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

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# 8 General Discussion

## 8.1 Introduction

In this thesis we examined the implementation of the evidence-based Triple P – Positive Parenting Program. Internationally effective interventions are often adopted and implemented in other countries. However, the procedures by which effective interventions are chosen for adoption and the implementation are often not conducted systematically (Cuijpers, de Graaf, & Bolhmeijer, 2005). We took the following systematic approach in implementing the evidence-based Triple P – Positive Parenting Program in the Netherlands.

First, we made an overview of the (inter)national base rates of behavioral and emotional problems in Dutch children, aged 0 to 12 years to judge whether there is a problem. We found that, in general, the prevalence of behavior- and emotional problems in children, aged 2 to 12 is about 15%, 10% of which are mild problems and approximately 5% severe, clinical problems (Van der Ploeg, 1997; Zeijl, Crone, Wiefferink, Keuzenkamp, & Reijneveld, 2005; Ter Bogt, Van Dorsselaer, & Vollebergh, 2003).

Second, we reviewed the rationale for the implementation of a parent intervention. We found that it is widely accepted that dysfunctional parenting practices are powerful predictors of children's mental health problems in general (e.g., Loeber, Green, Lahey, Frick, & McBurnett, 2000; Sanders, Markie-Dadds, & Turner, 2003). Several reviews have documented the efficacy of behavioral family interventions as an approach to prevent and treat problems in children, particularly those with conduct problems (Kazdin, 1987; Sanders & Markie-Dadds, 1996; Taylor & Biglan, 1998; Webster-Stratton & Hammond, 1997).

Third, in a national expert team it was discussed whether there was a need for a new parenting program in the Netherlands. Triple P is a form of behavioral family intervention. This team concluded that there was a need for a tiered continuum of interventions of increasing intensity and for an evidence-based parenting intervention. The literature showed us that the Triple P – Positive Parenting Program was a possible program to implement in the Netherlands to fill the needs.

Those three steps were described in the general introduction. Before starting a broad-scale implementation, the following topics need to be discussed: the international evidence-based status of the program, the effectiveness of the program in the Netherlands, and the conditions to implement the program in the Netherlands. The results of this thesis will be discussed in reference to those three topics. Consequently, this will lead to implications for a broad-scale implementation. In addition, we will address the limitations of this thesis and formulate recommendations for future research.

## 8.2 The international evidence-based status of the program

### Effectiveness and efficacy of the Triple P- Positive Parenting Program

The last update of the research in Triple P dates from November 2007. At that time, 55 efficacy and effectiveness studies had been conducted on a form of Triple P, of which 29 randomized controlled trials, 11 effectiveness studies with a quasi-experimental design, and 15 uncontrolled pretest-posttest-follow-up test designs (Nowak & Heinrichs, 2008). Among the studies, several effectiveness trials have been conducted under conditions of usual service delivery. All studies demonstrate positive outcomes for children and parents. This extensive number of trials is still growing with new trials being conducted worldwide: 61% studies were conducted in Australia, 16% of which concerned level 1 to 3 interventions, 66% level 4 interventions, and 18% level 5 interventions.

The evidence that the effects of the Triple P program is demonstrated by means of high qualitative research can be illustrated by the following criteria. First, reliable designs are used. Randomized controlled trials are the most reliable designs. By taking an aselect sample of the respondents and assign them to the experimental- or control group, possible differences between groups occur accidentally. Furthermore, it will prevent the presence of systematic differences between the groups (Landsheer et al., 2003). Because 29 RCT's were conducted on a form of Triple P, this criterion is well supported. Second, reliable and valid used measures are used. Measures on behavior and emotional problems in children, and on parenting with high psychometric quality were used in most of the studies. In assessing behavior and emotional problems in children, both parent self report measures and more independent measures, such as observation measures or teacher's reports, were used. In most of the studies, parent self report measures are used. Third, the fact that the effects on child and family functioning have been replicated several times in different studies involving different research teams, corroborates the evidence. This can be confirmed by the fact that a number of these studies have been conducted in other, Western and non-Western, countries producing similar positive effects (e.g., Bodenman et al., 2007; Foster et al., 2008; Heinrichs et al., 2005; Yuki Matsumoto et al., 2007).

The evidence that Triple P is an effective parenting strategy for several different groups of parents and their children, is based on the following criteria. First, several studies have shown that parenting skills training used in Triple P produces predictable decreases in child behavior problems, which have been maintained over time. In addition, the results indicated that Triple P interventions reduced dysfunctional parenting styles in parents, improved parental competency, and decreased parental depression, anxiety and stress (e.g., Sanders, 2003). Second, the population varied in the different studies; parents of children with mild or more severe behavior problems were included. Clinically relevant outcomes for both children and their parents have been demonstrated for the standard, self-directed, telephone-assisted, group and enhanced interventions (e.g., Sanders et al., 2000; Sanders, 2003). Third, the program has also been successfully used for several different family types, including two-parent families,

single-parent families, stepfamilies, maternally depressed families, martially discordant families, divorced families, families with a child with an intellectual disability or an overweight and obese child (e.g., Sanders, Markie-Dadds, & Turner, 2003, Roberts, et al., 2006; West, 2007). Fourth, the effectiveness of different levels of Triple P interventions can be supported. On all levels, reliable outcomes for both children and their parents have been demonstrated (e.g., Sanders, 2003).

The meta-analyses conducted in this thesis underpin these international findings. The aim of the meta-analyses was to assess the effectiveness of Triple P level 4 interventions in the management of behavioral problems in children, and the effectiveness on dysfunctional parenting styles in parental competency by pooling the evidence from relevant studies that included level 4 interventions. The meta-analyses in this thesis included 15 studies on level 4 interventions: Standard, Group and Self-directed Triple P. This intervention level can target individual children at risk or an entire population to identify individual children at risk. To prevent the meta-analyses from comparing 'apples and oranges', we have statistically tested homogeneity to determine whether a grouping of effect sizes from different studies shows more variation than would be expected from sampling error alone. This provides an empirical test of whether studies show such disparate results that it may not be plausible to presume that they are comparable. As strict methodological criteria for inclusion were applied, ten effect studies were not included in this meta-analysis. One can be assured that the synthesis is based on only the best evidence, but its results may summarize only a narrow research domain. As long as this rationale is explicit, each person can judge for him or herself whether they are meaningful.

The meta-analyses on child behavior problems showed homogeneous mean effect sizes of 0.88 at post-measurement, an effect size of 1.07 at 6 months, and 0.84 at 12 months. These are large effects. The overall mean homogeneous effect size on dysfunctional parenting styles of 0.54 was found at post-measurement, and 0.51 at follow-up measurement (4 to 6 months), which are considered moderate effects. An overall homogeneous effect size of 0.57 on parental competences was found at post-measurement. At follow-up at 6 months, an overall homogeneous effect size of 0.74 was found. Those are moderate to large effects. These results concurred with the meta-analytic results reported by two other meta-analyses. Thomas and Zimmer-Gembeck (2007) employed a fixed-effects approach and found effect sizes for parenting and child behavior ranging between 0.38 - 0.70 and 0.31 - 0.73, respectively. Nowak & Heinrichs (2008), using a mixed-effects hierarchical model conducting a meta-analysis on all levels of the Triple P - program, estimated overall effect sizes for parenting and behavior problems in children in the range 0.35 - 0.48 for between-groups, and 0.45 and 0.57 for within-groups post-intervention comparisons. Those are moderate effects.

The systematic coding of study characteristics typical in a meta-analysis permits an analytically precise examination of the relationships between study findings and such study features as respondent characteristics, delivery modalities, age and gender,

etc. In our studies, we examined whether effects were moderated by the age and gender of children, the different modalities, and the initial behavior problem scores of the children (scoring problems at pretest in clinical range vs. nonclinical range). Few significant moderators were found in the effects on child behavior problems in our meta-analysis.

We found that studies with an initial behavior problem score in the clinical range (initial intensity score ECBI  $\geq$  127) have significantly larger long-term effects on behavior problems than those with nonclinical behavior problems. This can be due to the fact that higher problem scores provide a larger potential for positive change. Another reason might be that the level 4 interventions of Triple P are more beneficial to parents of more deviant children. Furthermore, in our meta-analysis we found that gender can influence the result, but studies including more girls are necessary to find out what this influence means, because the mean number of boys in the studies was 62.6% to 68.3%. Furthermore, the studies found promising effects for the Self-Help Triple P intervention, which is interesting because of the advantages of this type of intervention compared to face-to-face interventions: they are convenient, they enable users to repeat lessons, and they can be disseminated to many people (Starker, 1990). This effect was not found in the meta-analysis of Nowak & Heinrichs (2008), probably caused by the fact that in this meta-analysis a mixed set of measures and also more studies were included, because the study was not restricted to RCT's only.

## **Conclusion**

Triple P may be considered a well-researched parenting program that is based on high quality studies. Significant effects are reached at each level of the program, with most studies on level 4 interventions. Positive results are found on behavioral problems in children, parenting dysfunctional styles, parental competences, depression, anxiety, and stress in parents. Triple P can successfully be used with a diverse range of families (e.g., types of problems, delivery formats, age of the children). The results may be generalized from Australia to other countries. However, less is known about the effects on emotional problems in children, and this topic warrants more study in the future.

## **8.3 Implementation trial in the Netherlands**

Then, after establishing the evidence-based status of the Triple P program, we decided to conduct an implementation trial of interventions on level 1 to 4 of Triple P, to examine whether and under what conditions the program can be adopted and implemented in the Netherlands.

## **Effectiveness of the program in the Netherlands**

Because of the many effectiveness and efficacy trials on the program, we expected the program to be effective in the Netherlands too. However, to really know whether the program is effective in another country, it is important to test the effectiveness of the interventions in the adopting country. In this thesis we presented the results of two evaluation studies on Triple P: an evaluation of Primary Care Triple P, and several evaluations on Standard and Group Triple P.

### **Effectiveness of Primary Care Triple P**

The effects of Primary Care Triple P were studied in a one-group pretest-posttest-follow-up test design. The results showed significant decrease in emotional and behavioral problems, and improvement in social behavior. Furthermore, respondents demonstrated a reduction in the parenting styles laxness, overreactivity and overall inadequate parenting. In addition, improvement in parental satisfaction, in parental efficacy, and in overall parental sense of competence was found. These results indicate that Primary Care Triple P is effective for Dutch parents and their children with emotional and behavioral problems. The same study was conducted for the regular Dutch parenting consultations. Here we found also a significant reduction of emotional and behavioral problems, problems with peers and total problems in children. Respondents demonstrated a reduction in overreactivity and in overall inadequate parenting, but not in laxness. No significant improvement was found in parental satisfaction, parental efficacy or overall parental sense of competence. Those results indicate that the regular Dutch parenting consultations are effective for Dutch parents and their children. Finally, we compared the Primary Care Triple P and the regular Dutch parenting consultations with each other. We found no differences in behavioral and emotional problems. The results indicated that Primary Care Triple P resulted in more improvement in laxness and overall inadequate parenting. Furthermore, no differences were shown in satisfaction and efficacy. However, the results indicated that Triple P Primary Care reported more improvement in parental competency. What do these results mean? Both interventions turned out to be effective in child problems and no differences were shown between the conditions. As child problems are the main outcomes, we asked ourselves, based on those results: why implement a new intervention if care-as-usual is effective on child problems too? We will try to answer this question. First, the regular Dutch parenting consultations include a variety of intervention approaches. Most of those consultations are not standardized and not studied very well. The descriptions of the consultations are somewhat vague and mostly no resources (e.g., workbooks for parents or practitioner's manuals) are available. In addition, the underlying theories are not very well described, so no strong foundational theoretical evidence is available. This means that we still do not know what the effective ingredients in those consultations are, or what type of intervention is effective: all or just one of them? Second, the results showed that Primary Care Triple P improved more in parenting styles and parental competency than the regular Dutch primary care consultations. This indicates that Primary Care Triple P

is to be preferred above Dutch care-as-usual. Because parenting styles and parental competency are related to child behavior (e.g., Janssens, 1994; Olson, Bates, Sandy, & Lanthier, 2000; Prinzie et al., 2003; Wolfradt, Hempel, & Miles, 2003), we can expect that child problems may decrease more in the long term.

### **Effectiveness of Standard and Group Triple P**

We studied the effects of Standard and Group Triple P in four evaluations, conducted in mental health institutions. Three evaluations included a 'single-group design' and one a 'quasi-experimental design'. Before, after and three to six months follow-up assessments were taken. The results suggest that the interventions are effective in reducing problems in children, dysfunctional parenting styles, in improving efficacy and in reducing depression, anxiety and stress in parents. These effects were maintained after three and six months. These results concur with the results of international studies. The meta-analysis on the level four interventions (chapter 2 and 3) showed moderate effects on behavior problems in children, parenting styles and parental competency. In addition, the Triple P level 4 interventions have been successfully used for stressed and depressed parents (Sanders, 1999; Sanders & McFarland, 2000). In this last study it was shown that both standard and enhanced interventions of Triple P produced significant clinically reliable reductions in both maternal depression and child disruptive behavior.

This level of intervention can target individual children at risk or an entire population to identify individual children at risk. Group Triple P is appropriate as a universal (available for all parents) or selective (available to targeted groups of parents, e.g. high risk groups, children with diagnoses), or as an early intervention strategy for parents of children with current behavior problems. Therefore, results should be interpreted carefully. Smaller effect sizes would be expected in prevention studies than in treatment studies. In the four samples used in this thesis, parents were recruited in mental health institutions for children, youth care institutions, and a school for special education. In three samples no selection criteria were formulated, and parents were recruited by open registration or referred to parenting support because of severe child problems and parenting problems. In one sample, respondents had to have a clinical score on the Parenting Scale ( $\geq 3.2$ ). We found higher initial scores on parenting styles in this fourth sample ( $d = 3.70$ ), although the initial scores in two other samples were also just above the cut-off score ( $d = 3.26$  in sample 1,  $d = 3.37$  in sample 3). The data show that in all four samples the dysfunctional parenting styles significantly decreased at post and follow-up assessment (if available). These data suggest that Standard and Group interventions are effective for both prevention and treatment studies. Here it should be noted that in two of the four samples a mix of Standard and Group interventions was used. It would be better to distinguish those formats in further studies.

Our data suggest that the parenting management training Triple P improved parenting behavior, which leads to a reduction in the child behavior problems. Consequently, this is expected to contribute to the decrease of parental depression,

stress and anxiety. It is well-known that children of mothers with depression, anxiety and stress are at risk to develop social-emotional problems (Mäntymaa et al., 2004; Muris, et al., 1996; Turner, et al, 2003; Smith & Carlson, 1997). The data in our study confirmed the positive results of improved parenting on complaints of depression, anxiety and stress in parents, which can thus be expected to have impact on children's behavior and emotional problems. However, the initial scores on the measurement in our study were in the normal range, so it could not be concluded whether this also will reduce (sub)clinical psychological problems in parents. The data suggest that parental competency is a mediating factor. The data could, however, not confirm that the presence of behavior problems in children is a mediating factor in changing the parental depression, stress or anxiety.

## **Conclusion**

First, conclusions of the studies on Primary Care Triple P and Standard/Group Triple P have to be drawn cautiously. Respondents were not randomly assigned to the two conditions in the study on Primary Care Triple P, and no control group was used in three of the evaluations on Standard/ Group Triple P. Because randomized studies are difficult to combine with the implementation of an innovation, we decided to keep the research as simple as possible, which enhanced the participation of the practitioners. However, the results give us the first indication that the Triple P interventions are effective in the Netherlands too, in the reduction of behavior and emotional problems in children, and the improvement of parenting styles, parental competency and parental adjustment.

Given the fact that the regular Dutch parenting consultations were offered for many years by experienced professionals, and that the effects on child problems were similar in the Primary Care Triple P and care-as-usual group, it is difficult to exchange the Triple P for the regular consultations. However, given that Primary Care Triple P showed better effects in parenting styles and parental competency and efficacy, it is recommended to adopt the Primary Care Triple P, instead of improving the regular Dutch parenting programs.

Because of the relation between psychological problems in parents and psychological problems in children, and the positive influence of parenting management training to reduce both, the data suggest that the level four Triple P interventions can especially be applied to depressed, anxious or stressed parents, with the aim to diminish the parent problems, and the child behavior and emotional problems as well. In addition, the results show that the Triple P interventions are effective on behavioral problems and emotional problems in children. Most of the international research only focuses on children's behavioral problems. Our hypothesis is that Triple P offers support for those children too, partly caused by reductions in psychological problems in parents. Comparing the data of the study on Primary Care Triple P and on Standard/Group Triple shows that the last interventions focus more on clinical child problems and parenting problems than the first. This means that the target group of both interventions was reached. However, we found that 24% of the children in the Primary Care

study experienced clinical problems on the total score of the SDQ at baseline, and significant decreases were found on most of the subscales of the SDQ at post and follow-up assessment. Since the Triple P-program aims to provide the minimally sufficient level of support parents require, our data suggest that Primary Care Triple P can be given to some parents and their children who have clinically elevated problems. As Primary Care provides less intense, less expensive, shorter and easier access than youth care, it is worthwhile to study this topic further.

A central element in the program is the development of parents' capacity for self-regulation, which involves teaching skills to parents that enable them to become independent problem solvers. This self-regulatory framework is operationalized by Sanders et al. (2003) in four concepts: self-sufficiency, parental self-efficacy, self-management, and personal agency. In our study on Primary Care Triple P we found small to moderate effect sizes on parental efficacy, and moderate effect sizes on parental sense of competence, which were not found in regular Dutch parenting consultations. In the study on Standard/ Group Triple P we found that parental competency was a mediating factor in reducing parental psychopathology. Our data concur with this central element of the Triple P program.

One way to measure the maintenance of program integrity is to examine the effects of the interventions. The results of the studies in this thesis emphasize the maintenance fidelity of the Primary Care and Standard/Group interventions. Besides assessing the results, it is obvious that a high quality of training courses, resources for parents, and manuals for practitioners contribute to program integrity.

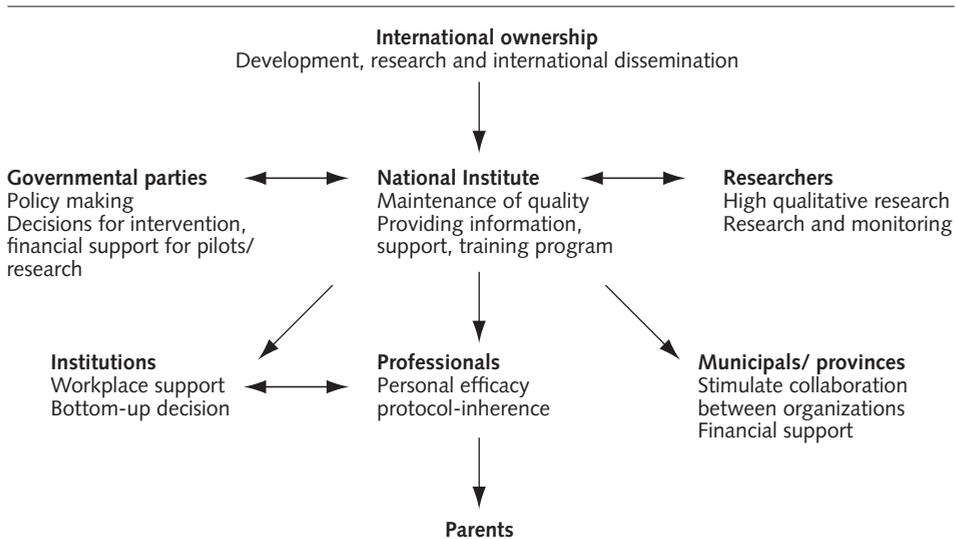
## **8.4 Implications for a large-scale implementation**

In chapter 5 we concluded that the implementation trial in the Netherlands was successful. In this trial 79 professionals followed a training course on level 2/3 or 4 of Triple P. Both parents and professionals were satisfied with the quality and content of the Triple P program. The multilevel approach of the program improved the collaboration among the participating institutions. In addition, more uniformity in approach to parents existed.

Main conditions for a successful implementation are: a) a good organization structure with a local coordinator; b) a national quality system at national level in addition to the high quality training materials, practitioner manuals, and parent resources of the international organization; c) collaboration between participating organizations to ensure the stepped care approach; d) a national institute in the adopting country to enroll the program at a national level and to guarantee the quality; e) practical guidelines to support agencies in implementing the program. Because many parties play a role in the implementation process, it is important that they are aware of their roles and tasks, so that they can take their own responsibility and know who to address in the case of uncertainties or questions. We assume here that the better the implementation is organized - in terms of responsibilities and tasks of the participating

parties - the better the implementation and maintenance of quality will be guaranteed. We present an overview of responsibilities and tasks of all participating parties, in which the implementation theories and the learned lessons of the implementation trial of Triple P in the Netherlands are included. These results are presented in Figure 1 which can be used as input for a discussion when implementing the Triple P –program in the Netherlands.

**Figure 1. A model of responsibilities and tasks in implementing Triple P in other countries**



### International level

The Australian University of Queensland is the owner of the Triple P – Positive Parenting Program. The University is responsible for further development and research in the Triple P program. The dissemination and implementation of the program is in hands of the Australian organization 'Triple P International' (TPI). The quality of the Triple P program is controlled by a system of professional training and workplace support, collaboration between researchers and practitioners, and by an ongoing refinement of interve0has now been implemented in sixteen other countries, the international owner is responsible for the dissemination and implementation in those countries. The international owners organize the education and supervision of native speaking trainers in other countries. To guarantee the program-fidelity at long-distance is more difficult and should be delegated to persons or institutes in the adopting country.

## National level

### *National government and national institutes*

Policy makers, e.g. the government and municipalities should make a decision whether or not to give financial support for the translation and adaptation of an evidence-based intervention. The Dutch government often supports such programs, but mostly only for a pilot-period. Because of the number of programs, and the working principles of market economy in the youth (mental) health care (i.e., interventions are often in competition with each other), the government does not choose for one single evidence-based program to implement on a broad-scale. Consequently, this means that after a pilot-period, a broad-scale implementation is not guaranteed. The municipalities at local level weigh up the pros and cons against the different programs, and choose to implement one program in their municipality. At this moment several different and competing programs are available for the same target group in the Netherlands. A discussion should be held about the pros and cons for implementing one evidence-based program in the Netherlands or several different programs for the same target group. Furthermore, an implementation plan and (financial) support should be arranged to guarantee the quality maintenance of the program. The national knowledge institutes should collaborate more in choosing what is the best program in the given context (target group and aim of the intervention).

### *National institute in adopting country*

It is recommended to designate one reliable institution which is responsible for all necessary support in a broad-scale. The Dutch National Youth Institute is responsible for this in the Netherlands. The responsibilities of this institute should be to give advice to municipalities and local organizations how to implement the program, to guarantee a competent application of the program, to organize supervisory structures for the practitioners and a peer supervision support network. Because responsibilities of the Dutch Youth Institute and the international owners can be overlapping, this should be geared to each other.

## Researchers

In implementing an evidence-based intervention to another country, it is not assumed that the results can be generalized to the adopting country. It is always possible that there are fundamental cultural differences. The contrast between cultures can be examined on the level of the professional, the target population and the health care system (Cuijpers et al., 2005).

In comparing the Australian and the Dutch cultures, we found several differences. First, the Australian system of youth care differs in some ways from Dutch youth care. To be able to refer Dutch parents and their children to more intensive youth care, they have to be diagnosed by another organization (Bureau Jeugdzorg) who can refer the clients to the more intensive youth care (indicated care). Second, the offer of the regular Dutch primary care parenting consultations exists of a variety of methods.

In a research-context this means that the 'care-as-usual' used for a control group in Australia differs from the 'care-as-usual' in the Netherlands. Third, the ethnic minority groups in the Netherlands exist of Moroccan, Turkish, Dutch-Antillean immigrants and refugees from all over the world. It will be necessary to examine the results on parenting and child behavior problems for this specific target groups. This can best be done in randomized controlled trials. The input from agencies is important for researchers undertaking research based on practice or field-generated issues (Sanders & Turner, 2005). The research should be conducted separately from the institute which is responsible for the implementation, to guarantee independent, non-biased, research.

## **Local level**

### ***Municipalities and Provincial Departments***

Primary Care institutions and Youth Care / Mental Health institutions are divided by the Dutch system. The local institutions and the provincial operating institutions are divided by financial support and by the referral of the families. The two divided sectors were not used to work together. However, in executing the Triple P program, they had to work close together. The level 3 Triple P interventions were implemented in the local Primary Care institutions, as the level 4 Triple P interventions in the Youth Care / Mental Health institutions. The municipalities and provincial departments have the responsibility to work together to stimulate the collaboration between organizations operating in the different areas.

### ***Local institutions***

Local institutions play a crucial role in the implementation process. First, they have to decide carefully whether or not to adopt an innovation. They should be well informed about the weaknesses and strengths of the new intervention, and discuss the need to adopt the new intervention. Preferably they use a 'bottom-up' strategy, meaning that as much of the analysis as possible was made by the staff members and practitioners together, and that they participated in decision-making about the concrete objectives. This soon will get a process of co-operation going on and create a permanent basis. A top-down imposition of an innovation without consultation by the staff designated to implement the innovation, may increase the resistance to the change (Backer et al., 1996; Webster-Stratton & Taylor, 1998).

Staff members of the institutions have to deliver the preconditions for a successful execution of the innovation. This means that they provide practical, methodical, and emotional support to the practitioners. In Triple P a system of professional training is set up. Practitioners should have enough time to prepare for the training program, including an accreditation, and to have the possibility to discuss the innovation in a peer support network. Workplace support is needed. This means that the institutions integrate the program with the usual caseload and other responsibilities of the practitioners and give access to supervision or peer support networks (Sanders & Turner, 2005). Our experience is that a central person available for continuous backup turned

out to be crucial. In interviews with practitioners it was indicated that practitioners appreciate that a person internal in the organization is approachable for administrative issues (e.g., data-management), logistic issues (e.g., organization of training course), emotional support (e.g., feelings of resistance towards the new structured program). Budget for innovations should be available in the institutions for research, development and implementation of the interventions (Van Yperen & Bakker, 2008). A structured plan for implementation should be written in which the preconditions can be established (e.g., time and financial support, workplace support, and collaboration with other organizations).

### **Professionals**

In the Triple P training the same self-regulatory approach is used as in the parent education program. The focus is on promoting professional behavior change through self-directed learning and personal responsibility for skill development (e.g., Karoly, 1993; Sanders & Turner, 2005). Professionals are encouraged to feel more competent and confident in problem solving and be able to act independently of others in decision-making. Besides the training program, workplace-support and peer support are important to reach this goal. A peer supervision network within an organization will increase practitioner confidence and self-efficacy in using a program. A supervision process is designed by the international owners to promote practitioner self-regulation (Sanders & Turner, 2005). The professional can be held responsible for the protocol-inherence of the intervention.

In the implementation trial we encountered that some professionals received a Triple P training program, but that they did not put the program into practice. It is important that an intervention is suited to the interpretation of one's job (Fleuren et al., 2002). It can be discussed whether it is a responsibility of the managers or the professionals to take care for a tie-up between the parenting intervention and the type of professional.

## **8.5 Limitations of the thesis**

This thesis has several limitations which should be pointed out. First, in the two meta-analyses a limited number of studies, Triple P interventions, outcome measures, and moderators were used. The main focus was on level 4 interventions, behavioral problems in children and parenting styles and parental competency, and less on the other Triple P interventions (level 1, 2, 3, and 5), emotional problems in children and parental psychopathology or marital discord. We examined whether effects were moderated by age and gender of children, format of the intervention, and initial behavior problem scores of the children, and we left out other moderators, such as gender and age of the parents. Second, the effectiveness studies of the Triple P-program were only conducted on Primary Care Triple P and Standard/Group Triple P. The effects of the interventions on the other levels of the program

should be examined too. Third, the effectiveness studies in this implementation trial were not tested by randomized controlled trials, which is the most reliable design to test effectiveness. Fourth, the return on investment (e.g., cost-effectiveness study) has not been conducted in the evaluation of the implementation trial, although it is one of the most important evaluations (Kilbourne, 2007). Fifth, the studies were based on self-report measures of parents on their own parenting and the child behavioral and emotional problems. Sixth, in the studies assessments were taken at a follow-up period of three months. This is not long enough to examine the associations between improved parenting styles and parental competency and the long-term decreases in child behavioral problems.

Finally, we used the available knowledge about the steps that should be taken in implementing an innovation. We had knowledge about the influencing factors on the process and failures (Rogers, 1995; Glaser et al., 1983; Grol & Wensing, 1991), and we used (an adaptation of) the effective 'Replicating Effective Programs' (REP) framework' (Kilbourne et al., 2007). However, we still do not know whether we used the optimal strategy in implementing the Triple P program. The implementation strategy should be examined in a study comparing a standardized implementation strategy with a 'care-as-usual' strategy, preferably in a randomized controlled trial.

## 8.6 Recommendations for further research

Finally, we would like to end the discussion with some recommendations and directions for future research. First, randomized controlled trials have to be conducted on all levels of the Triple P interventions in the Netherlands to know whether the interventions are effective in our country too. We formulated the following recommendations for these effectiveness studies:

1. Because less international studies have been conducted on the brief and universal interventions, this should be given priority.
2. Designs with longer term follow-up data beyond 3 years have to be applied. This would give good insight into the effect maintenance of the decrease in behavior problems in children and parenting problems.
3. More extensive analysis of the effects of Triple P on characteristics of the parents and children should be conducted (e.g., gender, age).
4. Cost-effectiveness studies are important to know whether the costs of the new intervention are lower than for the existing interventions.
5. Because several programs are available with the aim to reduce psychological problems in children, it would be worthwhile to add other parenting interventions in research designs, to examine what the extra effects of Triple are (or not) on specific target groups.
6. As the Triple P interventions will be revised, extended or culturally adapted to other ethnic groups or special needs for parents and their children, new Triple P

interventions have appeared and will appear in the future. These interventions can be implemented and investigated in Dutch society.

7. As the focus of the studies is mostly on behavior problems in children, we have to examine whether the interventions will reduce emotional problems in children too, for example anxiety, stress and depressed feelings in children.
8. Self-regulation of parents is a central element in the Triple P interventions. It could be examined whether this is the main working mechanism in the intervention.
9. Implementation-strategies should be examined to get more insights into what is the best way in implementing the multilevel program of Triple P.

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