assess parents' attitudes toward parenting as a public-health model because differences could arise between cultures and generations.

A one-size-fits-all approach

A public-health approach to parenting support requires that programs be flexible and varied since parents are a heterogeneous group. To ensure that as wide as possible a range of parents participate, the Triple P system varies program content depending on the developmental level of children (e.g., from infancy to adolescence), the type of child or adolescent problems targeted (e.g., typically developing children, children with different developmental disabilities), the degree of time investment required by parents (e.g., from single sessions to up to 12 sessions), and the delivery modality (e.g., in person, online, self-help). In addition, different Triple P program components target different risk and protective factors depending on parents' problems. For example, Pathways Triple P (Sanders et al., 2004), designed for parents at risk of child maltreatment, provides additional input on parental attributions and emotion regulation (e.g., anger management) because of the increased likelihood of problems in these areas for abusive parents. Stepping Stones Triple P was designed for parents who have a child with a disability (e.g., autism spectrum disorder). Although the parent is the

direct participant in Triple P programs, in Resilience Triple P, children take part in sessions that offer strategies to help with bullying (Healy & Sanders, 2014).

Implementation challenges

Population effects are unlikely to be observed when programs are implemented with low fidelity. Experience with the large scale rollouts of the Triple P system has highlighted key drivers of success that can inform practice. Having an available and trained workforce is no guarantee that practitioners will implement the program as planned or with fidelity to achieve targets. One way to meet this challenge is to develop implementation guidelines and then test these implementation models empirically. Such guidelines have been developed for Triple P (Brown & McWilliam, 2012) and can be used to assist organizations in implementation.

Importance of engaging parents as consumers

Practitioners and parents are the consumers of parenting programs. Actively involving target parenting groups in planning an intervention can lead to more tailored or customized delivery of the program (Kirby & Sanders, 2012, 2014; Metzler, Sanders, Rusby, & Crowley, 2012). The aim of this approach is to enhance the ecological fit of the intervention to the intended target group.

Addressing cultural diversity

In culturally diverse settings, when parents and practitioners are asked to comment on Triple P, parents' ratings of the program's cultural relevance and acceptability tend to be higher than practitioners' ratings of these characteristics (Morawska et al., 2011). This may reflect the gateholder phenomenon, whereby practitioners can be overprotective of communities they serve and may have opinions that differ from the group of parents that is targeted. However, practitioners working with indigenous groups have had to adjust the content and mode of delivery of the program (Turner, Richards, & Sanders, 2007). For example, in Australia, practitioners working with Aboriginal parents have instituted longer sessions, relied less on workbook materials, and produced an indigenous video to engage parents.

Need for effective partnerships

One study (Fives et al., 2014) identified the advantages and challenges in maintaining partnerships with partner organizations that supported the implementation of Triple P. Organizations contributed in an unequal way, but were considered necessary to ensure that targets were reached. When establishing partnerships, different partners may make different contributions to a rollout of an intervention and reviews should be conducted throughout the implementation process. Initial partnership goals may not go as expected, as they may be over-ambitious or under-ambitious, and can be affected by factors such funding cuts or how staff members were selected initially for training.

Training and supporting a workforce

Traditionally, parenting programs were disseminated using a "train and hope" model in which staff of an organization would be trained in the program and then left to deliver the intervention without support from the training organization. Many of the steps to ensure the success of an intervention occur prior to and after training (Brown & McWilliam, 2012). Each rollout of an intervention benefits from an implementation consultant, who follows an implementation framework and works directly with an organization to troubleshoot implementation challenges (e.g., reaching participation targets, managing crises). More empirical research is necessary to test the effectiveness of such implementation frameworks to determine if they improve population-level effects.

Conclusions

In this article, we have argued for adopting an integrated, multilevel, public-health model of parenting support. However, for such a model to be effective, continued policy reforms are needed to advance the goals. For example, as part of parental leave programs, providing financial support to

parents to access evidence-based parenting support could improve outcomes. Another option is to provide employees access to EBPPs.

The evidence base is growing regarding the value of a public health approach, although more research is needed, especially replication studies using place randomized trial methodology to document the effects of a public-health approach. A public health model to parenting support holds promise to destigmatize preparation for parenthood so it becomes socially normative to participate in EBPPs, increasing a community's capacity to reduce the rates of childhood social, emotional, and behavioural problems as well as maltreatment in childhood.

Conflict of interest statement

The Triple P-Positive Parenting Program is owned by The University of Queensland. The University through its main technology transfer company, UniQuest Pty Ltd, has licensed Triple P International Pty Ltd to publish and disseminate the program worldwide. Royalties stemming from published Triple P resources are distributed in accordance with the University's intellectual property policy and flow to the Parenting and Family Support Centre, School of Psychology, Faculty of Health and Behavioural Sciences, and contributory authors. No author has any share or ownership in Triple P International Pty Ltd. Matthew Sanders is the founder and lead author of the Triple P-Positive Parenting Program, and is a consultant to Triple P International. James Kirby is a co-author of Grandparent Triple P.

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Figures and Tables

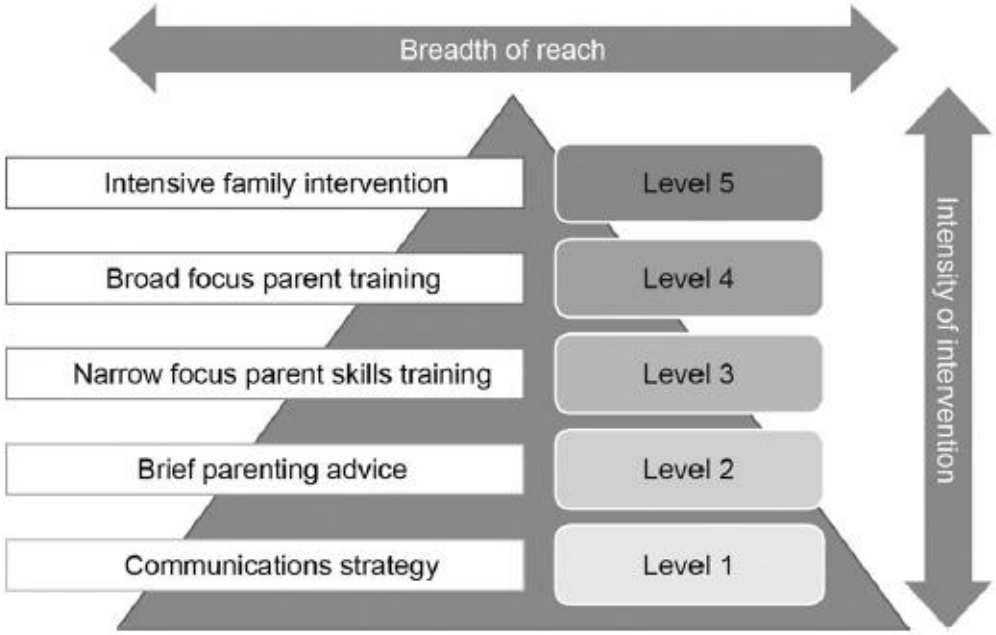

Figure 1. The Triple P model of graded reach and intensity of parenting and family support services, which indicates that the higher levels of Triple P (i.e., Levels 4 and 5) are more targeted interventions that reach relatively fewer parents, than lower levels of the program (i.e., Levels 1 and 2) that adopt a universal approach and attempt to reach all parents.

Table 1
The Triple P System of Parenting and Family Support

Level of intervention	Intensity	Program variant	Target population	Modes of delivery	Intervention methods used
Level 1					
Media and communication strategy on positive parenting	Very low intensity	Stay positive (website example: http://www.triplep.net/glo-en/the-triple-p-system-at-work/population-approach/stay-positive-website/)	All parents and members of the community interested in information about parenting to promote children's development and prevent or manage common social, behavioral, and emotional problems	Website to promote engagement. May also include television programming, public advertising, radio spots, newspaper and magazine editorials	Coordinated media and promotional campaign to raise awareness of parent issues, destigmatize, and encourage participation in parenting programs. Involves electronic and print media
Level 2					
Brief parenting interventions	Low intensity	Selected Triple P Selected Teen Triple P Selected Stepping Stones Triple P http://www.pfsc.uq.edu.au http://www.triplep.net	Parents interested in general parenting information and advice or with specific concerns about their child's development or behavior	Series of 90-min stand-alone large-group parenting seminars; or one or two brief individual face-to-face or telephone consultations (up to 20 min)	Parenting information promoting healthy development or advice for a specific developmental issue or minor behavior problem (e.g., bedtime difficulty)
Level 3					
Narrow focus parenting programs	Low–moderate intensity	Primary Care Triple P Primary Care Teen Triple P Primary Care Stepping Stones Triple P	Parents with specific concerns as above who require brief consultations and active skills training	Brief program (about 30 min) over three to four individual face-to-face or telephone sessions);	Combination of advice, rehearsal, and self-evaluation to teach parents to manage discrete child problems
		Triple P Discussion Groups http://www.pfsc.uq.edu.au http://www.triplep.net		Or series of 2-hr stand-alone group sessions dealing with common topics (e.g., disobedience, hassle-free shopping)	Brief topic-specific parent discussion groups
Level 4					
Broad focus parenting programs	Moderate–high intensity	Standard Triple P Group Triple P Self-Directed Triple P Standard Teen Triple P Group Teen Triple P Self-Directed Teen Triple P Online Triple P http://www.pfsc.uq.edu.au http://www.triplep.net	Parents wanting intensive training in positive parenting skills	Intensive program (about 10 hr) with delivery options including ten 60-min individual sessions; or five 2-hr group sessions with three brief telephone or home visit sessions; or 10 self-directed workbook modules (with or without telephone sessions); or eight interactive online modules	Broad focus sessions on improving parent–child interaction and the application of parenting skills to a broad range of target behaviors; includes generalization enhancement strategies
		Standard Stepping Stones Triple P Group Stepping Stones Triple P Self-Directed Stepping Stones Triple P http://www.triplep-steppingstones.net/au-en/home/	Parents of children with disabilities who have, or who are at risk of developing, behavioral or emotional problems	Targeted program involving ten 60- to 90-min individual sessions or 2-hr group sessions	Parallel program with a focus on parenting children with disabilities

Table 1 (cont)

Level of intervention	Intensity	Program variant	Target population	Modes of delivery	Intervention methods used
Level 5 Intensive family interventions	High intensity	Enhanced Triple P	Parents of children with behavior problems and concurrent family dysfunction such as parental depression or stress, or conflict between partners	Adjunct individually tailored program with up to eight individual 60-min sessions (may include home visits)	Modules include practice sessions to enhance parenting; mood management and stress coping skills; and partner support skills
		Pathways Triple P	Parents at risk of maltreating their children. Targets anger management problems and other factors associated with abuse	Adjunct program with three 60-min individual sessions or 2-hr group sessions	Modules include attribution retraining and anger management
		Lifestyle Triple P	Parents of overweight or obese children. Targets healthy eating and increasing activity levels as well as general child behavior	Intensive 14-session group program (including telephone consultations)	Program focuses on nutrition, healthy lifestyle and general parenting strategies
		Family Transitions Triple P http://www.pfsc.uq.edu.au http://www.triplep.net	Parents going through separation or divorce	Intensive 12-session group program (including telephone consultations)	Program focuses on coping skills, conflict management, general parenting strategies, and developing a healthy coparenting relationship

Note. Only program variants that have been trialed and are available for dissemination are included. Adapted from Sanders (2012).