# Adopting a Public Health Approach to the Delivery of Evidence-Based Parenting Interventions

MATTHEW R. SANDERS
The University of Queensland

**Abstract**

A public health perspective to the delivery of parenting programs has the potential to greatly increase the impact of evidence-based psychological interventions targeting parents and families. However, a population-level benefit is unlikely to be achieved unless sustained programmatic efforts are undertaken to further increase the reach of efficacious interventions. In addition, such programs need to be adapted to local circumstances, be delivered in a culturally relevant manner, and be used in a sustained way by adoptee organisations if the potential benefits of these interventions are to be realised. The multilevel Triple P system of parenting interventions is used as an example to illustrate the benefits and challenges involved in delivering a comprehensive system of parenting interventions, services, and programs. Practical implications for large-scale implementation and possible future directions for research are identified.

*Keywords:* Triple P, public health, parenting, evidence-based, intervention

There is little doubt that parenting interventions based on behavioural and social learning theories are effective in the management of behavioural and emotional problems in children and adolescents (Eyberg, Nelson, & Boggs, 2008; Kazdin, 2005). Although the evidence is strongest for parents of children with conduct problems, parenting interventions can also be effective for a range of other social, emotional, behavioural, and health-related problems, including parents of children with feeding difficulties, pain syndromes, and children with various developmental disabilities and for maltreating parents (see de Graaf, Speetjens, Smit, de

Matthew R. Sanders, Parenting and Family Support Centre, School of Psychology, University of Queensland.

Correspondence concerning this article should be addressed to Matthew R. Sanders, Parenting and Family Support Centre, School of Psychology, The University of Queensland, Brisbane 4072, Australia. E-mail: m.sanders@psy.uq.edu.au

Wolff, & Tavecchio, 2008a, 2008b; Nowak & Heinrichs, 2008; Sanders, 2008; World Health Organisation, 2009).

## Benefits of Adopting a Public Health Approach to Parenting Support?

A public health approach to parenting support is an ambitious undertaking to reduce the prevalence rates of inadequate parenting at a whole of population level. This population-based approach contrasts with a more traditional individual clinical interventions (e.g., Eyberg & Boggs, 1989; McMahon & Forehand, 2003; Patterson, Reid, Jones, & Conger, 1975) that target children who are considered at risk for developing or who have already developed serious emotional or behavioural problems.

With the adoption of a public health perspective, the target of intervention shifts from the clinical management of individual families and their children to entire populations of families and children living in defined communities. The relationship between health promotion, universal prevention, selective prevention, indicated prevention, and treatment are seen as on a continuum, and preventive and treatment approaches should ideally complement and support each other (Weisz, Sandler, Durlak, & Anton, 2005). Key concepts that inform a population-based approach to parenting support include: (a) having specific local knowledge about the base rates of child problems and associated parenting and family risk and protective factors that affect the way children are raised; (b) having knowledge from efficacy trials that shows by changing key risk and protective factors children's problem behaviours also change; (c) making effective and culturally appropriate interventions more widely available; and then (d) tracking outcomes beyond the level of individual children and families and measuring population level indicators that are expected to shift with a parenting intervention. A comprehensive population approach may involve a blending of universal and more indicated or targeted parenting interventions for certain high-risk groups (e.g., parents of a child with a disability). The major benefits of a population approach are that a much larger number of parents and children can receive assistance, and it can involve better utilisation of the existing workforce who provide counsel or advice to parents about children.

## Policy Support for Evidence-Based Parenting Programs

There has been substantially increased international recognition of the value of positive parenting programs, particularly toward

young children, by both professional bodies and major policy influencing groups. Examples of this proactive stance to increase the availability of parenting programs include the recent Institute of Medicine's Report (United States) on *Preventing Mental, Emotional and Behavioural Disorders Amongst Young People* (National Research Council and Institute of Medicine, 2009), which recommends that parenting programs be more widely disseminated and prevention interventions. A report from the American Psychological Association (APA) Task Force on the prevention of child maltreatment (APA, 2009) also recommends the wider implementation of evidence-based parenting programs as does the World Health Organisation (2009). In England, the National Institute of Clinical Excellence and Social Care (NICE) recommended that group-administered parenting programs be made available for parents of children with conduct problems (NICE, 2006). Policy initiatives have taken place in a number of other European countries such as Norway, Sweden, Belgium, and Switzerland to increase access to evidence-based parenting programs.

## From Individual Therapy to Public Health: A Brief History

Although traditional group and individual parenting programs have been used as a treatment for decades, the benefits of these interventions have been limited because of the relatively small number of parents who access such programs (Sanders & Prinz, 2008; Taylor & Biglan, 1998). Recognition that parenting programs need to reach a far larger number of children to make a significant impact on child problem behaviours was the primary driver for the development of a population-based approach to parenting support (Sanders, 1999, 2008). The Triple P-Positive Parenting Program was gradually developed over a period of years and to date is the only evidence-based multilevel system of parenting intervention designed as a population level intervention.

The model had modest beginnings as an individually administered, home-based xintervention for parents of preschool-aged children with disruptive behaviour problems (Sanders & Glynn, 1981). The early evaluations of what is now called Triple P used single-subject designs within the applied behaviour analytic tradition (Baer, Wolf, & Risley, 1968). From the early 1980s to the mid-1990s, a small group of researchers and graduate students at the University of Queensland undertook the long process of developing and evaluating whether different delivery modalities for the program could be effective. The behavioural family intervention model was also tested different types of children and families. A group variant of the program was developed (Turner, Markie-Dadds, & Sanders, 2002; Zubrick et al., 2005), followed by a self-directed variant (Sanders, Markie-Dadds, Tully, & Bor, 2000), and a variant that could be delivered over the phone (Markie-Dadds & Sanders, 2006a; Morawska & Sanders, 2006a, 2006b). The efficacy of each variant was tested and if demonstrated to be effective became part of the system.

To improve the reach of the program, we sought to develop procedures that would create a more supportive ecological context of parenting support. This involved developing media interventions, large-group seminars on positive parenting, small-group programs, and brief primary care variants of the program (Turner & Sanders, 2006). All these derivative programs used the same theoretical framework and principles of positive parenting so that

different levels of intensity of the same intervention could be offered to parents (see Sanders, 2008). The age range of children targeted by the intervention expanded from a narrow focus on disruptive preschool-aged children (Sanders & Glynn, 1981) to parents of children of all ages from infancy to adolescence (Ralph & Sanders, 2004).

As the intervention continued to evolve, our attention turned to ensuring that evidence-based parenting programs were available to an increasingly diverse group of parents. The concept of evidence-based parenting programs for every parent became the goal. An inclusive population approach that provides quality parenting support for all parents requires program developers to allow tailoring and adaptation of interventions to address the special needs of particular groups of parents. Hence, new variants and derivative programs were developed for parents of children with a disability, indigenous parents, parents from ethnically and culturally diverse groups, and parents of children with special needs. This latter group has included parents of gifted and talented children (Morawska & Sanders, 2008) and parents of children with health related problems, including chronic illnesses such as asthma.

## Enhancing the Impact of Population-Based Parenting Programs

Although the core five level Triple P system has features that made it a good candidate for "scaling up" the intervention, additional efforts were required to maximise the public health benefit of the intervention system. The following section illustrates steps taken to further enhance the value of the intervention as a public health strategy. The application of the RE-AIM framework of Glasgow, Vogt, and Boles (1999) provides a useful conceptual model for examining the potential public health benefit of a parenting intervention. This model argues that the public health benefit of an intervention is a function of the interaction between five factors including the reach of the intervention (R), its efficacy (E), its adoption by agencies serving the target population (A), the extent to which trained providers implement the program (I), and the extent to which they maintain or continue to use the program over time (M). Our efforts to address each of these factors are discussed below.

### Improving the Reach of the Intervention

Reach refers to the percentage of persons in a target population who participate in a program. It is measured by comparing records of program participants and complete sample or "census" information for a defined population, such as all members in a given clinic, HMO, or worksite. The reach of a parenting intervention can be defined as the proportion of eligible parents in a defined catchment area who participate in or are exposed to the intervention.

A number of strategies have been implemented in an effort to improve the reach of Triple P. These strategies include improving the ecological "fit" between the intervention itself (materials, number of sessions, mode of delivery) and the service delivery context of the intervention (e.g., home, clinic, paediatric setting, mental health facility, school); developing a multilevel system of intervention (universal, selected, primary care, standard and en-

hanced); and developing strategies to improve the engagement of parents. Each is discussed below.

Improving the ecological fit of an intervention involves developing interventions that can actually be delivered by service providers given their service delivery setting, clientele, and service priorities. Whether an intervention is considered to have a good fit depends on having a program that can be effectively deployed by a service provider with appropriate professional training. For example, if practitioners are trained to deliver an intensive variant of the program, such as a 10-session Standard Triple P or 12- to 16-session Enhanced Triple P, they have to work in a setting and have a job description that enables them to deliver the interventions on a weekly basis over a period of 2 to 3 months. If a practitioner typically consults with parents during brief consultations over a shorter time period, then longer interventions will have a poor fit, will be unlikely to be used after initial training, and will not become core business.

The lack of fit between existing evidence-based interventions and the workforce to deliver the interventions was behind the development of Primary Care Triple P—a brief four-session program designed to be delivered during 15- to 3-min consultations with primary care providers including nurses, general medical practitioners, and paediatricians. This level of intervention was originally conceptualised as brief intervention for parents of children with behavioural or emotional problems that did not require more specialist or more intensive services.

**Having multiple levels increases parental choice.** A multi-level system increases the number of options a parent has to access parenting support and means that parents' specific circumstances and preferences can be more easily taken into account. Some parents participate in Triple P as a media intervention (Level 1); for example, watching a television series showing parents participating in Group Triple P over a period of weeks through a six-episode observational documentary series called *Driving Mum and Dad Mad* (Calam, Sanders, Miller, Sadhnani, & Carmont, 2008). Others attend either a three-session seminar series on positive parenting (Level two), a four-session individual program with a primary care provider (Level 3), a more intensive group or individual program (Level 4), or an enhanced individual intervention (Level 5).

**Having flexible variants mean similar problems can be tackled differently.** Not all parents with the same problem require the same intensity of intervention. For example, a parent with a 3-year-old with early onset conduct problems may benefit from either a "light touch" or a more intensive intervention, depending on the associated risk and protective factors, as well as the expressed concerns and aspirations of the parent. However, if a parent has ongoing marital conflict, is recently separated or divorced, or suffers from significant depression, the intervention may need to address the broader relationship context and parents' emotional coping strategies. For example, a parent diagnosed with depression may need parenting skills coupled with mood management strategies (Sanders & McFarland, 2000).

**Improved engagement increases impact.** The effects of an intervention are enhanced when parents are initially attracted to, enrol, and then are retained through to the completion of the program and postintervention assessment of outcome. Social marketing strategies can be employed to increase awareness of the availability of parenting programs in a community. Several large-scale population level trials of the Triple P system (e.g., Sanders et al., 2008) have successfully employed active media outreach and communication strategies (e.g., radio announcements, newspaper columns, editorials, television features, and promotion of programs through the Web). These media strategies aim to increase parental knowledge and awareness of Triple P in the community and to provide a navigation route for parents to enrol. A comprehensive communication strategy to support the roll out of Triple P in the City of Amsterdam (Kielstra-van der Schalk, 2009) involved a multipronged campaign involving a dedicated Web site, posters, brochures, and magazines to facilitate parents accessing a trained Triple P provider in the community. Although there is evidence that media campaigns can increase parental awareness, further research is required to identify variables that promote program engagement following initial awareness being raised.

Several recent studies provide some indication of potentially modifiable variables that might improve parental engagement. For example, Heinrichs (2006) examined whether financial reimbursement (paid vs. unpaid) and training setting (individual vs. group) affected parental engagement. The study recruited parents by advertising the study describing only the indicated condition (i.e., group-unpaid, or individual-paid, etc.). Results showed that a small financial incentive for low-income parents significantly improved session attendance. However, training setting alone did not influence engagement. Other strategies include the judicious use of parent and professional testimonial advocacy. Several studies are underway the University of Queensland and University of Manchester to test to efficacy of different types of testimonials on session attendance.

**Efficacy.** Efficacy trials test the effects of an intervention under optimal conditions of program delivery. Population level change is more likely to occur through a multilevel system of intervention when each element of the system has been demonstrated to be effective with a defined target population of parents. A major program of research is required to produce enough evidence of sufficient quality to justify investment of public funds in a population-based approach to parenting programs.

**Adoption of a self-regulation framework to support population-level change.** Although many parents are extremely interested in receiving information and support in their parenting role, parents generally do not want to be told how to raise their children. The adoption of a self-regulation framework is extremely helpful in achieving the dual goals of fostering the personal responsibility of parents to make informed parenting decisions and at the same time sharing knowledge and skills about how to parent effectively to promote children's well-being and healthy development. The self-regulation perspective is also very helpful in communicating with the public and policymakers about parenting and family issues. It is also fundamental to designing, implementing, and evaluating specific programs within the system. A self-regulation framework embraces the notion that it is the parent who must decide how best to raise their children not the government or anyone else. This emphasis on personal parental responsibility for making informed choices about raising children helps to address concerns about unwarranted and unsolicited intrusion by the State who are cast as interfering with family life and restricting parental rights. A self-regulation framework also helps in combating beliefs that evidence-based, manualised interventions are too prescriptive and not attuned to cultural diversity in a community.

The goal of the self-regulation approach is independence and autonomy of parents. To become self-regulated, parents choose their own goals, select from a range of parenting practises that will enable them to achieve outcomes they value, and assess whether they have achieved what they set out to accomplish. Parents' goals can be informed by their own culture, traditions, beliefs, and values. Self-regulated parents become better informed and more skilled, more self-confident, independent, and self-reliant, and become more observant and reflective about their parenting. This self-observational capacity encourages parents to change course if what they are doing is not working or requires refinement through independent problem-solving effort.

**Adopting a consumer perspective.** Adoption of a consumer perspective is a necessary concomitant of adopting a self-regulation framework. Consumer research into parental preferences has provided valuable insights into what parents are looking for in undertaking a parenting program, as well as clues regarding how programs need to respond to parent aspirations. For example, Sanders, Haslam, Calam, Southwell, and Stallman (under review) surveyed 722 working parents in the United Kingdom and found that no single mode of delivery (e.g., group, individual, over the phone, Web, self-directed) for an employee assistance program targeting the transition to and from work accounted for more than one-quarter of parents. Similarly, Metzler, Sanders, Rusby, and Crowley (2009) found that the most-preferred mode of accessing a parenting program in a multiethnic U.S. sample of parents of 3- to 6-year-olds was through a television program, followed by the Web. The three least preferred modes were through home visiting, attending a parenting class, and visiting an individual practitioner.

**Developing "light touch" interventions.** Although parenting groups have been shown to be effective in teaching parents to implement positive parenting skills, the level of commitment required of parents is significant. For example, most of the evidence-based group programs last between 8 and 12 weeks, and some more specialised ones for parenting of obese children can require 17 weeks (West & Sanders, 2009). If less intensive programs were available and shown to be effective, the number of parents who can attend would be increased substantially. At present, there is some pilot evidence suggesting that a three-session, large-group seminar series on positive parenting may be effective. Sanders, Pryor, and Ralph (2009) found a reduction in parental reports of problem child behaviour and dysfunctional parenting styles with a single introductory seminar on the *Power of Positive Parenting*. However, exposure to all three seminars (*Raising Confident, Competent Children; Raising Resilient Children*) was associated with significant improvements in dysfunctional parenting styles and lower levels of interparental conflict. These findings show promise but require further replication studies.

**Using more intensive interventions for high-need groups.** In addition to universal elements, a comprehensive system of targeted parental support are required for parents who have children with special needs or who find themselves in situations that compromise their capacity to parent well. To address these additional concerns, we have developed specific variants of Triple P for parents of children with a disability, parents of children with feeding disorders, pain syndromes, parents who are in discordant marital situations, and parents who have experience separation or divorce.

Recent variants targeting parents who have experienced separation or divorce (Family Transitions Triple P; Stallman & Sanders, 2009) and parents of children who are overweight and obese (Lifestyle Triple P; West & Sanders, 2009) have been developed. A randomised trial of Family Transitions Triple P showed moderately large effect sises on child behaviour, parent distress (anger), and dysfunctional parenting practises. Another randomised trial of Lifestyle Triple P (West & Sanders, 2009) showed significantly greater changes on body mass index (BMI) and lifestyle behaviour management than those in a waitlist control group.

**Adoption.** The level of population benefit achieved by a parenting strategy depends greatly on service providers and agencies delivering services to parents to adopt evidence-based programs and delivering them to parents with fidelity. Program adoption can come through many different routes. In the case of Triple P, it has ranged from individual practitioners hearing about the program first hand at a conference or professional meeting and then championing its adoption through a service system until it is supported. On other occasions, there have been ministerial level policy endorsements where the program is implemented state-, province-, city-, or in some cases countrywide.

**Understanding the sociopolitical context.** Efforts to promote better parenting services are improved when professionals interested in promoting evidence-based practise are informed about policy priorities and settings and actively seek to influence these settings. An unfortunate political reality is that elections are not typically won or lost on the basis of child or parenting issues. Considerable political rhetoric can be devoted to explaining how government policy affects families; however, this is often not matched by funding streams that allow for the implementation of evidence-based interventions on anywhere near the scale that is needed to make a population level impact. Strategies we have found helpful in influencing policy include simply being better informed about public policy statements made from time to time typically through the mass media about parenting or family issues, identifying funding streams that become available to support various program initiatives, and establishing relationships with policy leaders in government. However, influencing policy to promote a population health to parenting support is quite another matter. The prevailing view in many countries is a narrowly focused one of simply targeting high-risk children with better programs not the adoption of a wider blend of universal and more targeted programs with the goal of reducing the prevalence rates of targeted problems. Volunteering to participate in policy influencing committees, preparing submissions, and supporting coalitions with other groups can lead synergistically to great leverage and influence over the development of policies that promote better outcomes for children and families.

## Economic Analyses

One way of influencing policy is to mount a persuasive economic case that investing in parenting programs reduces the cost of government services that might otherwise be required (Foster, Prinz, Sanders, & Shapiro, 2008). Although economic arguments are important particularly in times of economic downturn, many decisions to invest in parenting stem from intense personal championing of a cause by a committed political leader. Many politicians are also parents or grandparents themselves, and their own families are not exempt from considerable personal concerns about children. A carefully selected example can be very persuasive when

it is personally relevant to a politician because it addressed issues that the politician may have spoken about previously or supported publically. It helps to communicate messages about parenting and prevention in ways that have high personal salience to the audience.

## Robust Implementation

There are many fads in therapy that are adopted with great enthusiasm only to be ditched and replaced by the next "hot" idea. For a population approach to parenting to be successful, not only do practitioners need to be trained, they also need to be supported in their use of the program. We initially tried and then abandoned using a "train the trainer" model of dissemination that is so popular with government departments around the world. We did so because it resulted in a significant loss of quality control and unacceptable program drift "at source." Instead, all training is handled by a training and dissemination organisation that runs professional training courses in various countries and languages around the world (www.triplep.net). However, apart from training, two other factors are important in ensuring that there is a well-trained workforce. The first relates to the level of organisational support available to workers providing parenting services, and the second relates to the capacity of practitioners to tailor the delivery of the intervention to the identified needs of the target client population served by the organisation.

## Strengthen Organisational Support

We have sought to strengthen organisational support for the public health approach by conducting manager briefings, providing specific guidance on how to prepare staff properly who will attend training (including who to select and guidance of what level of training or type of course staff should complete), and by demystifying training through providing staff with clear expectations relating to what they will be expected to do with respect to implementation of the program following training. Change is sometimes threatening, and staff can be very used to doing their job in a particular way. Ways of doing things that are safe and familiar competes with ideas that are the new and challenging. Many staff concerns can be anticipated and allayed when managers are well informed and are supportive of their staff undertaking the training in a new program. In the absence of such support many trained staff will not use the program and therefore the investment in training has a low yield.

## Customising Delivery While Maintaining Fidelity

At first glance, it may appear that the dual goals of ensuring flexible tailoring of a program to the individual needs of parents and maintaining adherence to an intervention model and an intervention protocols are incompatible. We have sought to write practitioner manuals and additional training resources that provide clear guidance regarding the conducting of sessions. Additional advice is also provided concerning how to appropriate tailor the delivery of the intervention to the needs of families. Manualised interventions that fail to allow for tailoring are likely to be perceived by practitioners as rigid and prescriptive. These perceptions ultimately contribute to practitioners abandoning evidence-based practises. Examples of permissible tailoring include lengthening a

session if needed, choice of examples to make them salient to a particular client group, providing opportunities for more-or-less within session practise depending on the skills level of the parent.

## Maintenance

The public health impact of adopting then implementing evidence-based practises is greatly influenced by the extent to which practitioners continue to implement the program after their initial training. The survival of evidence-based programs after initial dissemination influences the impact of these interventions. High-impact interventions are more likely when practitioners adopt, implement, and then continue to implement the program over time. This group of dedicated and committed users is likely to be instrumental in a program achieving good program reach in the community. The role of the posttraining environment in fostering sustained implementation of programs is discussed below.

**Establish quality maintenance systems.** A quality maintenance process involves creating the conditions that foster the continued use of evidence-based programs after initial dissemination. Quality maintenance strategies include the work practises within an organisation and technical support provided to an organisation by third parties, including the dissemination organisation who provided the staff training. Provision of regular workplace supervision, clarifying work roles so that the delivery of parenting programs becomes core business of the organisation, and the use of clinical assessment tools to systematically track client outcomes are all examples of work practises that are influenced by organisational leadership and line management support. External technical support and consultation includes providing regular updates to practitioners regarding new research, program variants, and the experiences of other local and international groups implementing Triple P. We operate a password protected provider network to support accredited practitioners with their implementation of Triple P (www.triplep.org).

## Evolving and Responding to New Evidence

No parenting programs can afford to be complacent or to remain static. As new knowledge about the impact of a program emerges, new impetus and a favourable motivational context for program innovation and evolution is created. Demands for changing or adapting a program can come from parents, providers and by program developers themselves. New iterations of Triple P are being developed and tested in randomized clinical trials. New variants are being trialled for grandparents, foster parents, parents of anxious children, parents of children with chronic health conditions, and parents who themselves have a mental illness.

## Conclusion and Implications

The evolution of a public health approach to the provision of parenting support over the past decade has been associated with a renewed impetus to develop interventions that reach and effectively engage parents who might benefit from support in parenting. Recent evidence showing that the implementation of population-based approaches to parenting can affect rates of child maltreatment and behavioural and emotional problems is encouraging, although further research is still required (e.g., Prinz, Sanders,

Shapiro, Whitaker, & Lutzker, 2009; Sanders et al., 2008; Zubrick et al., 2005). Of the many psychological interventions that can promote the well-being of children, the prospect of quality evidence-based parenting programs being readily accessible to all parents holds the greatest promise to produce a future generation of healthy, happy, and resilient children with the social and emotional life skills they need to contribute to the well being of our community.

## References

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: American Psychological Association.

Baer, D., Wolf, M., & Risley, R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis, 1,* 91–97.

Calam, R., Sanders, M. R., Miller, C., Sadhnani, V., & Carmont, S. (2008). Can technology and the media help reduce dysfunctional parenting and increase engagement with preventative parenting interventions? *Child Maltreatment, 13,* 347–361.

de Graaf, I., Speetjens, P., Smit, F., de Wolff, M., & Tavecchio, L. (2008a). Effectiveness of the Triple P Positive Parenting Program on behavioural problems in children: A meta-analysis. *Behavior Modification, 32,* 714–735.

de Graaf, I., Speetjens, P., Smit, F., de Wolff, M., & Tavecchio, L. (2008b). Effectiveness of the Triple P Positive Parenting Program on parenting: A meta-analysis. *Family Relations, 57,* 553–566.

Eyberg, S. M., & Boggs, S. R. (1989). Parent training for oppositional-defiant preschoolers. In C. E. Schaefer & J. M. Briesmeister (Eds.), *Handbook of parent training: Parents as co-therapists for children's behavior problems. Wiley series of personality processes* (pp. 105–132). Oxford, England: Wiley.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behaviour. *Journal of Clinical Child and Adolescent Psychology, 37,* 215–237.

Foster, E. M., Prinz, R. J., Sanders, M. R., & Shapiro, C. J. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review, 30,* 493–501.

Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: The RE-AIM framework. *American Journal of Public Health, 89,* 1322–1327.

Heinrichs, N. (2006). The effects of two different incentives on recruitment rates of families into a prevention program. *The Journal of Primary Prevention, 27,* 345–365.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York: Oxford University Press.

Kielstra-van der Schalk, C. (2009, April). *A positive message to all parents: Universal Triple P in Amsterdam.* Invited address presented at the Helping Families Change Conference, Toronto.

Markie-Dadds, C., & Sanders, M. R. (2006a). A controlled evaluation of an enhanced self-directed behavioural family intervention for parents of children with conduct problems in rural and remote areas. *Behaviour Change, 23,* 55–72.

McMahon, R. J., & Forehand, R. L. (2003). *Helping the noncompliant child: Family-based treatment for oppositional behavior* (2nd ed.). New York: Guilford Press.

Metzler, C. (2009, April). *The Triple P Parenting media trial: Enhancing the efficacy of media interventions on parenting.* Invited address presented at the Helping Families Change Conference, Toronto.

Morawska, A., & Sanders, M. R. (2006a). Self-administered behavioral family intervention for parents of toddlers: Part I. Efficacy. *Journal of Clinical and Consulting Psychology, 74,* 10–19.

Morawska, A., & Sanders, M. R. (2006b). Self-administered behavioural family intervention for parents of toddlers: Effectiveness and dissemination. *Behaviour Research and Therapy, 34,* 259–275.

Morawska, A., & Sanders, M. R. (2008). Parenting gifted and talented children: What are the key child behaviour and parenting issues? *Australian and New Zealand Journal of Psychiatry, 42,* 819–827.

National Institute of Clinical Excellence and Social Care. (2006). *Parent-training/education programmes in the management of children with conduct disorders.* London: National Institute of Clinical Excellence and Social Care.

National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.* Washington, DC: National Academic Press.

Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P-Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review, 11,* 114–144.

Patterson, G. R., Reid, J. B., Jones, R. R., & Conger, R. E. (1975). *A social learning theory approach to family intervention: Volume I. Families with aggressive children.* Eugene, OR: Castalia Publishing Co.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science, 10*i, 1–12.

Ralph, A., & Sanders, M. R. (2004). The "Teen Triple P" Positive Parenting Program: A preliminary evaluation. *Trends and Issues in Crime and Criminal Justice, 282,* 1–6.

Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review, 2,* 71–90.

Sanders, M. R. (2008). The Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology, 22,* 506–517.

Sanders, M. R., & Glynn, E. L. (1981). Training parents in behavioral self-management: An analysis of generalization and maintenance effects. *Journal of Applied Behavior Analysis, 14,* 223–237.

Sanders, M. R., Haslam, D. M., Calam, R., Southwell, C., & Stallman, H. M. (2009). Designing effective interventions for working parents: A survey of parents in the UK workforce. Manuscript submitted for publication.

Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P- Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68,* 624–640.

Sanders, M. R., & McFarland, M. (2000). Treatment of depressed mothers with disruptive children: A controlled evaluation of cognitive behavioral family intervention. *Behavior Therapy, 31,* 89–112.

Sanders, M. R., & Prinz, R. J. (2008). Ethical and professional issues in the implementation of population-level parenting interventions. *Clinical Psychology: Science and Practice, 15*(2), 130–136.

Sanders, M. R., Prior, J., & Ralph, A. (2009). An evaluation of a brief universal seminar series on positive parenting: A feasibility study. *Journal of Children's Services, 4*(1), 4–20.

Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., et al. (2008). Every family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention, 29,* 197–222.

Stallman, H. M., & Sanders, M. R. (2009). *Practitioner's manual for Family Transitions Triple P.* Brisbane, Australia: Triple P International.

Taylor, T. K., & Biglan, A. (1998). Behavioral family interventions for improving child rearing: A review of the literature for clinicians and policy makers. *Clinical Child and Family Psychology Review, 1,* 41–60.

Turner, K. M. T., Markie-Dadds, C., & Sanders, M. R. (2002). *Facilitator's manual for Group Triple P* (rev. ed.). Brisbane, QLD, Australia: Triple P International.

Turner, K. M. T., & Sanders, M. R. (2006). Help when it's needed first: A controlled evaluation of brief, preventive behavioral family intervention in a primary care setting. *Behavior Therapy, 37,* 131–142.

Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60,* 628–648.

West, F., & Sanders, M. R. (2009). The Lifestyle Behaviour Checklist: A measure of weight-related problem behaviour in obese children. *International Journal of Pediatric Obesity, 1,* 1–8.

World Health Organization. (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: World Health Organization.

Zubrick, S. R., Ward, K. A., Silburn, S. R., Lawrence, D., Williams, A. A., Blair, E., et al. (2005). Prevention of child behavior problems through universal implementation of a group behavioral family intervention. *Prevention Science, 6,* 287–304.