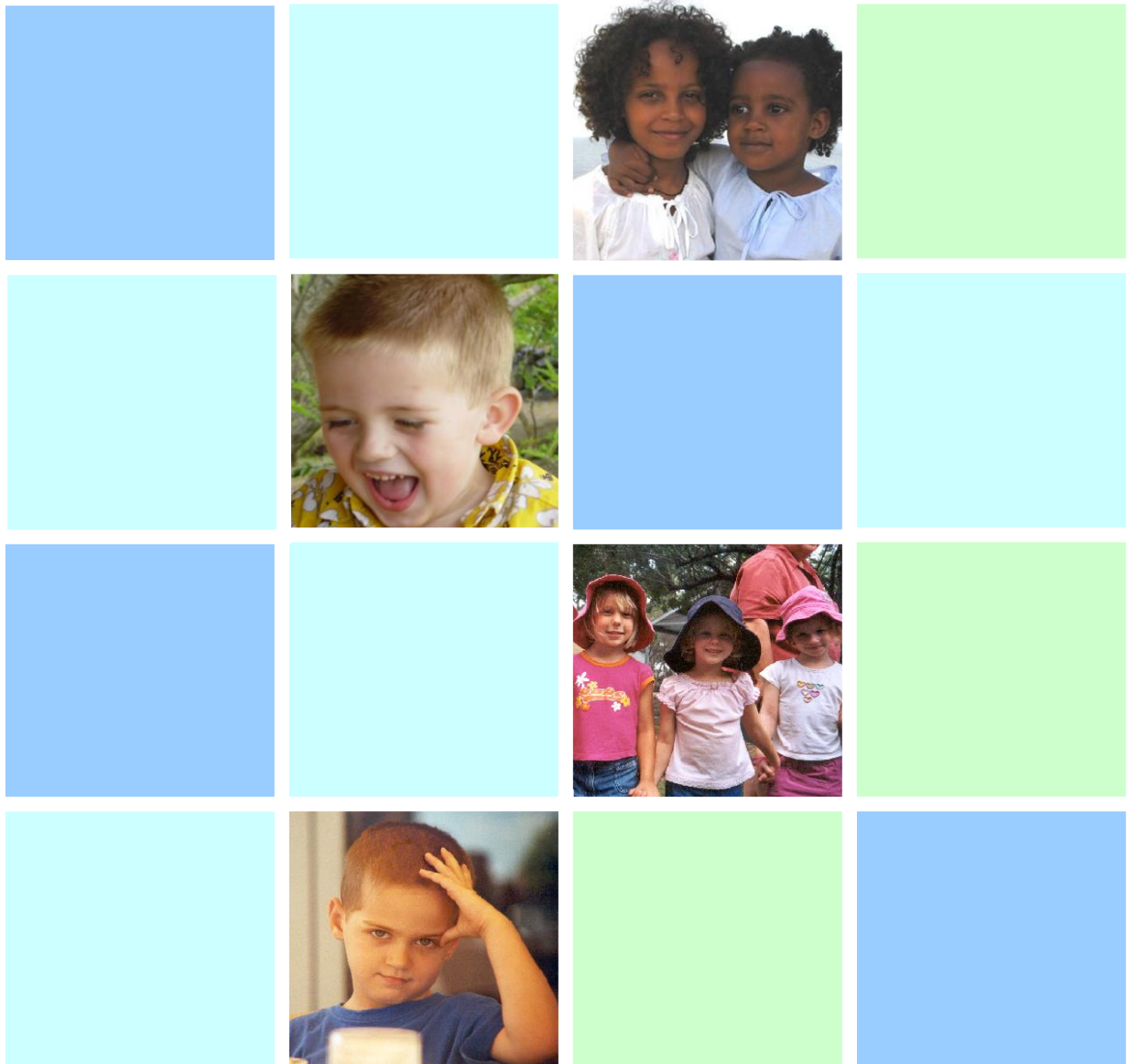




# Triple P-Positive Parenting Program

## Review of Evidence



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## 1. Executive summary

The Triple P-Positive Parenting Program is a multi-level system of parenting and family support developed by Professor Matt Sanders and colleagues in the Parenting and Family Support Centre at the University of Queensland. It is supported by over 35 years of evaluation research and is the most extensively studied parenting intervention in the world. Triple P is currently implemented in 25 countries, translated into 18 languages, and has reached an estimated 7 million children globally.

- *Triple P has a substantial evidence base.* The Triple P evidence-bases comprises 157 evaluation studies conducted by (see Appendix A)
  - 429 different researchers
  - 129 different institutions
  - 13 countries
  - 36% of studies have been independent evaluations
- *The vast majority of studies show positive effects:* Of these studies, 151 (96.2%) show significant positive effects across a range of child and parent outcomes (see section 2.3).
- *A wide range of children benefit.* Children shown to benefit from Triple P interventions include children with oppositional defiant disorders; conduct disorders, ADHD, developmental disabilities, autism spectrum disorders; anxiety disorders; chronic illnesses and pain syndromes; persistent feeding difficulties; who steal and lie.
- *A wide range of parents benefit.* A wide range of parents have also participated and shown to benefit from Triple P including socially disadvantaged parents, parents experiencing serious mental health concerns (e.g., major depression, bipolar disorder), parents experiencing separation and divorce, parents with difficulties controlling their anger. Positive effects have been demonstrated for both mothers and fathers (although more mothers than fathers typically participate in parenting programs), indigenous parents, and grandparents.
- *Triple P has also been shown to work in many different cultures.* Triple P has been implemented in 25 countries and translated into 18 languages. The cultural acceptability and effectiveness of parenting strategies used in Triple P have been documented with parents in Australia, New Zealand, Japan, Singapore, Hong Kong, Iran, Scotland, England, Ireland, Sweden, Belgium, the Netherlands, Germany, Turkey, Switzerland, United States, Canada, South Africa and Panama. Audio visual case examples documenting the impact of Triple P can be found at <http://evidence.triplep.org>.
- *Triple P has been shown to be a highly cost effective intervention.* Several economic analyses conducted in Australia and internationally have provided evidence for the cost effectiveness of Triple P.
- *Only a small minority of studies show no effects.* Six (6) studies comprising 3.8% of available evidence failed to find a significant positive effect of Triple P. These few studies which fail to show positive effects contained methodological shortcomings, interpretational errors, or used a variant of Triple P that has not been made available to the public or professionals (see section 2.5).
- *Triple P is internationally recognized by independent experts as a quality program.* Triple P appears in many evidence-based lists of scientifically supported interventions (e.g. Blueprints for Violence Prevention) and is cited as an evidence-based program in many policy documents (e.g. WHO, UNODC; see section 3).

### Summary

Triple P is the world's most extensively evaluated, strongly supported and widely implemented system of parenting intervention. Triple P produces empirically supported, beneficial effects across multiple indices of child, parent and family functioning, across cultures, socioeconomic groups, and age groups from toddlers to teenagers. Triple P is the only parenting intervention to have demonstrated population level effects on child maltreatment.

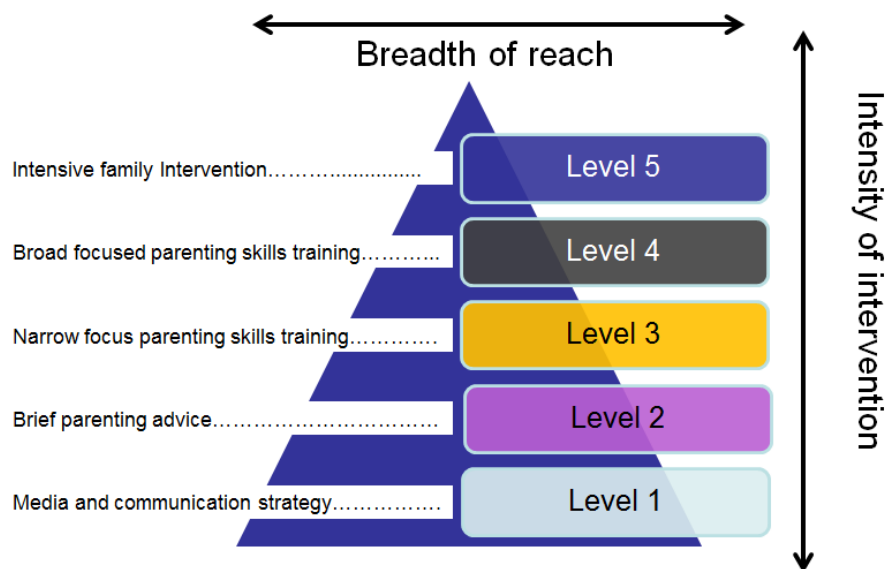
## 2. Review of evidence supporting the effectiveness of Triple P

Triple P has an extensive evidence-base documenting the effectiveness of the intervention on children and parents. This evidence has accumulated over a 35 year period. It has a successful history of implementation in Australia and many countries throughout the world.

### 2.1 What is the Triple P system?

The Triple P-Positive Parenting Program (Triple P) has its origins in social learning theory and the principles of behaviour, cognitive, and affective change articulated in the 1960s and 1970s. The public health model of parenting support used in Triple P took 35 years to develop and involved the collective efforts of a number of staff and postgraduate students at the University of Queensland (see Sanders, 2012).

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



**Figure 1.** The Multilevel Triple P System of Parenting Support an Intervention varying as a function of reach and intensity across the 5 levels of intervention.

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

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

## 2.2 The evidence-base website

The evidence supporting the Triple P system is accessible to all through the published literature and through the Triple P Evidence Base website maintained by the Parenting and Family Support Centre. The evidence-base website contains the most comprehensive and up to date listing of all Triple P related research and can be found at <http://www.pfsc.uq.edu.au/research/evidence>

## 2.3 Findings from a comprehensive analysis of all Triple P studies

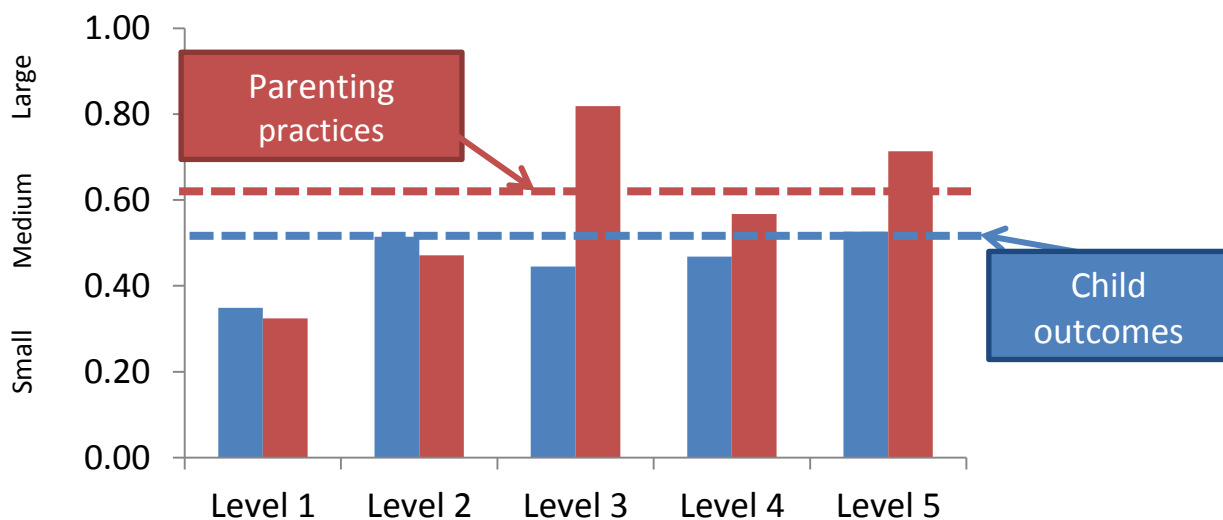
Sanders, Kirby, Tellegen, and Day (2013) have conducted the most comprehensive meta-analysis of Triple P evaluation studies reported to date. The analysis involved a comprehensive literature search and included both published and unpublished studies on Triple P (N=157). The final analysis included a total of 101 studies which provided outcome data on the effects of Triple P and met the eligibility criteria for inclusion in the review (e.g., single N and population level trials could not be included in the analysis). Child and parent outcome data from these studies were combined and analysed to determine the overall effects that Triple P had on children and families.

The analysis included data from a total of 17, 577 families, from 13 countries, with a target child age range of 0-17yrs (mean age of 5.68yrs). The meta-analysis followed the PRISMA guidelines (see [www.prisma-statement.org](http://www.prisma-statement.org)) for reporting the results of meta-analyses. Several different sources of bias were examined including publication bias and investigator bias.

A wide range of child parent and family outcomes were assessed including: (1) Parent reports of child social, emotional and behavioural outcomes; (2) Parenting practices; (3) Parenting satisfaction and confidence; (4) Parental adjustment (e.g. levels of stress, depression, anxiety in parents); (5) Parental relationship satisfaction (e.g. happiness between parents and conflict between parents); and (6) Independent observations of child behavior (observed child appropriate and inappropriate behaviours).

An effect size was calculated for each outcomes measure for each study. An effect size gives a measure of the strength of an intervention effect. It shows the extent to which an intervention has an impact on the outcomes it is targeting. In a meta-analysis, the effect sizes found across studies were combined to give an overall effect size.

Figure 2 summarizes the overall positive effect sizes Triple P attains for both child outcomes and parenting practices (the primary targets of the intervention). Table 1 shows the short-term intervention effects (improvements seen in families when measured immediately after completing intervention). Table 2 shows the long-term intervention effects (improvements seen in families 2-36 months after completing Triple P). Effect sizes can be interpreted using Cohen's (1988) guidelines: 0.2 = small effect; 0.5 = medium effect; 0.8 = large effect. Analysis of moderators of the intervention effects demonstrated benefits to children and parents regardless of whether the study was led by developer or independently, was published or unpublished, or used a large or small sample.



**Figure 2.** Effect sizes for child and parent outcomes as a function of level of intervention

**Table 1.** Meta-Analysis Short-term intervention effects

Outcome and level	Number of samples	<i>d</i> (overall effect size)	<i>p</i> value for significance
<b>Child social emotional and behavioural outcomes</b>			
All levels combined	104	0.467	0.000 ***
Triple P Level 1	4	0.349	0.047 *
Triple P Level 2	8	0.514	0.000 ***
Triple P Level 3	6	0.445	0.000 ***
Triple P Level 4	75	0.468	0.000 ***
Triple P Level 5	11	0.526	0.000 ***
<b>Parenting practices</b>			
All levels combined	98	0.575	0.000 ***
Triple P Level 1	4	0.324	0.090 **
Triple P Level 2	9	0.471	0.000 ***
Triple P Level 3	5	0.819	0.000 ***
Triple P Level 4	69	0.567	0.000 ***
Triple P Level 5	11	0.714	0.000 ***
<b>Parenting satisfaction and confidence</b>			
All levels combined	73	0.519	0.000 ***
Triple P Level 1	4	0.243	0.006 **
Triple P Level 2	7	0.547	0.000 ***
Triple P Level 3	6	0.711	0.000 ***
Triple P Level 4	49	0.505	0.000 ***
Triple P Level 5	7	0.743	0.000 ***
<b>Parental adjustment</b>			
All levels combined	88	0.339	0.000 ***
Triple P Level 1	3	0.109	0.119 <i>ns</i>
Triple P Level 2	7	0.121	0.023 *
Triple P Level 3	3	0.348	0.026 *
Triple P Level 4	65	0.374	0.000 ***
Triple P Level 5	10	0.368	0.014 *
<b>Parental relationship</b>			
All levels combined	61	0.228	0.000 ***
Triple P Level 1	3	0.161	0.144 <i>ns</i>
Triple P Level 2	6	0.363	0.001 **
Triple P Level 3	2	0.500	0.014 *
Triple P Level 4	43	0.231	0.000 ***
Triple P Level 5	7	0.198	0.015 *
<b>Child observational data</b>			
All levels combined	21	0.483	0.000 ***
Triple P Level 1	-	-	-
Triple P Level 2	1	1.874	0.000 ***
Triple P Level 3	3	0.221	0.232 <i>ns</i>
Triple P Level 4	12	0.410	0.001 **
Triple P Level 5	5	0.525	0.000 ***

\*  $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ ; *ns* = not significant

**Table 2.** Long-term intervention effects

Outcome and level	Number of samples	<i>d</i> (overall effect size)	<i>p</i> value for significance
<b>Child social emotional and behavioural outcomes</b>			
All levels combined	54	0.531	0.000 ***
Level 1	3	0.622	0.050 *
Level 2	4	1.352	0.000 ***
Level 3	3	0.615	0.002 **
Level 4	36	0.401	0.000 ***
Level 5	8	0.793	0.006 **
<b>Parenting practices</b>			
All levels combined	46	0.494	0.000 ***
Level 1	3	0.367	0.053 ns
Level 2	4	0.820	0.000 ***
Level 3	2	0.463	0.020 *
Level 4	30	0.451	0.000 ***
Level 5	7	0.810	0.007 **
<b>Parenting satisfaction and efficacy</b>			
All levels combined	39	0.556	0.000 ***
Level 1	4	0.578	0.028 *
Level 2	3	0.844	0.052 ns
Level 3	3	0.784	0.001 **
Level 4	23	0.508	0.000 ***
Level 5	6	0.978	0.011 *
<b>Parental adjustment</b>			
All levels combined	43	0.483	0.000 ***
Level 1	2	0.364	0.088 ns
Level 2	3	0.462	0.010 *
Level 3	1	0.439	0.034 *
Level 4	31	0.460	0.000 ***
Level 5	6	0.731	0.035 *
<b>Parental relationship</b>			
All levels combined	35	0.225	0.000 ***
Level 1	2	0.198	0.103 ns
Level 2	3	0.309	0.077 ns
Level 3	1	0.480	0.033 *
Level 4	24	0.225	0.000 ***
Level 5	5	0.348	0.029 *
<b>Child Observation</b>			
All levels combined	13	0.380	0.011 *
Level 1	-	-	-
Level 2	-	-	-
Level 3	1	-0.032	0.560 ns
Level 4	7	0.906	0.006 **
Level 5	5	0.806	0.017 *

\*  $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ ; ns = not significant

## 2.4 Evidence from other meta-analyses of Triple P studies

The Triple P evidence-base includes seven published meta-analyses. Six of these are independent of the program developers. All of these meta-analyses have reported significant improvements in child behavior problems and parenting practices. Table 3 lists the existing independent meta-analyses of Triple P and the effect sizes obtained in these studies across both child outcomes and parenting practices. The consistent finding across all published meta-analyses is that Triple P produces positive effects on children's behaviour and parenting practices.

**Table 3.** Outcomes of independently Published Meta-Analyses of Triple P

Meta-Analysis Paper	Child Outcomes	Parenting Practices
Thomas & Zimmer-Gembeck (2007)	$d = 0.31-0.73$	$d = 0.38-0.70$
de Graaf, Speetjens, Smit, de Wolff, & Tavecchio (2008a)	Not Reported	$d = 0.68$
de Graaf, Speetjens, Smit, de Wolff, & Tavecchio (2008b)	$d = 0.80$	Not Reported
Nowak & Heinrichs (2008)	$d = 0.35-0.57$	$d = 0.38-0.55$
Fletcher et al. (2011)	Not Reported	$d = 0.77$
Tellegen & Sanders (2013)	$d = 0.54$	$d = 0.73$
Wilson et al (2012)	$d = 0.61$	Not Reported

## 2.5 Null-findings in the context of complete evidence

There have been six out of the 157 published and unpublished Triple P papers, which have found little or no evidence to support the effectiveness of the intervention evaluated. From these, two unpublished PhD studies evaluated a new version of Triple P (Baby Triple P), which has not been disseminated to the wider public population based on these findings (Spry, 2013; Tsivos, 2013). Another study was a Masters thesis based on a sample of only 17 parents and evaluated the effectiveness of providing tipsheets to parents of children with disabilities while providing no other support (Cassidy, 2009). The final three studies which found no significant effects had considerable problems with the implementation of the Triple P Program (Eisner et al., 2012; Little et al., 2012), used measures that had poor reliabilities (Eisner et al., 2012), or had a comparison group that significantly improved in parallel with the positive changes in the Triple P group (Schappin et al., 2013).

Cassidy, K. (2001). *Evaluation of the Effectiveness of Stepping Stones Tip sheets to Manage Challenging Behaviours in Children with Developmental Disability*: Unpublished Masters dissertation, Curtin University of Technology, Perth, Western Australia.

Eisner, M., Nagin, D., Ribeaud, D., & Malti, T. (2012). Effects of a universal parenting program for highly adherent parents: a propensity score matching approach. *Prevention Science, 13*(3), 252-266.

Little, M., Berry, V., Morpeth, L., Blower, S., Axford, N., Taylor, R., . . . Tobin, K. (2012). The impact of three evidence-based programmes delivered in public systems in Birmingham, UK. *International Journal of Conflict and Violence, 6*(2), 260-272. doi: 0070-ijcv-2012293

Schappin, R., Wijnroks, L., Venema, M., Wijnberg-Williams, B., Veenstra, R., Koopman-Esseboom, C., & Jongmans, M. (2013). *Triple P - Positive Parenting Program for parents of preterm born preschoolers: A randomised, clinical trial*. Manuscript submitted for publication.

Spry, C. (2013). *A randomised control trial examining the efficacy of Baby Triple P, a group based couple intervention*. Manuscript in preparation.

Tsivos, Z. (2013). *A pilot randomised controlled trial to evaluate the feasibility of the Baby Positive Parenting Programme in women with Postnatal Depression*. Manuscript submitted for publication.



## 2.6 Developer involvement in evaluation studies

Triple P has generated considerable scientific interest around the world. A wide range of studies have been conducted to date involving 429 different researchers, in 129 different institutions, across 13 countries, including studies conducted in NSW. 36% of these studies have been independent evaluations. Studies comprising the evidence base include: Published research (including RCTs, population trials, Single N studies), manuscripts under review, manuscripts in preparation, unpublished Masters and Doctoral dissertations, unpublished Professional Doctorate dissertations. All studies included involve some reporting on a study outcome regarding parenting, emotional functioning, partner relationship, or child behaviour/emotion. This list of studies excludes evaluation studies of the effects of professional training, and cultural acceptability studies. These additional studies can be found in the Triple P evidence base [www.pfsc.uq.edu.au/evidence](http://www.pfsc.uq.edu.au/evidence).

Table 4 shows that the highest proportion of studies of Triple P (36%) were independent studies with no involvement of the developer. The remaining studies were either led by the developer or have some level of developer involvement.

**Table 4.** Triple P studies as a function of level of developer involvement

Level of developer involvement	Description	Number of Trials	Percentage of Trials
No Involvement	Developer not involved in any stage of study	58	36.94%
Developer Led	Developer involved in study conceptualisation, design, method, analysis of results, and write-up	47	29.94%
Developer involvement, but not led	Developer involved in study conceptualisation and design	40	25.48%
Minimal involvement	Developer consulted in aspects of study design and implementation	12	7.64%
TOTAL		157	100%

## 2.7 Evidence concerning cost effectiveness

In addition to outcome evaluations Triple P has been subjected to a series of economic analyses that show the program to be one of the most cost effective interventions available. Foster et al. (2008) estimated that the infrastructure costs associated with the implementation of the Triple P system in the US was \$12 per participant, a cost that could be recovered in a single year by as little as a 10% reduction in the rate of abuse and neglect.

Lee et al. (2012) from the highly respected Washington Public Policy Institute in the US reviewed a wide range of evidence-based interventions (including a range of other parenting programs) and rated Triple P as the most cost effective parenting program. The authors conducted a careful economic analysis of the costs and benefits of implementing the Triple P system only using indices of improvement on rates of child maltreatment (out of home placements and rates of abuse and neglect). Their findings showed that for an estimated total intervention cost of \$143 per family, if only 10% of parents received Triple P, there would be a positive benefit of \$722 per participant, with a benefit to cost ratio of \$6.06. The benefit to cost ratio would be even higher when higher rates of participation are modeled. Other economic analyses of implementation of Triple P as a system have similarly shown the intervention to be highly cost effective in the prevention of antisocial behavior (e.g. Mihalopoulos et al. 2007, 2011).

### 3. Inclusion of Triple P in evidence-based lists of effective interventions

Triple P evaluation studies have met the stringent criteria for inclusion on a range of independent Lists of Evidence Based Practices:

- Substance Abuse and Mental Health Services Administration<sup>5</sup>
- The California Clearing House for Evidence-Based Programs<sup>6</sup>
- The UK's National Academy of Parenting Research (NAPR)<sup>7</sup>;
- The UK Department for Education<sup>8</sup>
- The US Blueprints for Violence Prevention<sup>9</sup>
- National Institute for Clinical Excellence and Social Care (NICE)<sup>10</sup>
- KidsMatter<sup>11</sup> – The Australian Government's primary schools mental health initiative recognises Triple P as being the gold standard for evidence based parenting programs awarding it the maximum four stars for evidence of effectiveness.

#### 3.1 Recognition in International and National Policy Documents

Triple P has been referred to as one of the few evidence-based parenting programs by the following sources:

- American Psychological Association<sup>1</sup>;
- Institute of Medicine<sup>2</sup>
- United Nations<sup>3</sup>;
- World Health Organisation<sup>4</sup>

1. American Psychological Association. (2009). Effective strategies to support positive parenting in community health centers: Report of the Working Group on Child Maltreatment Prevention in Community Health Centers: Washington, DC: Author. 2. National Research Council and Institute of Medicine (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner (Eds.), Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. 3. United Nations Office on Drugs and Crime [UNDOC], Vienna. (2009). Guide to implementing family skills training programmes for drug abuse prevention. New York: United Nations. 4. World Health Organisation [WHO] (2009). Preventing violence through the development of safe, stable and nurturing relationships between children and their parents and caregivers. Series of briefings on violence prevention: the evidence. Geneva, Switzerland: WHO. 5. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Community Resilience and Recovery Initiative. (2010). CCRI: Request for Applications (RFA) No. SM-10-015. 6. The California Clearing House for Evidence-Based Programs. (2011). Retrieved from: <http://www.cebc4cw.org/program/triple-p-positive-parenting-program> 7. The National Academy of Parenting Research (NAPR; 2011). Retrieved from : <http://www.parentingresearch.org.uk/Default.aspx> 8. The Department of Education. (2011). Parenting Early Intervention Programme: 2nd interim report. 9. Blueprints for Violence Prevention. (2012). Retrieved from 10. National Institute of Clinical Excellence and Social Care (2006). Parent-training/education programmes in the management of children with conduct disorders. London: Author. 11. KidsMatter (2013). Australia Early Childhood Mental Health Initiative. Triple P-Positive Parenting Program. Retrieved from <https://www.kidsmatter.edu.au/early-childhood/programs/triple-p-positive-parenting-program>. Lee S, Aos S, Drake E, Pennuci A, Miller, M. Anderson, L (2012). Return on investment: Evidence-based options to improve statewide outcomes April 2012 Update. Wash. State Inst. Pub. Policy. Olympia, WA. Mihalopoulos C, Vos T, Pirkis J, Carter R. 2011. The economic analysis of prevention in mental health programs. Annu. Rev. Clin. Psychol. 7:169-201 Mihalopoulos C, Sanders MR, Turner KMT, Murphy-Brennan M, Carter R. 2007. Does the Triple P - Positive Parenting Program provide value for money? Aust. NZ. J. Psychiat. 41:239-46

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#### 3.2 Endorsement by independent experts

***"The Triple P parenting program is one of the great advances in preventive psychiatry internationally and it has been pioneered and scaled up by one of our great innovators in mental health Professor Matt Sanders from Queensland. It targets one of the key risk/protective zones influencing mental health and wellbeing in children and young people and the trajectory of their lives. This highly evidence based program should be as widely available as possible throughout Australia and around the world."***

Professor Patrick McGorry

Australian of the Year, 2010.

Executive Director, OYH Research Centre, University of Melbourne, Australia

***“Triple P is a remarkable program, a potent world-wide implementation of a particularly strong intervention for conduct problems in children. A major strength is that it is designed to take multiple forms, at differing levels of intensity, depending on the level of child risk involved and the context within which intervention or prevention will be carried out. The materials used to support implementation—including masterfully produced videos—are first-rate, and the ability of the Triple P organization to capture public attention and engage public agencies and government entities, is most impressive. Triple P beautifully illustrates the power of a public health approach to child mental health care.”***

Professor John R. Weisz, Ph.D., ABPP  
Department of Psychology, Harvard University  
Harvard Medical School, USA

***“I write in strong support of the Triple P Program an evidence based initiative which has been extensively implemented and valued internationally. It is one of a number of valuable resources aimed at mitigating mental health problems for children and families.”***

Professor Beverley Raphael AM  
Professor of Population Mental Health and Disasters  
University of Western Sydney, Australia

***“The program is a revolution by which ordinary families will have access to the best that the past 30 years of research on families can offer. The materials are outstanding, the program design is excellent and the science is superb. The program is the best in the world.”***

Professor Patrick McGrath  
School of Psychology, Psychiatry and Biomedical Engineering  
Dalhousie University, Canada

***“Triple P is the only research-based parenting program that provides the flexibility to adapt to the needs of families and to a variety of service settings. It is highly appealing to me as a paediatrician because it provides a set of tools that allow me to address common concerns of parents efficiently and effectively.”***

John C. Duby, M.D.  
Director, Division of Developmental and Behavioral Pediatrics  
Akron Children’s Hospital, Ohio, USA

***“Triple P offers straight forward, sensible techniques that have proven to be very effective.”***

Professor Fiona Stanley AC  
2003 Australian of the Year  
Patron, Telethon Institute for Child Health Research, Australia

***“The Triple P Model is unique because it has created a family of parenting programs that can meet the numerous challenges that parents face in parenting and family life. It is impressive that the broad-based use of Triple P practical ideas can both improve the quality and enjoyment of parenting for the average parent as well as reduce the community-wide rates of maltreatment in families that are very challenged by risky circumstances.”***

Professor Mark Greenberg, Ph.D.  
Bennett Chair of Prevention Research  
Penn State University, USA

*“Triple P is a great program. To my mind, it is the best in the world at addressing the needs of the whole community. The different components are carefully tailored to the needs of a range of parents. The content is based on best scientific practice, and is accessible and fun. Above all, it has been proven in numerous controlled trials to be highly effective.”*

Professor Stephen Scott  
Institute of Psychiatry, Kings College  
University of London, UK

*“An excellent example is the Positive Parenting Program (Triple-P), a parenting program developed in Australia to treat disruptive behavior in preschool children (Sanders, 2008; Sanders & Murphy-Brennan, 2010). Early studies demonstrated efficacy in applications with individual families. Over a period spanning 25 years, efforts were made to develop brief and cost-effective versions of the program, ways of delivering treatment through groups, and flexible delivery through telephone consultation and the media. The range of interventions available from this one “treatment” encompasses versions of the program that can be intensively provided to individual families or provided as preventive interventions via media widely available (e.g., DVD, online).”*

Professor Alan Kazdin, Yale University, USA.  
From article by Kazdin & Blaze (2011) in Perspectives of Psychological Science.

*As I struggle in my visits as a physician to rural NSW where I come into contact with distraught families having difficulty in managing their children’s complex behavioural and learning problems I am confronted with a sense of powerlessness. The need for support for these families is massive. I know the published international and national evidence of the effectiveness of the Triple P programme. In the rural settings I visit, where services generally are deficient and there is a large Aboriginal population, Triple P is run through the now Medicare Local and I know it has been especially tailored to meet the needs of Aboriginal people in that community. Nevertheless, in this environment, it very difficult for the marginalised families to get access to the programme. There is a pressing need for such an effective programme with its potential for prevention as one of the best investments society could make in prevention. Beyond my direct experience of the needs and effectiveness of Triple P, I have appreciated its significance in suicide prevention; I chair the Australian Suicide Prevention Advisory Council and over the last decade we have supported wide implementation of Triple P and related programmes. Suicide prevention is in a sense the ultimate test of the effectiveness of early interventions but interventions in the pathways of risk have the capacity to prevent other adverse outcomes – disengagement of education, future joblessness, alcohol and drug problems and mental health problems. It would be undoubtedly true that Triple P is capable of prevention of these youthful harms.*

Professor Ian Webster, AO, Chair Australian Suicide Prevention Advisory Council  
Emeritus Professor, University of New South Wales, Australia

### 3.3 Awards and international recognition

Professor Matt Sanders, the developer of Triple P, has been recognised both nationally and internationally for contributions to children’s mental health and family functioning through a range of awards including:

- Triple P has Twice won the Australian violence Prevention Award (1995, 1997)
- Trailblazer Award, Association of Behavioural and Cognitive Therapies (2007)
- President’s Award for Distinguished Contribution to Psychology, Australian Psychological Society (APS)
- International Collaborative Prevention Research Award, Society for Prevention Research (SPR)
- Triple P’s founder Professor Matt Sanders was Queenslander of the Year (2007) for his contribution to Queensland children and families
- Honorary President, Canadian Psychological Association (2009)

## 4.0 Conclusion

There is a broad consensus of scientific and professional opinion that the Triple P system of intervention has made an outstanding contribution to the wellbeing of Australian children and their families. Although not without its critics it has by far the most substantial evidence base supporting its efficacy of any Australian developed parenting program and is the only intervention internationally to have demonstrated when implemented on a whole of community basis it reduces the population level of child maltreatment.

Over a thirty-five year period Triple P has evolved into a whole-of-population parenting support strategy. The Triple P system adopted a public health approach to the delivery of universal parenting support with the goal of increasing parental self-efficacy, knowledge and competence in the use of skills that promote positive development in children and adolescents. This change in focus has enabled millions more children around the world to experience the benefits of positive parenting and family environments that promote healthy development and as a consequence fewer children have developed behavioral and emotional problems or episodes of maltreatment.

When parents are empowered with the tools for personal change they require to parent their children positively, the resulting benefits for children, adolescents, parents, and the community at large are immense.

## Appendix A

### Comprehensive listing of the Triple P evidence-base

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