Scaling Family-Focused Preventive Interventions: The Triple P System

Ron Prinz, Ph.D.
Parenting & Family Research Center
University of South Carolina

IOM-NRC Forum on Promoting Children’s Cognitive, Affective, and Behavioral Health
April 1-2, 2014

Acknowledgments

• Funding from:
  – Centers for Disease Control and Prevention
  – National Institute of Child Health & Human Development (NICHD/NIH)
  – National Institute on Drug Abuse (NIDA/NIH)
  – National Institute of Mental Health (NIMH/NIH)

• Consultant to:
  – Centers for Disease Control and Prevention
  – Triple P International (joint venture with the University of Queensland)

At a glance

Public health, population approach

Overcoming barriers

Implementing fully

What’s next

Triple P—Positive Parenting Program

• System of interventions
• Developed by Matt Sanders and colleagues at the University of Queensland
• Designed as a public health, population approach
  – Intended for “scale” from the outset
Blended prevention model
- Combines universal and targeted components
- “Universal” = universal access (not program delivery to every parent in the population)
- Concurrently addresses:
  - High baserate problems (common parenting issues; child social, emotional, behavioral & health problems)
  - Low baserate problems (child maltreatment)
- Aims for population-based prevalence reduction

Reduce stigma and reach out to the whole community

Triple P: Multi-level system
- Intensive family intervention
  - Level 5
- Broad focused parenting skills training
  - Level 4
- Narrow focus parenting skills training
  - Level 3
- Brief parenting advice
  - Level 2
- Media and communication strategy
  - Level 1

Intensity of intervention

Additional Triple P variants
- Stepping Stones Triple P: children with developmental disabilities
- Teen Triple P: parents of teens
- Pathways Triple P: parents at high risk for child maltreatment
- Lifestyles Triple P: childhood obesity
- Transitions Triple P: divorcing parents
**Triple P History**

- Program development begins
- Program is given a name
- International dissemination starts
- Demonstration of population effects
- Additional population evaluations

**How effective is Triple P?**

N=16,009 families, 101 studies

- Parenting practices overall $d=0.50$
- Child outcomes overall $d=0.47$

**Multiple sectors of the community**

- Public health and healthcare systems
- Education (preschools, childcare centers, schools)
- Mental health system
- Social services
- Juvenile justice system
- Non-governmental organizations
- Several parts of the existing workforce (many disciplines that serve families)
Multiple formats to match parental preferences

- Individual brief consultation
- Large group parenting “seminars”
- Small group programming
- Longer individual programming (home-delivered; clinic or center delivered)
- Self-directed (offline)
- Online delivery
- Media and communication exposure

Creating efficiencies

- Over-represent the less intensive levels of Triple P
- Principle of minimal sufficiency
- Serve multiple goals with the same parenting intervention system, for example:
  - Reduce behavior problems at school entry
  - Strengthen parenting effectiveness broadly
  - De-escalate child social, emotional and behavioral problems before adolescence
  - Reduce prevalence of child maltreatment

Potential consequence of a population approach

Children in the clinically elevated range for conduct problems (N=1500)

What if we moved the population mean down 0.5 Std?
Percentage Reduction

What if we moved the population mean down 1 Std?

Population-based approaches like Triple P can be cost effective

- Triple P system impact in the context of child welfare
- Benefit to Cost Ratio (return on one dollar investment) $8.74

WSIPP determination
Public health, population approach
Implementing fully
Overcoming barriers
What’s next

Addressing ongoing challenges
Better outcomes for children and parents
Improving implementation quality
Improving our interventions
Achieving wider reach

Ongoing challenges
Improving quality of interventions
Better outcomes for both children and parents
Improving implementation
Achieving better reach

Going beyond “train and hope”: The drivers of implementation success
Create strong local partnerships and internal champions
Ensure line management support and funding
Well-trained and supervised staff
Establish achievable targets
Access available technical and consultation support
Make routine evaluation of outcomes mandatory
Organizational climate matters

- High enablers and low barriers
- Sustained use of program
- Lower cost per family $$
- High

Organizational context

- Low enablers and high barriers
- No use or little use
- Higher cost per family $$$$$
- Low

Increasing population reach

- Higher adoption of blended prevention
- More families participate at lower cost

Organizational climate matters

- Public health, population approach
- Overcoming barriers
- Implementing fully

Greater input from parents as key consumers
Boost the media/communication strategy: Promote engagement, build social momentum

Greater use of technology to increase population reach

Conclusions about Triple P

- Evidence base and implementation learnings continually growing
- Public health, population strategy like Triple P
  - Operating at scale built into the model
  - Model generates multiple sources of cost efficiency
- Ultimate goal: to shift effectiveness and attitudes about parenting
  - Norms for positive parenting
  - Change the community context
  - AND assist parents who have greater needs