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Helping families change: The adoption of the Triple P - Positive Parenting Program in the Netherlands

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7 Summary of preceding chapters

7.1 General introduction

Behavioral and emotional problems are quite common in children and adolescents. Because parenting is associated with the well-being of children, parenting programs are developed to address the child problems. Among all developed parenting programs, the Behavioral Family Interventions (BFI) have the strongest empirical evidence.

The Triple P- Positive Parenting Program is a behavioral family intervention and aims to enhance family protective factors and reduce those risk factors known to be associated with severe behavioral and emotional problems on the part of preadolescent children. This is done by increasing the knowledge, skills, and confidence of the parents. The program was developed by Sanders and colleagues at the Parenting and Family Support Center of the School of Psychology at the University of Queensland. Triple P incorporates five levels of intervention of increasing intensity for parents of children between the ages of 0 and 16.

In 2006 and 2007 an implementation trial on the Triple P – Positive Parenting Program was conducted in the Netherlands. In a one-year period interventions of different levels of the Triple P program for parents of children between the ages of 0 and 12 were implemented in two regions in the Netherlands: universal Triple P, concerning a small local campaign (level 1), selected Triple P (level 2), Primary Care Triple P (level 3), and Standard and Group Triple P (level 4).

The aim of this thesis was to evaluate the implementation trial of the Triple P program in the Netherlands by answering five questions:

1. What are the effects of Triple P on parenting?
2. Is Triple P effective on behavior problems in children?
3. Is Primary Care Triple P an addition to the primary care parenting support in the Netherlands?
4. How to implement a multilevel program in another country?

In this Summary we will return to these questions.

7.2 What are the effects of Triple P on parenting?

Chapter 1 presents the results of the meta-analyses that were conducted to assess the effectiveness of Triple P level 4 interventions on parenting styles and parental competency across different target groups and to assess the impact on the effects of different child variables (age and gender), intervention modalities, and the initial behavior problem scores of the children. We conducted two meta-analyses: one to assess the effectiveness of Triple P on parenting styles and competences of parents in the Triple P group compared with a control group, and the second one assessed

the degree to which postintervention effects were maintained over time in the intervention group. Nineteen studies were selected in these analyses. Large effect sizes were found on parenting styles at post-measurement ($d = 0.68$) and follow-up measurement 3 to 12 months ($d = 0.80$). Large effect sizes were found on parenting competences at post measurement ($d = 0.65$) and at follow-up measurement 3 to 12 months ($d = 0.67$). Studies with a higher percentage of boys ($\geq 68.3\%$) were found to show significantly greater long-term effects on parental competency than studies with a lower percentage ($d = 0.50$ vs. $d = 1.20$). None of the other moderator variables were significant. The positive results indicated that the interventions can be used in a diverse range of families.

7.3 Is Triple P effective on behavior problems in children?

Chapter 2 gives a report of the results of the meta-analyses that were conducted to assess the effectiveness of Triple P level 4 interventions in the management of behavioral problems in children and to assess whether the effects were moderated by the age or gender of children, and the intervention modalities. We conducted two meta-analyses. In the first meta-analysis, we assessed the effectiveness of Triple P on behavioral problems of children compared to the control group, as directly measured at the end of the intervention. In the second meta-analysis, we assessed the degree to which post intervention effects were maintained over time in the intervention group. We found 25 studies that focused on the Level 4 intervention, and of these, 15 were selected for the meta-analyses. For each study a standardized effect size, d , was calculated and a random-effects meta-analysis was conducted. Moderate to large effects on behavior problems of children were found that lasted for 6 to 12 months in follow-up measurements. A large effect size was found at both post intervention ($d = 0.88$), and at 6 months and 12 months follow-up, with overall mean effect sizes of $d = 1.07$ and $d = 0.84$, respectively. Few significant moderators were found, indicating that Triple P can be successfully used with a diverse range of families, types of problems, delivery formats, and ages of the children. Studies with a higher proportion of girls have larger long-term effect sizes than studies with fewer girls ($d = 1.08$ vs. $d = 0.37$). More analyses are needed to examine the meaning of this result, because boys were overrepresented in all studies. In the long term, the effects in the seven studies with initial scores in the clinical range on behavior problems were larger than in the nine studies with lower scores ($d = 0.36$ vs. $d = 1.08$). It was concluded that the level 4 interventions of the Triple P program improve the problem behavior of the children.

Conclusion chapter 1 and 2

The analyses in both meta-analyses on parenting behavior (chapter 1) and on child behavior problems (chapter 2) involved both universal prevention samples and high-risk samples. This means that the interventions are applicable both in prevention

departments of mental health institutions and youth care departments. The positive results seem to support the widespread adoption and implementation of the program in an increasing number of countries around the world.

7.4 Is Primary Care Triple P an addition to the primary care parenting support in the Netherlands?

Chapter 3 presents the results of an evaluation study on both the regular Dutch parenting consultations and Primary Care Triple P. The Dutch primary care system includes a variety of intervention approaches. Both interventions target parents of children with mild to moderate behavioral and/or emotional problems. The interventions were examined in pre-, post and follow-up assessments, and final results were compared. Both groups were matched by income of the parents, percentage one-person households, number of inhabitants, and urbanization grade. During a one-year period of recruitment, a total of 189 participants were approached and 129 parents agreed to participate: 42 families were helped with regular Dutch parenting consultations and 87 families were supported with Primary Care Triple P. Significant decreases in the emotional and behavioral problems of children were found that lasted for over 3 months for both groups. For both groups, parenting styles were also found to have improved significantly at both post-test and follow-up, except laxness in the regular Dutch parenting consultation group. Only for the Triple P group significant effects on parental satisfaction, parental efficacy and overall parental sense of competence were found. When compared to the regular Dutch parenting consultation group, the Triple P group showed significantly less dysfunctional parenting styles and a higher score on parental competency at both post-test and follow-up. These results are promising for both regular Dutch primary care parenting programs and Primary Care Triple P. Given that Primary Care Triple P produced better results for parenting styles and parental competency, however, it is possible that the emotional and behavioral problems of the children may decrease even more in the long term, and thereby make at least Primary Care Triple P the preferred program. More research is needed to confirm those promising results, preferably conducted as randomized controlled trials.

7.5 What is the impact of Group and Standard Triple P on children's behavior, parenting and parental psychopathology in the Dutch practice?

In chapter 4 the results of four evaluations of Triple P level 4 interventions are presented. Three evaluations used a 'single-group design' and one a 'quasi-experimental design'. Before, after and three to six months later assessments were taken. In total 298 parents were included in this four samples. The first aim was to examine the effects of the Standard and Group Triple P interventions on children's behavior and emotional problems and parenting. Second, the study focused on parental distress and

psychological health of parents. Third, the relation between parenting and parental psychopathology was studied. Results indicated that the interventions are effective in reducing problems in children, dysfunctional parenting styles, in improving parental efficacy and in reducing depression, anxiety and stress in parents. We have evidence that the treatment effects are maintained after three and six months. This results concur with the international studies on the Triple P level 4 interventions. Although international studies indicated that reduction in emotional and behavioral problems in children is a mediating factor in reducing parental psychopathology, the results of this study could not affirm this. In our study, we found that parental feelings of competence mediated the reduction of parental psychopathology. An increase in the feeling of parental competence, caused by the improvement in parenting behavior, turned out to be the mediating factor. It was concluded that the standard and group Triple P interventions can be an important addition for the mental health institutions in the Netherlands, especially for parents with depression, anxiety or stress. Further research is recommended, preferably to be conducted as randomized controlled trials.

7.6 How to implement a multilevel program in another country?

In chapter 5, the implementation process of the multilevel Triple P Program is described using the effective 'Replicating Effective Programs' (REP) framework. According to this framework, the implementation process is divided into four phases: precondition, preimplementation, implementation, and maintenance and evolution. We adapted the framework by adding or deleting elements to make it suitable for a multilevel intervention program. In doing this, a practical framework for implementing evidence-based multilevel programs in another country was developed. In addition, we evaluated the implementation trial. For this aim, semi-structured interviews among professionals, managers and experts were undertaken, and we measured the collaboration with a questionnaire.

The REP model was highly usable for the implementation of the multilevel program Triple P. The framework was a structured approach to implement this program. Because the main steps in the four implementation-phases were described in detail, it was very helpful to organize the implementation trial, and in developing a model for multilevel programs. There were three main adaptations made for implementing an evidence-based multilevel program in another country. First, cross-cultural transferability is indispensable to determine potential fundamental differences. Furthermore, the resources have to be translated in non-English speaking countries. Second, the organization of the implementation differs. The organization of implementing a multilevel program in another country is more complex than a stand-alone intervention. To implement an evidence-based intervention in another country, we made an organization structure on four levels: international, national, local, and institutional level. The third adaptation concerns the collaboration. In the implementation of the multilevel

program, it is important that the conditions necessary for collaboration are present to guarantee or improve the collaboration in the long term.

Overall, we can conclude that the implementation trial was successful. In both local regions, the interventions were embedded structurally into the care system and the program is now implemented in 17 other municipalities and new ones are interested. Four main success factors in implementing the multilevel Triple P program in the Netherlands were discussed. First, the systematic approach of the REP-model has supported a successful implementation. Second, the high quality of the triple-P program itself was a success factor. Third, the results in this study show that workplace support is an important condition for a successful implementation. The fourth success factor is the fact that it is a multilevel program, which offers possibilities to realize a tailored system. Working with the same pedagogic vision connects the different organizations. Triple P offered the possibility to develop a stepped care program.