Dissemination of evidence-based parenting and family support strategies: Learning from the Triple P—Positive Parenting Program system approach

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Abstract

This paper discusses the evidence for parenting skills training and behavioral family intervention (BFI), and the need for early intervention and prevention programs. It presents a conceptual framework for a comprehensive multilevel parenting and family support strategy for reducing the prevalence of parenting difficulties and other family risk factors associated with child maltreatment and the development of behavioral and emotional problems in children and adolescents. The framework for the system of intervention known as the Triple P — Positive Parenting Program (Triple P) is described. Also discussed are issues in the dissemination of evidence-based psychological interventions. A dissemination approach is presented which is based on a systems-contextual perspective that views practitioner uptake as being influenced by a range of program design, training, quality maintenance, organizational and motivational variables. Our experience in the widespread dissemination and implementation of Triple P at a population-level are shared and recommendations and future directions for dissemination of evidence-based preventive family interventions are noted.

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Keywords: Triple P—Positive Parenting Program system approach; Systems-contextual perspective; Multilevel family support strategy; Dissemination; Prevention; Behavioral family intervention

Contents

1. The relevance of behavioral family intervention ................................................................. 178
2. Effective interventions do not equal population impact .................................................. 179
3. The need for prevention and early intervention ................................................................. 179
4. Dissemination of evidence-based prevention and early intervention programs .................. 180
   4.1. Defining key constructs ................................................................................................. 180
   4.2. Obstacles for program disseminators ......................................................................... 181
       4.2.1. Lack of empirically validated dissemination theory .................................... 181
       4.2.2. Lack of funding for dissemination activities ................................................. 181
       4.2.3. Lack of incentives for program innovators .................................................... 181

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Family life has a central role in maintaining the physical, psychological and social wellbeing of children and parents (Sanders, 1999). The field of developmental psychopathology has identified a broad array of specific risk and protective factors linked to adverse developmental outcomes in children. Many of these risk factors, such as coercive or limited parent–child interaction (Hart & Risley, 1995; Rutter, 1985a), couple relationship conflict (Grych & Fincham, 1990), and parental distress such as stress and depression (Patterson & Reid, 1984; Rutter, 1985b), appear to make their impact through dysfunctional family interactions such as coercive parenting and low emotional responsivity (Webster-Stratton & Hammond, 1999), or may be ameliorated through quality parenting (Pound, 1994). Such risk factors have the potential to be targeted and modified in family intervention and prevention programs.

The development of interventions that promote positive, caring, and consistent parenting practices has been repeatedly highlighted as being critical to any attempt to reduce the incidence of child maltreatment or behavioral disorders in children (Azar, 1997; Sanders & Cann, 2002). Over the past 30 years a great deal of attention has been given to the development of evidence-based parenting and family interventions. However, much less attention has been given to what is required to make these interventions accessible to parents or to professionals serving the public. As dysfunctional parenting (e.g., inconsistency, coercive discipline and violence) is related to a wide range of health, social and educational problems in children and young people, it is alarming that few families of children with identifiable conduct problems or who are at-risk of child abuse notification receive treatment (Zubrick et al., 1995).

Although there is a wide range parent education and family support approaches, relatively few have been formally evaluated and those that are based on careful research are not widely available (Taylor & Biglan, 1998; Weisz, Weiss, & Donenberg, 1992). Many services continue to use non-evaluated parenting and family support programs (Webster-Stratton & Taylor, 1998). If parents access untested and ineffective services or try out strategies without adequate
support, they may conclude that interventions “do not work” (Patterson & Chamberlain, 1994) and may be less likely to seek further help or become more resistant to therapeutic suggestions.

There is general consensus that access to effective parenting programs needs to be improved for the families who most need them. Traditionally, however, maltreating parents have not participated in parenting programs available in the community and of those parents who do, it is an unfortunate reality that many are resistant and at greater risk of dropping out. The lack of success of traditional parent training programs in engaging parents who are at-risk of maltreating their children, or families who have been notified to protective services for child maltreatment, suggests that special efforts need to be made to engage families who might benefit from such interventions, and to focus on prevention and early intervention.

This paper examines the role of parenting interventions in the prevention and management of child maltreatment. We argue that the reduction of abuse potential of parents must be tackled within an ecological or systems-contextual framework within a comprehensive multilevel model of parenting and family support available at a population-level. We also discuss issues in the dissemination of evidence-based interventions and provide recommendations based on our experience in disseminating the Triple P—Positive Parenting Program.

1. The relevance of behavioral family intervention

Poor discipline practices and lack of parental monitoring have been shown to account for up to 50% of the variance in criterion measures of child antisocial behavior (Forgatch, 1991). Parenting practices may also mediate the effects of other contextual factors such as social isolation, daily stress, parental depression, relationship conflict and social disadvantage on child behavior problems (Patterson, Dishion, & Chamberlain, 1993; Patterson, Reid, & Dishion, 1992). There is also increasing recognition of the influence of internal determinants of behavior, such as parents’ attributions, beliefs and expectations that are the residues of past reinforcements (Bandura, 1995a) and self-efficacy beliefs (Bandura, 1995b).

Behavioral family intervention (BFI) aims to promote children’s development and self-esteem and change their behavior by modifying dysfunctional parenting practices, interpersonal relationships, and interaction patterns identified as risk factors for the development of problem child behavior (Patterson, 1982; Sanders & Dadds, 1993). Typically, BFI programs have a core parenting skills training component where parents are taught to increase positive interactions with children and to reduce coercive and inconsistent parenting practices. Changes in other aspects of family functioning and parents’ psychological adjustment may also be intervention goals (Sanders, 1996). BFI may focus on parental cognitions and attributions as factors that contribute to parental self-efficacy, decision-making and behavioral intentions (Stern & Azar, 1998). In effect, in addition to parenting practices, BFI often addresses cognitive, affective and family contextual factors as well as the behavioral dimension of parent–child interaction (Sanders, 1996).

The theoretical underpinnings of BFI involve consideration of the cognitive and social interactional contingencies affecting the acquisition and maintenance of particular behavior patterns (Skinner, 1953; Baer, Wolf, & Risley, 1968; Bandura, 1977). Certain accidental reinforcers for aggression occur naturally in a child’s environment (e.g., thegressor getting a desired toy) and operant learning may take place by the inadvertent positive reinforcement of behavior, such as through increased attention while reasoning, trying to discipline, or attempting to placate a child (Taylor & Biglan, 1998). However, the primary contingencies for aggression in the home appear to involve negative reinforcement or escape conditioning, which often occur in the context of little contingent positive reinforcement for appropriate behavior, forming the basis for coercive interactions in which escalating problem behaviors terminate the aversive behavior of another (Patterson, 1982). This short-term gain increases the likelihood of coercive patterns of family interaction occurring again.

Current research on family intervention offers a strong empirical basis for BFI (Patterson et al., 1992). Rigorously designed studies showing the efficacy of this approach are more numerous than those supporting any other approach to treating children and families (Taylor & Biglan, 1998). The outcomes of these studies typically show reductions in parent negativity and dysfunctional parenting strategies and rapid improvements in children’s adjustment and behavior. Meta-analyses of treatment outcome studies have reported large effect sizes for children’s behavior (Serketich & Dumas, 1996). BFI outcomes for children have been demonstrated to generalize not only from the clinic setting to home, but also to community settings (e.g., Dadds, Sanders, & James, 1987; Webster-Stratton, 1998) and school settings (e.g., McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991; McTaggart & Sanders, 2003).
Parents show improvements in their parenting strategies and their attitudes towards their children (e.g., Webster-Stratton, 1984), reduced couple conflict over parenting (e.g., Nicholson & Sanders, 1999), a greater sense of parenting competence and reduced stress (e.g., Gross et al., 2003; Nixon, Sweeney, Erickson, & Touyz, 2003). Improvements in other areas of functioning are also often reported, including reductions in maternal depression (Sanders & McFarland, 2000) and improved relationship satisfaction (Dadds, Schwartz, & Sanders, 1987). Distress may be alleviated through parents developing better parenting skills which may reduce their feelings of helplessness, depression and stress (Webster-Stratton, 1994).

However, not all families show gains from parent training (Kazdin, 1997; McMahon & Slough, 1996). In particular, families with multiple problems may benefit from further intervention components targeting other areas of risk. The most common successful adjunctive interventions have included parent self-control training (Wells, Griest, & Forehand, 1980), parent communication skills, problem-solving and partner support strategies (Dadds, Schwartz et al., 1987), cognitive behavioral mood management strategies and coping skills for parental depression (Sanders & McFarland, 2000), social problem-solving skills for parents (Piffler, Jouriles, Brown, Etscheidt, & Kelly, 1990), anger management strategies for families at-risk for child abuse (Acton & During, 1992), and synthesis teaching for parents with many life stressors which is designed to enhance parents’ discrimination between stressful parenting situations and other stressors and therefore promote consistent parenting (Wahler, Cartor, Fleischman, & Lambert, 1993).

BFI outcomes hold for a variety of delivery formats, including individually administered face-to-face programs (e.g., Forehand & McMahon, 1981), group programs (e.g., Webster-Stratton, 1990; Zubrick et al., in press), telephone-assisted programs (e.g., Connell, Sanders & Markie-Dadds, 1997) and self-directed programs (e.g., Markie-Dadds & Sanders, submitted for publication). Long-term follow-ups typically show maintenance of intervention gains. When children with disruptive behavior problems participate in BFI during their early years, they show levels of functioning that are indistinguishable from non-clinic individuals as they move into adulthood (Long, Forehand, Wierson, & Morgan, 1994).

Although there is less parent training research with maltreating parents, available evidence suggests that parent training leads to improvements in parenting competence and behavior (James, 1994; Sanders et al., 2004), and that these changes are an important aspect of minimizing the risk for further abusive behavior, reports to protective agencies, and visits to hospital (James, 1994; Wekerle & Wolfe, 1993). These findings emphasize the need for prevention and early intervention work and highlight the importance of parenting interventions in any comprehensive preventive intervention designed to prevent child maltreatment.

2. Effective interventions do not equal population impact

Despite the evidence for the efficacy of BFI, and the trend for managed care and cost-effective practice (Task Force, 1995), the accessibility of empirically supported interventions is typically poor (Barlow & Hofmann, 1997) as the use of these empirically supported interventions in clinical practice is not widespread (Wilson, 1995). Families presenting to agencies that provide intervention services for children and families commonly do not receive BFI (Taylor & Biglan, 1998). Only the minority of children with identifiable conduct problems receives any form of treatment. In Australia, it has been estimated that between 2% and 20% of children with identified mental health problems receive any form of treatment from specialist mental health services (Sawyer et al., 2000; Zubrick et al., 1995) and only about 10% of parents participate in parent education (Sanders et al., 1999).

Although many BFI programs are available, there is no evidence that they have made a difference at a population-level in reducing the community prevalence of childhood and adolescent problems (Sanders, 2001). The injection of more funds into current services will not, in isolation, solve the problem. A key challenge in meeting the need for better parenting is to develop cost-effective, accessible programs capable of reducing the prevalence of parenting practices known to be associated with poor developmental outcomes in children (Taylor & Biglan, 1998).

3. The need for prevention and early intervention

For many years, there has been a call for an organized systemic revision of service provision, with prevention as the foundation of a hierarchy of child and family services (McClellan & Trupin, 1989). The Ottawa Charter for Health
Promotion (World Health Organization and Canadian Public Health Association, 1986) provided a framework for public policy to have an increased focus on prevention and early intervention. Prevention has since been advocated as a key strategy for producing a significant improvement in the health and adjustment of young people (e.g., National Health Service, 1999; National Institute of Mental Health, 1998).

Chamberlin (1992) proposed that the most effective approach for improving service provision is to develop a comprehensive, community-wide approach focused on: 1) preventing low- and medium-risk families from becoming high-risk; and 2) providing intensive services to those who are already of high-risk status. This approach seeks to identify families at-risk and to intervene to prevent their movement along a trajectory towards extreme conflict or diagnosable disorder. Research suggests that effective preventive interventions can ‘nip in the bud’ potential risk factors and reduce difficult behavior in the early years, before more severe problems become established (Webster-Stratton & Taylor, 2001).

Another consideration in prevention programming and research can be drawn from the public health arena. It is recommended that the focus on prevention should be redefined as a focus on health promotion (Kok, 1993). Thus, instead of focusing entirely on preventing the development of conduct problems and child psychopathology, the investigation of programs that help to develop and maintain known protective factors becomes paramount (Raphael, 1992).

4. Dissemination of evidence-based prevention and early intervention programs

The overall aim of dissemination is concerned with the effective management of knowledge. It involves the transfer of knowledge about how to successfully plan, implement and evaluate family intervention and prevention programs, communicate the outcomes in both scientific and clinical arenas (including service providers, agencies and policy makers), and support the adoption of evidence-based approaches. Effective dissemination can avoid re-inventing the wheel and minimize the promotion of programs that are ineffective. Dissemination efforts can also provide information about how to access training and provide support for evidence-based programs, and facilitate communication and networking between agencies, organizations and individuals involved in parenting and family support activities. Dissemination networks can provide a forum for communication of innovations and new findings and promote a culture of evaluation and accountability.

4.1. Defining key constructs

The terminologies and minimum empirical requirements for interventions to be regarded as ‘proven effective’ have been the subject of recent scientific debate. Efficacy is the term typically used to describe the outcomes from clinical evaluation of interventions within controlled research environments, with carefully defined populations, tight experimental controls (e.g., randomized group comparison methodology), and outcome measurement in targeted areas, using clinically validated tools. The terms empirically based or evidence-based refer to interventions that have undergone rigorous efficacy research. The APA Task Force on Promotion and Dissemination of Psychological Procedures (APA Task Force, 1995) took these definitions further and described guidelines for an intervention to be classified by level of empirical evidence as well-established, probably efficacious or experimental. The debate about the clinical utility of randomized controlled efficacy trials continues (see Persons & Silberschatz, 1998). Concerns have been expressed about the generalizability of their findings to community settings (Weisz, Donenberg, Han, & Weiss, 1995; Weisz et al., 1992). This form of efficacy study should not be the sole basis for conclusions about empirical validity.

A second axis proposed for consideration by the APA Task Force (1995) concerns the assessment of the applicability, feasibility and generalizability of an intervention of proven efficacy in the community settings for which it is designed. This extension of efficacy research into community settings is often referred to as pertaining to effectiveness, external validity or clinical utility. The aim is to test the robustness of interventions by evaluating their impact when delivered through regular clinical services, by clinical staff usually employed by those services. It has been argued that effectiveness research should involve similar levels of methodological rigor as efficacy research (Mintz, Drake, & Crits-Christoph, 1996). Effectiveness data should be available before system level dissemination to organizations (Folette et al., 2002, Society for Prevention Research, 2004).

Evidence of the widespread application of an intervention is necessary to assess its generality and impact (Stolz, 1981). This latter criterion involves the assessment of dissemination strategies. Dissemination trials test the effective-
ness of various strategies and procedures that seek to transfer knowledge regarding evidence-based practice and promoting its adoption. This involves a process of communication between those who know about an innovation (researchers and developers) and those who do not (practitioners in community settings). Adoption refers to the acceptance and implementation of an innovation by the dissemination targets, which may be individuals, organizations and/or policy makers. To be considered successful, adoption must occur while maintaining intervention fidelity, integrity or adherence. That is, the critical features of the intervention are implemented consistently across adopters and there is no drift from the original validated procedures. Successful dissemination does not rest with the initial adoption of an innovation. Maintenance refers to the sustained implementation of an innovation and its incorporation into usual practice.

To be considered ready for broad dissemination, a program must meet efficacy criteria (Task Force, 1995) and effectiveness criteria and have the ability to go to scale, including program materials (e.g., manual, training program and technical support), cost information, and monitoring and evaluation tools available for practitioners (Society for Prevention Research, 2004). Further examination of effectiveness in community settings following dissemination should involve assessment of the cost-effectiveness of evidence-based interventions, considering client outcomes within the context of staff training and staff retention (Strosahl, 1998) and changes in service delivery practices.

4.2. Obstacles for program disseminators

In the field of mental health promotion, prevention and early intervention, considerable effort has been devoted to efficacy trials, much less attention has been given to effectiveness trials and there is little solid empirical evidence guiding how to disseminate evidence-based programs. Several obstacles to successful dissemination have been identified:

4.2.1. Lack of empirically validated dissemination theory

Although there has been considerable theorizing about the dissemination of innovation, there is much less empirical evidence testing key assumptions underlying these theories (Glisson, 2004). There has been little empirical evaluation of theories of best practice for dissemination of evidence-based prevention and early intervention programs, and whether existing dissemination strategies are effective in changing the attitudes and behavior of service providers. Little research has been reported that identifies strategies and mechanisms which will increase the uptake of violence prevention or mental health promotion programs. Such research is needed to identify the best ways to disseminate programs that work.

4.2.2. Lack of funding for dissemination activities

Most funding agencies that have supported family intervention research activities have not funded the dissemination stage of a project. A constraint of non-recurrent, project-based funding is that there is a limited capacity to disseminate programs to others. Conversely, when programs are widely disseminated there is often no evaluation to provide a clear evidence-base that a program achieves its objectives in its disseminated form.

4.2.3. Lack of incentives for program innovators

Practitioners and program developers who have the knowledge and experience in developing interventions are often unable to disseminate their programs properly because of the lack of clear incentives or an opportunity to do so. In an environment of competing demands, where academic institutions value teaching, research and peer reviewed publication, and where career incentives or rewards for spending time on dissemination activities are severely limited, it is little wonder such activity is given low priority. Similarly, when project staff members are on short-term employment contracts, the ability of staff to develop and refine program resources and materials is limited.

4.2.4. Legal complexities

The laws in relation to copyright and intellectual property are complex. There is considerable potential for conflict between program developers, universities and governments over the question of ownership of programs. These issues are not easily resolved through authorial assignment of copyright or licensing arrangements, particularly where there
are already published resources and materials that have been used in funded projects and where the amount of funding received has not been sufficient to develop the program.

4.2.5. Lack of entrepreneurial thinking

Program innovators generally have the greatest investment in ensuring a program that works is properly disseminated. However, there is a need to develop business models and mechanisms of dissemination to support individuals and organizations that have developed evidence-based programs to develop a proper business case for training and resourcing practitioners to deliver worthwhile programs.

4.2.6. The real costs of dissemination

There is little information available about the actual costs of properly disseminating family intervention programs. Economic analyses are needed to determine the cost and benefits of interventions that have the potential to be widely disseminated. Lack of consideration of dissemination costs can lead to effective programs not being disseminated at all.

4.3. A model of dissemination influences

To be considered effective, a dissemination strategy needs to influence providers’ behavior through the adoption and implementation of programs. The following factors are likely to influence the extent of program adoption by agencies and service providers (potential influences are presented graphically in Fig. 1).

4.3.1. Characteristics of the program itself

Programs are more likely to be adopted if they have good resources (e.g., clinician manuals, client materials) that are professionally produced and user-friendly. Relatively low-cost resources that are perceived to be of high quality, flexible, and compatible to an organization’s clientele and core business are more likely to be used.

![Fig. 1. Conceptual model of dissemination.](image-url)
4.3.2. Quality of training provided to practitioners
The availability of adequate training for potential adoptees, and opportunities for accreditation, are also likely to increase program adoption. Training needs to be funded at a commercially viable and therefore sustainable level for organizations to make an ongoing commitment to program implementation.

4.3.3. Consumer advocacy and support
Programs that have strong consumer advocacy and that have a broad base of support within the community are more likely to be adopted than programs without such support. However, it does not follow that the only programs that will be adopted are those that have originated within and from the community.

4.3.4. Practitioner factors
The likelihood of program implementation by practitioners is related to the level of confidence and self-efficacy practitioners attain following training in the use of a program. Practitioners who are confident that they have the skills to implement a program are more likely to do so. Other factors that may influence uptake include their prior experience with the program or similar programs, their knowledge of the intervention and allegiance to the theoretical model of intervention, their perception of possible barriers to implementation and their level of exposure to training. Many of these variables have not been properly tested in dissemination trials.

4.3.5. A communication strategy using the media
Public and professional knowledge and support for an intervention can also be influenced by the media’s interest in the issue of violence prevention. Knowledgeable and insightful editorials, and the cultivation of good relationships with members of the media can affect the public profile of a program and the level of support in the broader community.

4.3.6. Organizational support
Effective dissemination requires more than having quality programs, good training, and competent staff available to deliver them. Service providers in a position to implement programs work in a broader organizational context and culture that can either support or impede the adoption and implementation of a program. Having internal champions or advocates within an organization refers to the extent to which an organization or agency sees the program as core business, provides or secures funds to support the implementation of the program, provides line management support and resources for program implementation, and facilitates staff access to training and supervision. Glisson (2004) argues that organizational change agents have an important role in assisting agencies and organizations to manage the process of change that is required for the successful adoption of evidence-based programs. Potential tasks include educating opinion leaders about the innovation, providing updates about recent developments, advising and assisting with conflict mediation, assessing problems in the adoption process, generating interest in the innovation in the wider community, and providing advice on how to establish interpersonal networks involving stakeholders.

4.3.7. Client variables
Practitioner judgments about the potential applicability of an intervention to their own work is also influenced by their perceptions of the similarity between the sample of clients used in a demonstration trial and their own client population, and therefore the degree of compatibility of the program to their clients needs. Factors such a program’s ease of use, flexibility, and capacity to be tailored to address the complex needs of “at-risk” groups who vary in severity and immediacy of risk, and the modifiability of risk factors and protective factors relating to family violence are also related to judgments of “user friendliness” with given client populations.

5. Dissemination of the Triple P—Positive Parenting Program
To reduce community prevalence rates of family conflict and dysfunctional parenting practices, and therefore emotional and conduct problems in children and adolescents, we contend that a population approach addressing the broader ecological context of parenting (e.g., Biglan, 1995; National Institute of Mental Health, 1998) as well as the knowledge, skills and confidence of parents is required.
5.1. Triple P multilevel system

The Triple P—Positive Parenting Program is a multilevel, parenting and family support system developed by the authors and colleagues at the University of Queensland in Brisbane, Australia. The system draws on social learning models that highlight the reciprocal and bi-directional nature of parent–child interactions (e.g., Patterson, 1982), and incorporates many successful behavior change techniques identified through research in child and family behavior therapy (Sanders, 1996). In its population approach, the Triple P model also draws on public health research on changing health risk behaviors that has been applied within a mental health framework (e.g., Becker et al., 1992).

The Triple P system of parenting and family support aims to promote family harmony and reduce parent–child conflict by helping parents develop a safe, nurturing environment and promote positive, caring relationships with their children, and to develop effective, non-violent management strategies for dealing with a variety of childhood behavior problems and common developmental issues (Sanders, Markie-Dadds, & Turner, 2001). The self-regulation of parental skill is a central construct in the program. Apart from improving parenting skills, the program aims to increase parents’ sense of competence in their parenting abilities, reduce couples’ conflict over parenting, and reduce parenting stress. Triple P also aims to change the ecological context of parenting by validating parenting experiences, increasing social and emotional support, and normalizing parent education.

Interventions range from a universal population-level media information campaign targeting all parents to primary care consultations targeting mild, discrete behavior problems, and extend to intensive parent training and family intervention programs and cognitive therapy for families with multiple risk factors (e.g., relationship problems, parental adjustment problems, family violence or attributional bias) or children with more severe behavioral problems or disabilities (see Table 1). The empirical basis of Triple P has been detailed elsewhere (e.g., Sanders, 1999, 2001; Sanders, Markie-Dadds, Tully, & Bor, 2000; Sanders, Turner, & Markie-Dadds, 2002).

The Triple P system is based on the principle of sufficiency and aims to determine the minimally sufficient intervention a parent requires in order to deflect a child away from a trajectory towards more serious problems. For parents concerned about their parenting skills or child’s behavior, there are differences in the severity of problems experienced, breadth of knowledge, motivation, access to support and additional family stresses (e.g., family violence, substance abuse, financial difficulties). Any one family intervention program is unlikely to cater for the requirements of all parents, therefore differing levels of support are offered. Consequently, Triple P allows the strength of the intervention to be tailored to the assessed needs and preferences of individual families. It incorporates five levels of intervention on a tiered continuum of increasing strength to maximize efficiency, contain costs, avoid over-servicing and to ensure the program has wide reach in the community. The varied delivery modalities and multidisciplinary reach of the program promote better utilization of the existing professional workforce in promoting competent parenting and reducing family conflict.

5.2. Triple P dissemination activities

For the past 10 years, our team at The University of Queensland has faced the challenge of building on successful efficacy and effectiveness trials of Triple P interventions, by undertaking and evaluating the dissemination of the Triple P system. We have viewed the process of changing professionals’ consulting practices as a complex interaction between the quality of the intervention, the skills training and the practitioner’s post-training environment.

5.2.1. Theoretical basis

Our approach to dissemination of program variants following empirical validation is underpinned by two complementary perspectives (see also Sanders and Turner, in press).

5.2.2. Self-regulation

As in our parent education programs, Triple P dissemination activities are based on a self-regulatory approach (e.g., Karoly, 1993) to promoting professional behavior change. To promote practitioner self-efficacy, program content and processes are introduced through active skills training with a focus on self-directed learning, personal goal setting for skill development, self-evaluation, and problem-solving.
<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Target population</th>
<th>Professionals delivering intervention</th>
<th>Intervention methods</th>
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<tbody>
<tr>
<td>Level 1</td>
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<tr>
<td>Universal Triple P</td>
<td>All parents interested in information about parenting and promoting their child’s development.</td>
<td>Professionals who offer advice and support to parents and/or work in the field of health promotion (e.g., parent aide volunteers).</td>
<td>Coordinated media and health promotion campaign raising awareness of parent issues and encouraging participation in parenting programs. May involve electronic and print media (e.g., community service announcements, talk-back radio, newspaper and magazine editorials).</td>
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<td>Media-based parent information campaign</td>
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<td>Level 2</td>
<td>Parents interested in parenting education or with specific concerns about their child's development or behavior.</td>
<td>Parent support during routine well-child health care (e.g., child and community health, education, allied health and childcare staff).</td>
<td>Health promotion information or specific advice for a discrete developmental issue or minor child behavior problem. May involve a group seminar process or brief (up to 20 min) telephone or face-to-face clinician contact.</td>
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<td>Selected Triple P</td>
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<td>Selected Teen Triple P</td>
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<td>Health promotion strategy/ brief selective intervention</td>
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<td>Level 3</td>
<td>Parents with specific concerns about their child’s behavior or development who require consultations or active skills training.</td>
<td>As above, with the ability to offer repeat brief consultations with families.</td>
<td>Brief program (about 80 min over four sessions) combining advice, rehearsal and self-evaluation to teach parents to manage a discrete child problem behavior. May involve telephone or face-to-face clinician contact or group sessions.</td>
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<td>Primary Care Triple P</td>
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<td>Primary Care Teen Triple P</td>
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<td>Narrow focus parenting skills training</td>
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<td>Level 4</td>
<td>Parents wanting intensive training in positive parenting skills. Typically parents of children with behavior problems such as aggressive or oppositional behavior.</td>
<td>Intensive parenting interventions (e.g., mental health, welfare and other allied health and education staff who regularly consult with parents about child behavior).</td>
<td>Broad focus program (about 10 h over 8–10 sessions) focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions.</td>
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<td>Standard Triple P</td>
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<td>Group Teen Triple P</td>
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<td>Self-Directed Triple P</td>
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<td>Self-Directed Teen Triple P</td>
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<td>Broad focus parenting skills training</td>
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<td>Level 5</td>
<td>Parents of children with concurrent child behavior problems and family dysfunction such as parental depression or stress or conflict between partners.</td>
<td>Professionals with appropriate mental health qualifications and experience in family intervention (e.g., psychologists, psychiatrists, social workers and family counselors).</td>
<td>An intensive individually tailored program (up to 11 one hour sessions) for families with child behavior problems and family dysfunction. Program modules include home visits to enhance parenting skills, mood management strategies and stress coping skills, and partner support skills.</td>
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<td>Enhanced Triple P</td>
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<td>Behavioral family intervention</td>
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<tr>
<td>Specialist</td>
<td>Families of preschool children with disabilities who have or are at-risk of developing behavioral or emotional disorders.</td>
<td>As for Level 4.</td>
<td>A parallel 10-session program that includes adaptations for parents of preadolescent children who have a disability. This program includes parent training and introduces additional strategies drawn from disability research. Involves individual consultation with parents.</td>
</tr>
<tr>
<td>Stepping Stones Triple P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathways Triple P</td>
<td>Parents at-risk of maltreating their children. Targets anger management problems and other factors associated with abuse.</td>
<td>As for Level 5.</td>
<td>A four session intervention strategy for parents at-risk of child maltreatment. Adjunctive intervention used in combination with either Group or Standard Triple P. This intervention focuses on addresses parental anger and attribution retraining.</td>
</tr>
</tbody>
</table>
5.2.3. Ecological context

The second perspective is a systems-contextual approach that aims to support practitioners’ program use in their workplace. As professional change is optimized when managers, administrators and colleagues support the adoption of the innovation (Backer, Liberman, & Kuehnl, 1986), and when adequate supervision and support is available (Henggeler, Melton, Brondino, Schereer, & Hanely, 1997), the work environment is also a target in our dissemination activities. We propose that an effective dissemination process must not only adequately train practitioners in the content and processes of an intervention, it must also engage participating organizations to ensure that program adoption is supported. Hence, Triple P training and accreditation address both practitioner skill development and a range of workplace support strategies.

5.3. Approach to dissemination

5.3.1. Professional training

Standardized professional training programs have been developed for all levels of Triple P intervention. These training programs involve an active skills training approach involving didactic presentation, video and live demonstration of core consultation skills, small group exercises to practice skills, problem-solving exercises, and practice to a set level of proficiency. There are also recommended readings; assessment of knowledge of program theory, content and process issues; and demonstration of core competencies for accreditation. Every training course is carefully evaluated and feedback elicited on the content, quality of presentation, opportunities for active participation and practitioners’ overall consumer satisfaction. Practitioner feedback is incorporated into revisions of the training courses. To minimize disruption to work schedules and reduce the need for relief workers, Triple P training was designed to be relatively brief (2–5 days training and a 1-day accreditation workshop). The only prerequisite is professional training in psychology, medicine, nursing, social work, counseling, education or related fields providing exposure to principles of child development. Most training courses involve an interdisciplinary mix and bring together professionals with diverse backgrounds, theoretical orientations, and clinical experience. All training is conducted by accredited trainers, typically clinical or educational psychologists with training and experience in the field of behavioral family intervention. To prevent program drift, all trainers use standardized materials (including participant notes, training exercises, and training videotapes demonstrating core skills).

5.3.2. Workplace support

Our ecological approach has focused on the goals of internal advocacy, supervision and administrative support. A survey of over 1000 professionals completing training in Primary Care Triple P (Turner, 2003) identified a number of barriers to delivering the program following training. Many of the barriers related to the work environment, such as integration of the program with usual caseload or responsibilities, access to supervision, and ability to schedule after-hours appointments. To maximize agency support for the introduction of Triple P, the team endeavors to provide support specific to the needs of each agency adopting the program (see Sanders, Turner, & Markie-Dadds, 2002). This support may include policy briefings and orientation for administrators, supervisors or managers about the program, the training and accreditation procedures, and the expectations of the agency and staff members to be involved in implementing the program. As advocates for agencies, we have provided regular updates to key stake holders. Other strategies include development of procedural guidelines and performance targets, provision of materials for program promotion, and back-up consultative advice to assist sites to identify and overcome any barriers to implementation. We also aim to support staff by providing regular updates on Triple P research and program development via newsletters, conferences and web sites (e.g., www.triplep.net), and offering downloadable clinical tools and promotional materials, a clinical database, and a question and answer forum. We encourage establishment of peer support networks and promote strategies such as self-monitoring and self-evaluation, personal goal setting and self-reward for goal attainment (Halford & Sanders, 1994). These self-regulatory skills enable practitioners to direct their own learning, skill acquisition and problem-solving subsequent to training. The supervision approach promoted is closely tied to the self-regulation process, with each practitioner showing a section of a videotaped consultation session, or discussing a consultation issue, self-evaluating strengths and weaknesses and setting goals for change. Further feedback or suggestions are offered by peers as appropriate. The group format enables practitioners to share concerns, receive support, and learn from each other. Practitioners are also encouraged to access ongoing consultative advice post-training, such as ongoing e-mail contact, teleconferences, staff meetings, and update days to address adminis-
trative issues (e.g., data management), logistical issues (e.g., referral strategies) and clinical issues (e.g., process problems).

5.3.3. Quality maintenance

Maintenance of program integrity is crucial to minimize drift from validated methodology. To address this, we have endeavored to develop high quality training materials, practitioner manuals which include session outlines and protocol adherence checklists (e.g., Sanders et al., 2001), and parent resources (e.g., Sanders, Markie-Dadds, & Turner, 1996) to ensure that the program is standardized, easy to follow, accessible, and culturally sensitive. A Triple P International Scientific Advisory Committee has been established that provides a context for identifying research questions, curriculum development targets and new project ideas to be pursued. Any intervention level may be revised in the light of new data, theory or feedback from program users and consumers following dissemination.

5.4. Reach of Triple P dissemination

Triple P has been widely disseminated to over 16,000 health, education and welfare professionals in 14 different countries (Australia, New Zealand, the United States, Canada, England, Scotland, Germany, Switzerland, Netherlands, Hong Kong, Singapore, Japan, Iran, and Turkey). The program is currently being delivered through a number of services and agencies including general medical practices, child health services, mental health services, preschools, schools, places of work, telephone counseling services, community organizations and mass media.

6. Recommendations for dissemination of evidence-based interventions

Our experience with Triple P has convinced us that a carefully planned strategy can lead to the successful dissemination of evidence-based programs. As the program has evolved, it has been clear that the strategies used to disseminate the program to the field require careful ongoing empirical scrutiny, with key considerations for dissemination efforts as follows:

6.1. Program and resource development

The foundation of any dissemination effort is the development of user-friendly program resources. In the dissemination of evidence-based interventions, intervention manuals can support intervention fidelity through the provision of detailed procedural guidelines, example verbatim scripts to suggest how to introduce material or activities, and session activity checklists. When designing such resources, a key consideration is ecological fit with the practice environment within which the program is to be used. To counter concerns about manuals constraining practice (Addis, 1997; Wilson, 1996), they can also be written to allow considerable tailoring of interventions based on professional clinical judgment and client needs.

In our experience, the availability of parent resources has also greatly supported program uptake and effectiveness. Practitioners look for practical tools to support their service provision. Families also report understanding and adopting concepts quickly when presented in video format, such as demonstrations of strategies by other parents. They also report returning to written resources as a quick prompt or refresher. The availability of easy-to-follow, culturally sensitive resources can enhance access and support intervention fidelity, independent of practitioner skill or experience with the program.

Once developed, these resources should not become static. Within a scientist-practitioner perspective, evidence-based programs should be revised and refined in response to theoretical advances, new empirical data, and feedback from practitioners and families. This feedback can be incorporated into revised editions, program extensions and program derivatives. The same process applies to adaptations of a program for specific populations. For example, over recent years Triple P has been adapted for Australian Indigenous families, parents of children with ADHD, and school teachers. Each derivative program then needs to be evaluated and, if effective, disseminated to the field as appropriate.

6.2. Quality training

Clinical training programs need to be more attentive to teaching evidence-based interventions, with students trained to demonstrable efficacy (Crits-Christoph, Chambless, Frank, Brody, & Carp, 1995). These recommenda-
tions should be considered not only for graduate training in mental health and welfare programs but also in health and allied health professions where much early intervention and prevention work are likely to occur in the future. When disseminating to practicing professionals, training programs must be carefully controlled to minimize program drift and ensure that practitioners receive the same training experience no matter where they are trained. To be licensed, Triple P trainers undergo intensive training and accreditation, use identical materials, adhere to a quality assurance process and join a trainer network. This network also allows for curriculum review and regular updates of materials in response to data from the field and in line with program revisions. While this approach has proven successful, further research is needed to identify the necessary and sufficient conditions for achieving successful training outcomes.

6.3. Promotion of practitioner self-efficacy

Given the central importance of practitioner self-efficacy (Turner, 2003), training programs and guidelines for subsequent self-directed learning and peer support should all focus on enhancing self-efficacy. The training process adopted in Triple P dissemination pays particular attention to the development of consulting skills as well as knowledge of program content and theoretical basis. Self-regulation is fostered by encouraging practitioners to take personal responsibility for their learning, and is favored over more directive training methods and feedback from others. Accreditation has become one of the key supports in both quality assurance following Triple P training and in fine-tuning practitioner skills, with subsequently enhanced self-efficacy. This joint focus on theory, practical skills training, and personal responsibility for learning may be responsible for the increased confidence practitioners report in their parent consultation skills (Turner, 2003).

As we have found with the Triple P Practitioner Network, an internet-based network for professionals trained in a program provides a forum for clinical problem-solving, clinical updates, and access to clinical resources. It also provides a web-based referral network as has been recommended by Satterfield (2000), and allows dissemination of summaries of research findings and updates based on new research as recommended to keep practicing clinicians informed (Glanville, Haines, & Auston, 1998). The result is to keep practitioners in contact with program developers, each other, and the state-of-the-art in relevant research findings.

6.4. Workplace support

Effective dissemination involves more than program adoption at an individual level, it involves the implementation of strategies to enhance systemic change and effect a supportive work culture and climate (Oldenburg, Hardcastle, & Kok, 1997). As adoption of new innovation is more likely to occur when leaders in an organization support the innovation, effective large-scale dissemination must involve the development of alliances with key stakeholders to ensure the adoption process is supported by administrators and staff (Backer et al., 1986; Parcel, Perry, & Taylor, 1990; Webster-Stratton & Taylor, 1998). This process involves strategies for providing information about the distinguishing features of the intervention, the potential benefits, the logistics involved, and costs of adoption. Central to this process is the identification of an internal advocate who can be engaged in interpersonal contact with dissemination staff in order to foster support for the new program (Backer et al., 1986; Webster-Stratton & Taylor, 1998). The identification of such an advocate has typically occurred in the large-scale dissemination of Triple P, whether through the establishment of new population trials or through organizational adoption, such as in government departments in new areas. As the departure of key personnel is inevitable, program disseminators must be prepared to inform new policy advisors and program managers about the program, the agency’s history of involvement with the program, and the benefits of providing continuing support.

Following program adoption, ongoing consultation (e.g., via email, face-to-face contact, teleconferencing, or video link-ups) can help foster organizational adoption of the program and development of a culture of acceptance and support for practitioners implementing the program. For example, supervision and administrative guidelines may not only increase program use, they may enhance quality assurance in the practical implementation of the program. In large organizations, misinformation and resistance to the introduction of new programs
are common (Kavanagh et al., 1993). Efforts to inform management and staff about the program and involving them in the process of dissemination go a long way to defusing potential organizational resistance. Myths may develop about the content or format of a program, or the populations for which it is best suited. These myths may be countered by presenting factual information from research trials (Sanders & Turner, 2002). Through training and ongoing consultation, practitioners may be encouraged to debate such misinformation in order to garner support in their workplace.

6.5. Supervision

Research has identified the importance of ongoing supervision in clinical practice for promoting use of the training undertaken by a practitioner (Holloway & Neufeldt, 1995) and to maintain program fidelity beyond initial training (Henggeler et al., 1997). Effective supervision of staff involved in a program dissemination effort includes peer support and mentoring of practitioners who are new to the program (Webster-Stratton & Taylor, 1998). In the dissemination of Triple P, establishment of peer support networks and a self-regulatory approach to supervision are promoted. Practitioners are more likely to use self-regulatory skills in organizational environments that support and encourage them to do so. Following training, practitioners are encouraged to establish or join peer support/supervision networks to prepare for the accreditation process. In the longer term, ongoing peer support is recommended to facilitate reviews of case management, continue skill development, prevent significant drift from original evidence-based clinical protocols, and foster colleague support to prevent burnout.

7. Conclusions

There is strong empirical support for BFI as an evidence-based parenting and family support strategy (Patterson et al., 1992; Sanders, 1999; Taylor & Biglan, 1998), however, much of this support stems from efficacy research, with little research into effectiveness or clinical utility (Taylor & Biglan, 1998). Many programs evaluated and supported through scientific rigor are not well disseminated following successful research trials. Despite the notion that BFI may be the most effective intervention available for at-risk families (Kazdin, 1991; McMahon & Wells, 1998), there has been little impact on population prevalence rates of child maltreatment or childhood behavioral and emotional problems as they are not widely available through community services (Taylor & Biglan, 1998). Effective dissemination is critical for evidence-based research to have any significant community impact. Furthermore, a system such as Triple P that seeks to reduce the prevalence rates of child and parenting problems requires disseminated interventions to be widely used by trained practitioners so that there is sufficient program reach or parental exposure to the intervention. Without this parental involvement population approaches will not be successful.

Of the parent training and family intervention programs that have been disseminated, many have been delivered late in the developmental trajectory as interventions for high-risk children already showing signs of behavioral disorder or diagnosed conduct problems, or for families notified for abuse or neglect, rather than as universal preventive programs. As the need for greater community access to quality parenting and family support programs has become apparent, there has been a shift toward preventive and health promotion interventions, as well as treatment of existing mental health problems in settings other than mental health and welfare services.

If parenting and family support strategies are to become part of core business in multidisciplinary services, professionals need better training and access to high quality, well-researched programs and resources (Taylor & Biglan, 1998). To date, there is little documented evidence for the effectiveness of clinic-based interventions with children and adolescents (Barlow, Levitt, & Bufka, 1999; Weisz et al., 1992), with even less examination of the clinical utility of BFI in non-mental health community services such as primary care settings (Bower, Garralda, Kramer, Harrington, & Sibbald, 2001). There is a great need for further evaluation of the application in clinical settings of interventions tested in controlled research. By evaluating not only the efficacy of psychological treatments, but also the effectiveness or clinical utility of such interventions, and best practice models of dissemination, we can bridge the gap between science and practice and thereby improve the dissemination of effective interventions and enhance their population impact.
References


