DBHR Triple P Initiative

Year 2 Evaluation: Findings from a community level implementation of Triple P Positive Parenting Program

Report Prepared by: Suzanne Kerns, Andrea Negrete and Erin McCormick

November 2014

Table of Contents

Executive Summary	1
Introduction	2
Methods	3
Participants	3
Communities, Coalitions, and Providers	3
Training	4
Measures	4
Data Collection Time Points	7
Response Rates	8
Human Subjects	9
Results	9
Part 1. Triple P Trained Provider Characteristics	9
Part 2. Triple P Trained Providers - Service Delivery Results	17
Part 3. Impact of the Triple P Training	29
Part 4. Providers and Coalition Members – Attitudes and Perceptions	32
Part 5. Analysis of Qualitative findings	37
Discussion	41
Limitations	43
Recommendations	43
Work Cited	45
Appendix A. Community Coalition Members - Demographics	46
Annendix B. Additional Analyses	// 0

Executive Summary

The Division of Behavioral Health and Recovery (DBHR) utilized Mental Health Block Grant funds to partner with the University of Washington's Division of Public Behavioral Health and Justice Policy (UW PBHJP) and Seattle Children's Research Institute (SCRI) to implement the Positive Parenting Program (Triple P) in three rural, Prevention Redesign Initiative (PRI) - funded community coalitions in Washington State. In the first year of funding, project staff worked with these communities to develop Triple P capacity and infrastructure to support Triple P services. The first half of the year focused on provider recruitment and implementation planning. Provider recruitment entailed identifying appropriate providers to delivery "light-touch" and traditional parenting interventions to families in identified communities. Each community targeted providers with a universal reach through primary care clinics, day cares and school systems as well as providers working with targeted populations (e.g. public health nurses). All recruited providers were invited to attend Triple P trainings in Primary Care Triple P, Seminar, Standard Triple P, or Group Triple P. Some providers in unique roles were invited to attend multiple training opportunities. After providers attended training, they were expected to begin delivering Triple P services to their community. While the majority eventually delivered at least some Triple P, the extent of service delivery was relatively small. Community coordinators were charged with developing supports for providers and service awareness campaigns for families. This Evaluation Report summarizes data from provider trainings and project specific evaluation activities.

During the first year of funding, and continuing through the second year, all communities increased their Triple P capacity, identifying and sending providers to Triple P trainings. The impact of training on provider skills was immediate and persistent, as providers reported higher levels of self-efficacy through all stages of training. There has been a modest improvement between Year 1 and Year 2 with regards to service delivery, however numbers of families served remains well below the number anticipated.

Evaluation efforts yielded interesting results about communities. While most providers showed improved skills and improved utilization of Triple P over time, we did not see significant changes in agency level activities. The communication between child-serving agencies and behavioral health referral systems did not significantly change in any community from the start of Triple P training to the end of Year 2.

Particular areas for further growth include:

- ✓ Ensuring providers have access to and attend peer support meetings (to maintain model fidelity and problem-solve implementation barriers)
- ✓ Strategize ways to improve communication and collaboration between primary care and behavioral health service systems
- ✓ Ensure a clear referral pathway exists for families
- ✓ Consider additional clinical supports or trainings to improve the number of families who complete the Triple P program.

Washington State Triple P Initiative Final Evaluation

Introduction

The Division of Behavioral Health and Recovery (DBHR) in partnership with the University of Washington's Division of Public Behavioral Health and Justice Policy (UW PBHJP) and Seattle Children's Research Institute (SCRI) utilized Mental Health Block Grant funds to implement the Positive Parenting Program (Triple P) in three rural, Prevention Redesign Initiative (PRI) communities. Initially, the project received one year of funding - October 2012-September 2013. The project received funding for a second year - October 2013-September 2014. UW staff submitted a summary of FY 12-13 findings in October 2013. This report summarizes the data collected during FY 13-14 and compares service delivery and implementation trends between fiscal years.

The Triple P system of interventions is an evidence-based approach to promoting positive parenting and preventing child abuse and neglect. The Triple P system consists of five intervention levels, ranging from universal prevention (level 1) to indicated prevention (levels 2 and 3) to intervention (levels 4 and 5). A detailed description of these intervention levels is available at www.triplep.net. A previous population-level study of Triple P implementation in South Carolina revealed that the Triple P system may 'move the needle' on indicators of child abuse, including rates of CPS referrals, placements into foster care, and hospitalization for intentional injury (Prinz et al., 2009). Given that strong parenting is associated with resilience across a range of domains (including recovery from trauma, self-regulation, and academic success) and coercive or neglectful parenting is a significant risk factor for outcomes including early initiation of substance abuse, conduct problems, and early school failure, focusing on creating strong families is an important component of building resilient and healthy communities.

This project involved PRI-funded communities, all with elevated risk indicators for substance abuse, academic failure and economic deprivation. PRI-funded communities contain coalitions who spearhead efforts to improve the health of their youth, families and communities.

During the first year of the project, DBHR, UW and SCRI staff negotiated two crucial project implementation supports during the initial planning period of the project: development of a Medicaid billing code for Triple P services and an Operations and Sustainability Guide. Project staff worked with Healthcare Authority staff to create specific billing codes for primary care providers who deliver Triple P services to patients. The underlying belief was that if providers could bill for services, they would deliver the services. The Operations and Sustainability guide helped communities plan for roll out, implementation and sustainability. The guide also provides a framework to think about monitoring all levels of implementation.

The project was structured to allow for an upward flow of technical assistance while maintaining a locally driven implementation plan. Project staff and functions remained constant from Year 1 to Year 2:

- 1. DBHR provided project oversight and billing technical assistance.
- 2. The UW and Children's team provided overall project management and project-specific technical assistance to communities as well as designed the project's evaluation plan.
- 3. At the local level, community coalitions retained a .25 FTE coordinator to manage the project through year two. The local coordinator recruited providers for Triple P trainings, offered local technical assistance to providers, developed a Triple P media campaign and collected data for the project evaluation.

As in Year 1, UW staff traveled to communities for site visits with local coordinators and Triple P providers. Also, project staff attended each Triple P training in Year 2 to provide on-site project support.

Methods

The DBHR funded Washington State Triple P Implementation Initiative completed data collection, analysis, and reporting for the first contract year or FY 12-13 in October 2013. The second contract year or FY 13-14 began in November 2013, with community-level data reporting beginning in January 2014. During FY 13-14, we continued to track Triple P implementation across three participating communities and across Triple P training levels to determine the project's impact on:

- ✓ system level outcomes;
- ✓ practitioner level outcomes; and
- ✓ number of families receiving Triple P-related interventions.

UW introduced a new service delivery platform in FY 13-14. This new platform allowed for timely and ongoing analysis of service delivery and implementation activities.

The present report presents findings from FY 12-13 and FY 13-14. Participants completed the same measure throughout the two years of funding, which allows for a repeated measures design to analyze implementation performance trends over time.

Participants

Communities, Coalitions and Providers

Three PRI-funded communities participated in the Triple P Initiative across two years (FY 12-13 and FY 13-14): Omak, Othello and Ocean Beach School District. This project involved PRI-funded communities, all with elevated risk indicators for substance abuse, academic failure and economic deprivation. PRI-funded communities contain coalitions who spearhead efforts to improve the health of their youth, families and communities. These coalitions submitted letters of interest and a preliminary readiness assessment to project staff in September 2012, and from those submissions, three communities were selected. Communities presented with varied degrees of Triple P knowledge and readiness to implement the program.

Local coalition members played a significant role in the initial application for funding and continued to play a vital role in the implementation of the initiative. In both years, we collected perceptions and awareness data from coalition members provided insight into potential impacts and the reach of the Triple P implementation efforts. This study folds data from Years 1 and 2 to demonstrate trends and/or changes across time. In the analysis section, coalition member data include those who completed assessments at pre, post, 6 month follow-up and 18-month follow-up. Note that there was significant change over time in the constellation of coalition members – for the purposes of this report, we focus on those who remained constant across years.

Across fiscal years, local coordinators, in collaboration with project staff, recruited community providers to attend Triple P trainings. Coordinators targeted providers appropriate for four (4) types of Triple P training: Level 2 Selected Seminars, Level 3 Primary Care, Level 4 Standard, and Level 4 Group. A select number of providers were eligible to attend multiple trainings. Each community trained providers in all available levels. In our FY 12-13 report, we captured implementation and service delivery efforts from practitioners initially trained in Primary Care and Standard Triple P. In this report, we track service delivery and implementation trends as they developed in FY 13-14 and with the more inclusive implementation levels. In our FY 13-14 evaluation efforts, project staff explored potential changes in Triple P trained providers, community coalitions and the communities themselves.

There was variability in participants responding to survey instruments over time. We detail the number of respondents in each section. However, we are not able to determine the representativeness of the 'respondents' compared to those who declined to participate. Further, at some time points and for some sub-

groups, the number of respondents is quite low. Caution should be applied in drawing strong conclusions from responses based only on a small number of respondents.

Training

Triple P is a public health approach to parenting – reaching as many parents as needed with a minimally sufficient dose. As mentioned in the introduction, Triple P contains 5 tiers of interventions, with intensity increasing with level. During our project, we provided support for Level 1 media-based strategies and training in 3 Triple P levels and 4 delivery formats. In total, six trainings were offered. Table 1 details the level, timing and location of all trainings held during the project.

Table 1. Triple P Training Opportunities

Year		FY 12	FY 1	3-14		
Level	Level 3 Primary Care	Level 3 Primary Care	Level 3 Primary Care	Level 2 Selected Seminars		
Month Offered	February 2013	March 2013	March 2013	September 2013	March 2014	March 2014
Location	Ocean Beach	Othello	Omak	Seattle	Ellensburg	Seattle

All training participants received a standardized Triple P training followed by an accreditation session 6-8 weeks post-training. Regardless of Triple P level, each training had a maximum of 20 practitioners per training. UW staff collaborated with Triple P America to hold trainings, and Triple P America provided doctoral level Triple P trainers for the trainings and accreditation sessions. Table 2 details the time commitment and delivery format of each Triple P training offered during the two-year project.

Table 2. Triple P training descriptions

Training	Time Commitment	Delivery Format
Level 2 Selected Seminars	1 day training, half day accreditation	Three 2-hr seminars
Level 3 Primary Care	2 day training, half day accreditation	Up to four (15-30 min) sessions
Level 4 Standard	3 training days, half day accreditation	10 (1hr) sessions delivered in-person
Level 4 Group	3 training days, half day accreditation	An eight week program involving five (2hr) group sessions and three (15-30 min) individual phone consultations

Measures

As in FY 12-13, UW staff used several measures to collect data from two participant populations: Triple P trained practitioners and community coalition members. The majority of measures remained the same across administrations, with a few additions to the provider surveys (Table 3).

Table 3. Data Collection Measures

	Participants	Measures	Status
TPA Measures	Triple P Practitioners	Parent Consultation Checklist Workshop Evaluation Survey	Fixed
UW Measures	Triple P Practitioners	Implementation Project Surveys – Providers	Additional Sections Added
	Coalition Members	Implementation Survey - Coalition	Fixed

Note: The service delivery survey was administered from March through September 2013

Provider Report of Skills, Perceptions and Service Delivery

Parent Consultation Checklist (PCSC). Parent Consultation Skills Checklist (PCSC) is a standardized tool developed by Triple P to assess a practitioner's self-reported proficiency in a number of core skill domains (assessment, active skills training, dealing with process issues and clinical application of positive parenting strategies) and their confidence in their parent consultation skills. The Level 2 Seminar, 3 Primary Care, and Level 4 Group PCSC consist of 20 items rated on a 7-point scale ranging from 1 (not at all confident) to 7 (very confident). Though the number of items is the same, the individual items are slightly different to reflect the different consultation tasks that are part of each respective program level. The Level 4 Standard PCSC consists of 24 items. The Standard PCSC contains four additional items. All utilize the same 7-point scale. This measure has high internal consistency (α =0.96). Maximum score for the Seminar, Primary Care and group PCSC is 140 and is 168 for the Standard PCSC. Higher scores indicate greater perceived skill. Providers completed this assessment by hand at four time points: pre-training, post-training, at accreditation and at the 18-month follow-up. For our crosstrained providers, we used their responses from their first Triple P training during analysis (note, PCSCs from Seminar are not considered in the analyses because all providers would have received other levels of training first).

Workshop Evaluation Survey (WES). The Workshop Evaluation Survey is a standardized tool developed by Triple P. The WES contains 15 items that explore a participant's preparation for and experience in the Triple P training session. Providers completed this measure in person at the end of training and at the end of the accreditation session.

Washington State Triple P Implementation Project Evaluation - Providers. Project staff created this questionnaire battery to collect information about providers' perceptions about evidence based interventions as well as community practices. UW staff administered this instrument through an online survey system (Catalyst). Providers received the survey battery prior to training, and then repeatedly, approximately every 6 months. UW staff offered an in-person option for the pre-training time point during the initial training session. The survey was comprised of seven sections:

Repeated across all time-points:

- Demographic questions about the provider and the population the provider serves.
- Questions adapted from the Evidence-Based Practice Attitude Scale (EBPAS). The EBPAS is a 15-item
 measure intended to assess the willingness of practitioners to adopt evidence-based practice (EBPs)
 based on the appeal of the EBP, requirements imposed by their organization, supervisor, or system and
 the practitioner's degree of openness to innovation and perceived importance of using research-based

interventions in their practice. We combined scores from the measure's subscales to produce an EBPAS total scale score to represent a practitioner's global attitude toward the adoption of EBPs (Aarons, 2005). The first subscale included eight questions rated on a scale from 0 "Not at All" to 4 "To a Very Great Extent." The second subscale contained seven questions rated on a scale from 0 "Not likely" to 3 "Very Likely." In order to calculate the EBPAS global score, the anchor points for items in the second subscale where transformed to match the first subscale.

- Questions about child serving systems and support in the provider's community, developed for the purposes of this evaluation.
- Questions about the behavioral health referral process in the provider's community. The items in this section were based on a referral technical assistance plan for addiction counseling competencies (http://kap.samhsa.gov/products/manuals/taps/21c_3.htm). The overall Cronbach's alpha reliability for the referral measure was $\alpha = .797^1$.
- Questions about the communication and collaboration between child serving agencies and primary care clinics in each community. The items used in this section were derived from a *Pediatrics* article (Taskforce on Mental Health, 2009) identifying strategies to coordinate mental health services with primary care services. The overall Cronbach's alpha reliability for the Communication & Collaboration measure was $\alpha = .827$.

Administered at final post-test only (18-month follow-up)

- Questions adapted from the Implementation Leadership Scale (ILS). The ILS is a 12-item scale that measures four subscales specific to the extent to which a leader is proactive, knowledgeable, supportive, and perseverant in regards to evidence-based practice implementation (Aarons, Ehrhart & Farahnak, 2014). The ILS is made up of two versions and was adapted for practitioners trained in the Triple P to report on the leadership of the local coordination of Triple P in their community and the other to be completed by the local coordinators to report about their leadership efforts surrounding the local implementation efforts. All items are measured on a 0 ('not at all') to 4 ('to a very great extent') scale. This measure was only administered at the final time point.
- Open-ended questions about the provider's impressions of Triple P effectiveness with diverse families (e.g., different cultural groups, linguistic groups, literacy levels, developmental functioning, etc.).

Monthly Service Delivery Survey. Due to the inconsistency of the service delivery data attained during FY 12-13, the UW staff created a streamlined, user-friendly online reporting platform in Google Documents. This online platform consisted of items assessing the delivery of Triple P services by training level, distribution of Triple P materials by type of materials (i.e. workbooks, tip sheets, etc.) and individual providers, and the Level 1 Triple P universal campaign efforts. This online platform was live in January 2014 and operative through September 2014. During that time, local coordinators collected monthly service delivery data from trained providers across all levels starting and entered activities into the Google Document. With this new platform and protocol, UW staff collected more reliable and consistent community data, which in turn allowed for more reliable tracking of key service delivery indicators across time and community.

Coalition Report of Perceptions and Awareness

Washington State Triple P Implementation Project Evaluation – Coalition. Project staff created this questionnaire battery to collect information about coalition members' perceptions about services and communication systems

¹ Cronbach Alpha is used to measure reliability (internal consistency) of a measure where a score above .7 is considered a satisfactory range.

in the community. The survey largely mirrored the provider survey, was administered across three time points, and consisted of four sections:

- The first section contained questions about their coalition's community, their individual tenure on the coalition, their background delivering behavioral health services, and their knowledge of Triple P.
- The second section contained questions about child serving systems and support in the provider's community. These questions were identical to the ones in the UW evaluation survey for providers.
- The third section contained questions about the behavioral health referral process in the provider's community. These questions were identical to the ones in the UW evaluation survey for providers.
- The final section contained questions about the communication and collaboration between child serving agencies and primary care clinics in each community. These questions were identical to the ones in the UW evaluation survey for providers.

Data Collection Time points

UW staff collected evaluation data at multiple time points during the Triple P implementation initiative, as reflected in Figure 1 below. For Triple P providers, participation in the evaluation began at the time of their first Triple P training. For Coalition members, participation in the evaluation began either prior to first Triple P training in FY 12-13 for those a part of the coalition since the beginning of the implementation initiative or at the onset of their membership to the Coalition if joined after the onset of the initiative.

Participants moved through assessments in a cohort, which was determined by their entry time into the study. Below are the descriptions of the project's cohorts.

Provider Cohort 1A. Participants of the FY 12-13 Primary Care and Standard trainings completed a pre-training (T1), post- accreditation (T2), and follow-up surveys (T3-5). In September 2014, practitioners completed an electronic survey called the "WA State Triple P Implementation Project Year 2: Final Follow-Up Survey" (T5). The final survey contained two additional sections specific to the leadership of their local coordinators and the application of Triple P with diverse families. UW staff modified survey dissemination procedure at this final time point, per local coordinator suggestion. UW staff sent the survey announcement via email to the local coordinators, who then forwarded the announcement to all community Triple P providers (active and non-active). Eligible providers received three reminder emails from their local coordinators before the electronic survey closed. Participating practitioners received a \$15.00 gift card for each survey completion.

Provider Cohort 1B. Participants of the Level 4 Group training completed a pre-training (T1), post-accreditation survey (T2) and follow-up surveys (T3-4). In September 2014, practitioners completed an electronic survey called the "WA State Triple P Implementation Project Year 2: Final Follow-Up Survey" (T4). The final survey contained two additional sections specific to the leadership of their local coordinators and the application of Triple P with diverse families. UW staff modified survey dissemination procedure at this final time point, per local coordinator suggestion. UW staff sent the survey announcement via email to the local coordinators, who then forwarded the announcement to all community Triple P providers (active and non-active). Eligible providers received three reminder emails from their local coordinators before the electronic survey closed. Participating practitioners received a \$15.00 gift card for each survey completion.

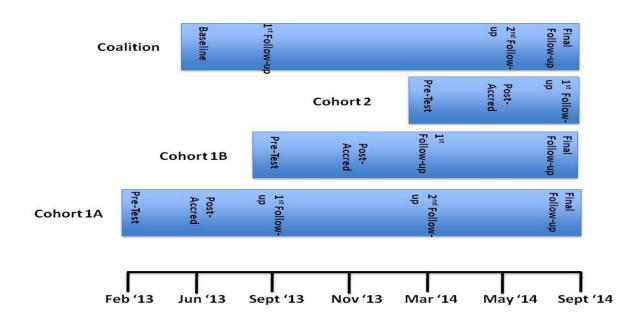
Provider Cohort 2. Participants of the FY 13-14 Primary Care and Seminar trainings completed a pre-training (T1), post- accreditation (T2), and follow-up survey (T3). In September 2014, practitioners electronically completed a survey called the "WA State Triple P Implementation Project Year 2: Final Follow-Up Survey" (T3). The final survey contained three additional sections specific to their Triple P implementation, leadership of their local coordinators and the application of Triple P with diverse families. UW staff modified survey dissemination procedure at this final time point, per local coordinator suggestion. UW staff sent the survey announcement via email to the local coordinators, who then forwarded the announcement to all community Triple P providers

(active and non-active). Eligible providers received three reminder emails from their local coordinators before the electronic survey closed. Participating practitioners received a \$15.00 gift card for each survey completion.

Coalition Member Cohort. Coalition members completed a baseline survey (T1) and follow-up surveys (T2-4). All follow-up surveys were all identical. In September 2014, coalition members completed a follow-up survey called the "WA Triple P Implementation Project Year 2: Final Coalition Member Follow-Up Survey" (T4). UW staff sent the survey announcement via email to the local coordinators, who then forwarded the announcement to all community Triple P providers (active and non-active). Eligible providers received three reminder emails from their local coordinators before the electronic survey closed. Participating practitioners received a \$5.00 gift card for each survey completion.

Though Triple P trainings occurred at discrete times, all providers complete electronic assessments at the same designated intervals: pre-training (T1), post-accreditation (T2) and follow-up (T3-5). The number of follow-ups administered is dependent on the length of time enrolled in the project. Community coalition members participated at discrete time points, and participants in the coalition cohort are those who are active on their respective coalition during the survey administration. Since coalitions experience turnover, coalition rosters ever changing, with some continuity.

Figure 1. Data Collection Timeline across Time and Cohort



Response Rates

Across all training levels, fifty-eight providers (100%) completed the pre-training assessment. Fifty-seven providers (98.3%) completed the post-training, forty-five providers (77.6%) completed the post-accreditation, and twenty-eight providers (48.3%) completed the follow-up assessment. Any repeated-measures data analysis only includes providers who completed assessments at all-time points. Because of the small sample size, multiple imputation strategies to account for missingness was not feasible.

Human Subjects Research

UW staff submitted an IRB application to the University of Washington prior FY12-13 data collection. The UW IRB deemed the project exempt from human subjects review. The UW IRB extended approval for FY 13-14, as all activities continued to fall within program evaluation/quality assurance and therefore exempted from review.

Results

In this section, we describe:

- Part 1. The characteristics of providers who were trained and participated in the initiative;
 - i. Demographic characteristics
 - ii. Pre-training perceptions of 'reach'
 - iii. Results from training: Number trained preparedness, confidence, and self-efficacy in service delivery.
- Part 2. The extent to which providers were able to implement the Triple P model (service delivery), including modifications to Triple P protocols;
- Part 3. The extent to which Triple P training impacted other aspects of provider practice (e.g., attitudes towards evidence-based practices, integration of Triple P principles into other aspects of work); and
- Part 4. The extent to which the overall initiative impacted perceptions of communication, collaboration, and referral pathways (provider and coalition members).
- Part 5. A summary of qualitative responses

Part 1. Triple P Trained Provider Characteristics

Demographics. 58 unique providers participated in the two-year initiative. At baseline, each provider reported information about themselves and the populations they served. Across communities, providers were overwhelmingly female (81.0%). The majority worked in the mental health system (25.5%), with providers in the healthcare system being a close second (24.1%). Almost half of the providers (43%) delivered services in Spanish or worked in agencies providing translation services. Providers served a large proportion of Medicaid clients with almost half of practitioners reporting more than 60% of their clients on Medicaid. Providers have an average of 6.3 years of parent consultation experience and spend an average of 5 hours a week in parent consultation. Almost half of the providers (44.8%) have prior experience delivering parenting interventions. Table 4 details the demographic data of Triple P trained providers by community.

The DBHR Triple P Initiative was successful in training a range of different providers, increasing the diversity of access points for parenting consultation in the three communities. The majority of trained providers remained active throughout the evaluation period.

Table 4. Triple P-training provider demographics

	Omak	Othello	Ocean Beach	Total	Missing
	(n= 20)	(n= 23)	S.D. (n= 15)	(N=58)	
Gender					
Male	4	3	4	11	
	(20.0%)	(13.0%)	(26.7%)	(19.0%)	
Female	16	20	11	47	
	(80.0%)	(87.0%)	(73.3%)	(81.0%)	
Profession ²					3
Mental Health Professional	6	6	2	14	
Mental Health Floressional	(30.0%)	(26.1%)	(13.3%)	(24.1%)	
Dublic Hoolth Nurse	0	2	2	4	
Public Health Nurse	(0.0%)	(8.7%)	(13.3%)	(6.9%)	
Dhusisis	3	2	0	5	
Physician	(15.0%)	(8.7%)	(0.0%)	(8.6%)	
Casa Massa	0	3	3	6	
Case Management	(0.0%)	(13.0%)	(20.0%)	(10.3%)	
	1	2	0	3	
Community Health Worker	(5.0%)	(8.7%)	(0.0%)	(5.2%)	
	1	1	0	2	
Physician Assistant	(5.0%)	(4.3%)	(0.0%)	(3.4%)	
	0	2	0	2	
Nurse	(0.0%)	(8.7%)	(0.0%)	(3.4%)	
	0	0	3	3	
Program Director	(0.0%)	(0.0%)	(20.0%)	(5.2%)	
	0	2	0	2	
School Counselor	(0.0%)	(8.7%)	(0.0%)	(3.4%)	
	1	1	0	2	
Prevention Specialist	(5.0%)	(4.3%)	(0.0%)	(3.4%)	
	(3.0%)	0	0	(3.470)	
Chemical Dependency	(10.0%)	(0.0%)	(0.0%)		
				(3.4%) 10	
Other	5 (25.0%)	0	5		
	(25.0%)	(0.0%)	(33.3%)	(17.2%)	
Nork Setting ³					2
_	0	0	2	2	
Daycare or preschool	(0.0%)	(0.0%)	(13.3%)	(3.4%)	
	7	9	2	21	
Mental Health system	(35.0%)	(39.1%)	(13.3%)	(36.2%)	
	(55.070)	3	4	(30.270)	
Social service system	(5.0%)	(13.0%)	(26.7%)		
	(5.0%)			(13.8%) 7	
Elementary schools		3	2		
Chumah and a war a second at the	(10.0%)	(13.0%)	(13.3%)	(12.1%)	
Churches/synagogues/other	1	0	1	2	
faith based setting	(5.0%)	(0.0%)	(6.7%)	(3.4%)	

-

² Gender and Profession demographic data are based on the PCSC report at time of training. When surveyed post-accreditation, 24 out of 27 total respondents indicated that their job titles/positions had not changed since the training.

³ Participants were asked to check all that apply, therefore percentages will sum up over 100%.

	Omak	Othello	Ocean Beach	Total	Missing
	(n= 20)	(n= 23)	S.D. (n= 15)	(N=58)	
Non-governmental agency	1	0	1	2	
Be reea. a.Bee,	(5.0%)	(0.0%)	(6.7%)	(3.4%)	
Healthcare system	7	5	2	14	
, , , , , , , , , , , , , , , , , , ,	(35.0%)	(21.7%)	(13.3%)	(24.1%)	
Other	4	2	3	9	
	(20.0%)	(8.7	(20.0%)	(15.5%)	
Language Capacity (in addition to					27
English)	8	12	2	22	
Spanish ⁴	(40.0%)	(52.2%)	(13.3%)	(38.0%)	
Spanish with interpreter	0	3	0	3	
	(0.0%)	(13.0%)	(0.0%)	(5.0%)	
Medicaid Clients					8
0-20%	1	1	2	4	
0 20/0	(5.0%)	(4.3%)	(14.3%)	(8.0%)	
21-40%	4	0	1	5	
21-40/0	(20.0%)	(0.0%)	(6.7%)	(10.0%)	
41-60%	3	2	4	9	
41-00%	(15.0%)	(8.7%)	(26.7%)	(18.0%)	
61-80%	0	7	2	9	
01-80%	(0.0%)	(30.4%)	(13.3%)	(18.0%)	
91 100%	8	10	5	23	
81-100%	(40.0%)	(43.5%)	(33.3%)	(46.0%)	
Median Yrs. of experience in parent consultation	5.3 years	4.7 years	10.1 years	6.3 years	4
Median number of hrs./week spent in parent consultation	4.5 hours	1.5 hours	8.0 hours	5.0 hours	7
Previous Experience w/Parenting Interventions (BH)					15
` '	9	10	7	26	
Yes	(45.0%)	(43.5%)	, (46.7%)	(44.8%)	
	3	9	5	17	
No	(15.0%)	(39.1%)	(33.3%)	(29.3%)	

_

⁴ One reported speaking "Spanish Mixteco"

<u>Potential reach</u>. Prior to training, we asked providers for perspectives on the potential reach of the Tripe P program. This included gathering information about the number of

children and families served by each provider on a weekly basis (Table 5) and the number of families that they see for whom they think would benefit from Triple P services (Table 6).

Of the providers who answered these questions, the majority served between 1 and 15 children a week, with five providers reporting zero children a week (these may be individuals who were trained in Triple P because they needed to know the information for their positions but they do not anticipate using the

Most providers can deliver Triple P in Spanish (or through an interpreter)

mode – e.g., community coordinators, agency administrators). Over half of providers (53.2%) believed that between one and six families served a week could benefit from targeted services.

Table 5. Average number of children served (n=53)

	Pre-training
Children Served per week	N (%)
0	5 (9.4%)
1-5	13 (24.5%)
6-10	12 (22.6%)
11-15	8 (15.1%)
16-20	2 (3.8%)
21-25	4 (7.5%)
>29	6 (11.3%)
Other	2 (3.8%)
N/A	1 (1.9%)
Total	53 (100%)

Table 6. Approximate number of families who could benefit from targeted services (N=47)

	Pre-training
Number of families	N (%)
1-6	25 (53.2%)
7-8	6 (12.8%)

Total		47 (100%)
	N/A or Unsure	1 (2.1%)
	50% or more (write in)	1 (2.1%)
	30-40	1 (2.1%)
	20-30	5 (10.6%)
	12-15	8 (17.0%)

^{*}Participants provided either a discrete number or a range as a response. For those who reported a range, we calculated the average number.

Triple P Trained Providers – Training Results

Across the two-year initiative, fifty-eight (58) unique providers were trained, of which, thirteen (13) were trained in 2 or more levels (Table 7).

From FY 12-13 to FY 13-14, the cadre of trained practitioners expanded as well as the Triple P bandwidth of individual providers. The majority of participating providers were trained in FY 12-13, and FY 13-14 trainings were selected by UW staff in collaboration with local communities. Primary Care training drew the largest number of "new to the initiative" providers, while other trainings contained more providers who had already received training in another level. By community, the number of providers trained are:

- Omak: 20 providers -- 5 were cross-trained in 1 or more levels. Of the 20 trained, 16 remain active.
- Othello: 23 providers -- 5 were cross-trained in 1 or more levels. Of the 23 trained, 17 remain active.
- Ocean Beach: 15 providers -- 3 were cross-trained in 1 or more levels. Of the 15 trained, 11 remain active.

By project's end, each community has the capacity to deliver all offered levels of Triple P. Table 7 provides the training, accreditation, active statuses of providers across communities. Total number trained will exceed number of unique providers due to providers receiving training in multiple levels. Throughout the initiative, we lost Triple P providers to short-term situations (e.g. maternity leave and summer vacation for school-employed practitioners) and others to permanent situations (e.g. left their agencies). Additionally, a few providers decided not to offer Triple P services because of the incongruent fit between the Triple P model and their current job responsibilities. In these cases, providers were categorized as having dropped out of the initiative. Providers who as of September 2014 still indicated plans to deliver Triple P were designated as active.

Table 7. Triple P trained providers across levels and communities

Community	Omak			mmunity Omak Othello				Ocean Bea	ach SD			
Triple P Level	PC	ST	GR	SEM	PC	ST	GR	SEM	PC	St	GR	SEM
Completed Training	11	8	4	2	17	5	4	4	12	2	2	3
Became Accredited	11	8	4	2	16	5	4	4	5	2	2	3
Total Active	8	5	4	2	12/11*	5	3	4	9/5*	1	2	3

Key: PC=Level 3 Primary Care; ST=Level 4 Standard; GR= Level 4 Group; SEM=Level 2 Seminar

The analysis for the provider preparedness and confidence sections breaks out provider's responses by the first Triple P training they received as part of this initiative. Additionally, there were two providers for which Level 2 Seminar was their first training, however, data was missing at accreditation and therefore their responses were not included in the analysis.

Providers felt significantly more prepared to deliver parent consultation as a result of training.

Provider Degree of Preparedness to Conduct Parent Consultation

At pre-training, post-training, and at accreditation, providers rated how prepared they felt to conduct parent consultations about child behavior. Data analysis only includes providers who completed assessments at all 3 time points (n=44). One-way repeated measures ANOVA was conducted to determine whether there were statistically significant differences in provider's degree of preparedness to conduct parenting consultations over the

course of their training and accreditation across all levels. Table 8 details provider feelings of preparedness over time.

Level 3 provider's self-reported degree of preparedness demonstrated statistically significant changes over time, F(1.641, 47.587) = 57.95, p < .0005, with a significant increase from pre-training to post-training and from pre-training to accreditation. Level 4 Standard provider's change in level of preparedness also showed statistically significant changes over time, F(1.187, 11.874) = 18.81, P < .01, with a significant increase from pre-training to post-training and from pre-training to accreditation. Level 4 Group providers degree of preparedness to conduct parent consultation increased a similar amount, though because of the small number of providers reflected in the analysis, results only approached significance, F(2, 4) = 6.250, P = .059. No change occurred from post-training to accreditation.

Table 8. Provider Degree of Preparedness to Conduct Parent Consultations

Level of Triple P	Time Point	Mean	SD	N
	Pre-Training	3.7	1.29	30
Level 3 Primary Care	Post-Training	5.53***	.90	30
	Accreditation	5.77**	.86	30
	Pre-Training	3.64	1.57	11
Level 4 Standard	Post-Training	5.45*	.69	11
	Accreditation	5.91**	.30	11

Level of Triple P	Time Point	Mean	SD	N
	Pre-Training	4.00	1.00	3
Level 4 Group	Post-Training	5.67	.577	3
	Accreditation	5.67	.577	3

Note: ***p < .001, **p<.01; *p<.05

Provider <u>Confidence</u> in Conducting Parent Consultation

At pre-training, post-training, and at accreditation, providers rated the degree of confidence in conducting parent consultations. Data analysis only includes providers who completed assessments at all 3 time points (n=45). One-way repeated measures ANOVA was conducted to determine whether there were statistically

The Triple P training was successful in dramatically increasing provider confidence.

Providers trained in Level 3 and Level 4 Standard further increased their confidence as time went on! significant differences in provider's confidence to conduct parenting consultations over the course of their training and accreditation across all levels. Table 9 details provider feelings of preparedness over time.

Level 3 providers degree of confidence demonstrated statistically significant changes over time, F (1.623, 48.699) = 51.93, p < .0005, with a significant increase from pre-training to post-training, from post-training to accreditation and from pre-training to accreditation. Level 4 Standard providers results also elicited statistically significant changes in level of preparedness over time, F (2, 20) = 8.832, P<.01, with a significant increase from pre-training to post-training and from pre-training to accreditation. Level 4 Group providers degree of preparedness to conduct

parent consultation did increase from pre-training to post-training to accreditation, however, results were non-significant, F(1, 2) = 4.750 P=.16 because of the small sample size.

Table 9. Provider Confidence in Conducting Parent Consultations

Level of Triple P	Time Point	Mean	SD	N
Level 3 Primary Care	Pre-Training	3.55***	1.34	31
	Post-Training	4.97***	1.08	31
	Accreditation	5.65***	1.02	31
	Pre-Training	3.82	1.54	11
Level 4 Standard	Post-Training	5.18*	0.98	11
	Accreditation	5.64*	.82	11
	Pre-Training	4.00	1.00	3
Level 4 Group	Post-Training	5.67	.577	3
	Accreditation	5.00	1.000	3

Note: ***p < .001, **p < .01; *p < .05

Provider <u>Self-Efficacy</u> in Delivering Parent Consultation

As part of the standardized assessment, providers rated their abilities in specific parent consultation skills at pretraining, post-training, and at accreditation, and at follow-up at the end of FY 13-14. Data analysis only includes providers who completed assessments at all 4 time points by Triple P level. For this particular analysis, providers were organized by lowest to highest level of training. The skills items were aggregated for the assessments into a single score for each provider. A one-way repeated measures ANOVA was conducted to determine whether there were statistically significant differences in provider's belief in their own capabilities (or self-efficacy) to conduct parenting consultations over the course of their training and accreditation across all levels. Primary Care provider's self-efficacy was

statistically significantly different at different time points during the implementation initiative, F (3, 30) = 11.505, P<.0001. Particularly from pre-training to post-training and from pre-training to accreditation. There was a non-significant decrease at follow-up.

Providers trained in both Seminar and Primary Care on the other hand experiences an upward trend from pre-training to post-accreditation. At follow-up, their self-efficacy was what it was during post-training. Due to the small sample size, statistical significance could not be tested.

Providers trained in the higher levels of Triple P (Standard) and cross-trained were similar to Level 3 Primary Care in that there was statistically significantly differences across time points during the implementation initiative, F (3, 24) = 20.66, P<.001.

Provider self-efficacy was highest at just after accreditation.

Providers trained in Level 4 and/or multiple levels of Triple P maintained high levels of self-efficacy.

Particularly from pre-training to post-training and from pre-training to accreditation and a significant difference at follow-up. Table 10 details the means scores over providers across levels by time point.

Table 10. Provider Self-Efficacy Mean Scores⁵

Level of Triple P	Time Point	Mean	SD	N
Primary Care	Pre-Training	3.98	1.05	11
	Post-Training	5.30*	0.64	11
	Accreditation	5.92**	0.35	11
	Follow-Up	5.00	1.12	11
	Pre-Training	2.23	1.35	2
	Post-Training	3.86	.71	2
Seminar and Primary Care	Accreditation	4.54	.13	2
	Follow-Up	3.86	.58	2
	Pre-Training	4.33	1.09	9
	Post-Training	5.81**	.58	9
Standard and All Other Cross-Trained	Accreditation	5.78*	.52	9
	Follow-Up	5.77**	.62	9

Note: ***p < .001, **p<.01; *p<.05

⁵ Participants were excluded if they were missing more than 20% of questions on each measure.

Part 2. Triple P Trained Providers - Service Delivery Results

Service delivery data was collected on a monthly basis by local coordinators and in the final UW follow-up survey. In this report, we provide information about service delivery using data collected from both tools. For service delivery numbers (sessions completed, program completed, materials distributed), we use information compiled on a bi-monthly basis from local coordinators. We had a limited response to the final evaluation, so service delivery numbers reported through that measure would not be an accurate reflection of service delivery throughout FY 13-14. To show impact of Triple P on the provider, we use data collected in the final follow-up survey.

Service Delivery - Ongoing Local Reports

Coordinators reported (every other month) on unique families served, programs completed, program drop out and distributed materials by provider.

- Othello reported service delivery information for <u>22 providers</u> during the report period. Seventeen providers (77%) stayed active during the entire period, and 12 providers (55%) delivered services.
- Omak reported service delivery information for <u>18 providers</u> during the report period. Fifteen providers (83%) stayed active during the entire period, and 7 (38%) delivered services.
- Ocean Beach reported service delivery information for <u>15 providers</u> during the report period. Ten providers (67%) stayed active during the entire period, and 5 providers (33%) delivered services.

Across communities, providers reported delivering Triple P services to <u>235</u> unique families from January-September 2014. Figure 2 displays the breakdown of families served by community and Triple P level.

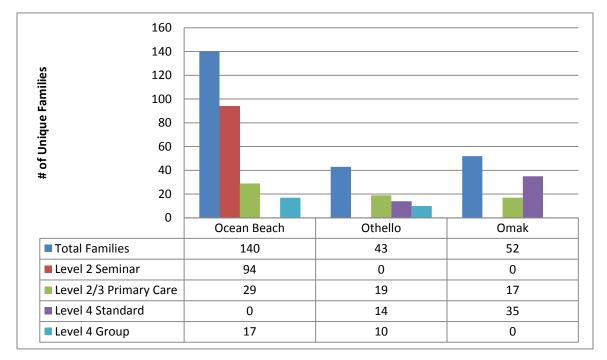


Figure 2. Number of Unique Families Served in FY 13-14 by Community

Each community delivered a range of Triple P services, and each community has found a service niche. Othello is the only community to have a medical provider bill for Triple P services. The community has spread its service delivery across Primary Care and Standard Triple P. They had momentum with Triple P Group; however, they have struggled to secure funding. Ocean Beach, on the other hand, has found much success in Triple P Group and Selected Seminars, through the support of a Child Protective Services contract. The group format of both

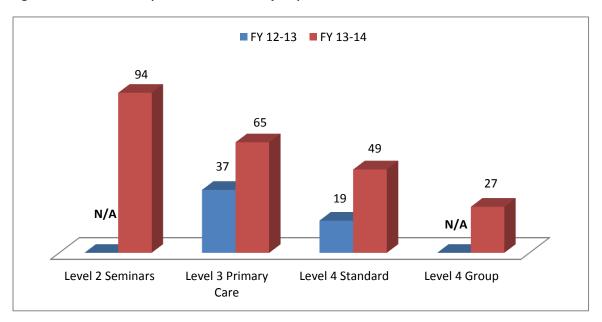
All communities improved service numbers over time

However, there was significant variability in the number of families served across communities

programs has resulted in the highest service reach of any community. Omak has the most momentum with Level 4 Standard.

Figure 3 compares aggregate service delivery between FY 12-13 and FY 13-14. In FY 13-14, providers served a greater number of families in the two formats (Primary Care and Standard) offered in FY 12-13. Selected Seminars and Group were added in FY 13-14, and both formats were a huge component of the service delivery increase in our second year. Seminars served the greatest number of families, and Level 4 Group served more families than Level 4 standard did in FY 13-14.

Figure 3. Number of Unique Families Served By Triple P Level



During FY 13-14, Triple P providers completed a Triple P program with <u>53</u> families. More Primary Care and Standard families completed the program in FY 13-14 than in FY 12-13, and a large majority (78%) of families who attended group, completed Triple P Group (Figure 4).

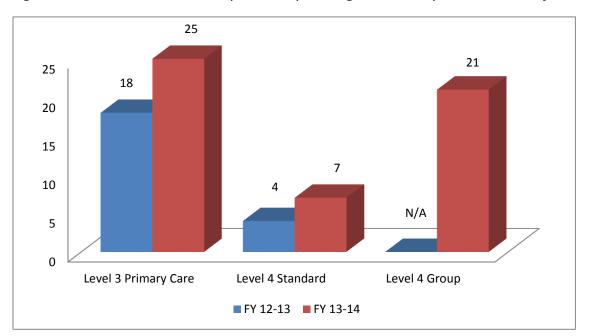


Figure 4. Number of Families who completed a Triple P Program across Triple P levels and Project Years

Along with an increase in families served and programs completed, FY13-14 also included a substantial increase

in the distribution of Triple P materials. Table 11 compares the distribution of key Triple P support material between fiscal years.

There were significantly more tip sheets and workbooks distributed – and especially with regard to the tip sheets, this may provide further insight into the number of families actually receiving 'active ingredient' components of Triple P. A brief parenting consultation using a Tip Sheet has been evaluated and demonstrated to be effective for minor behavioral concerns with relatively recent onset.

While many more resources were delivered to families, relatively few families completed the intervention.

Table 11. Comparison of Triple P material distribution

Type of Support Material	FY 12-13	FY 13-14
Tip Sheets	72	188
Every Parent Workbooks	26	66

Service Delivery - Final Follow-Up Survey

A final follow-up survey was conducted, in part to better understand provider satisfaction with Triple P after ample implementation time. We also inquired about the extent to which providers reported needing to alter or modify the program to fit their service setting or perceptions of clinical need.

Twenty-eight providers participated in the final follow-up survey. The distribution of respondents is relatively equal across communities, with Ocean Beach comprising 32%, Omak comprising 29% and Othello comprising 39% of the total. The vast majority of respondents (72%) received Primary Care as their first Triple P training,

and almost half of the providers (43%) received training in multiple Triple P levels. This cross-trained population contains providers from each community: Omak (5), Othello (4), and Ocean Beach (3). The majority (52%) of respondents worked in health care or mental health settings (Figure 5).

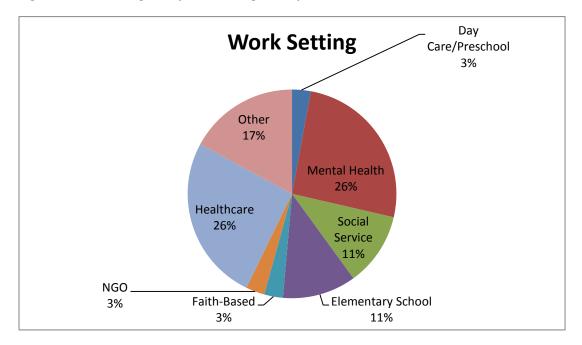


Figure 5. Work setting of Triple P Training Participants

Of the 28 respondents, 18 (62%) reported using Triple P with families. Those 18 providers responded to specific questions about the relevance of Triple P to the families they serve, usability of the program, agency support for their Triple P work and their satisfaction with the Triple P support materials. As a whole, the respondent population agreed that Triple P meets the needs of the parents and children they serve and is easy to use. Additionally, providers agreed that Triple P materials are satisfactory and that agencies have been supportive of Triple P.

To obtain a more nuanced understanding of the responses, UW staff divided grouped respondents by training level and number of completed trainings. The following groups were created: 1) Trained in level 3 Primary Care only, 2) Trained in both level 2 Seminars and 3) level 3 Primary Care, and Trained in Level 4 and any other Triple P level. For the most part, providers trained in lower levels (Primary Care only as well as Primary Care and Seminar) reported consistent levels of agreement across questions, except for the satisfaction with materials. In that instance, combined provider showed lower levels of satisfaction. Across questions, the level 4 group showed higher level of agreement with questions than their Level 2 and 3 counterparts in all questions except for satisfaction with materials. Primary Care Only and Level 4 Combined showed equal amount of agreement in satisfaction with materials.

Table 12. Practitioner's agreement with the following Triple P service delivery statements (n=18)

	Training Level	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean	SD	N
Triple P meets the child behavior problems	Level 3 Only			3	1	3.25	0.50	4
faced in my daily work with families	Levels 2 and 3			3	1	3.25	0.50	4
	Level 4 and Cross			5	3	3.37	0.52	8
Triple P addresses the parenting needs faced	Level 3 Only			3	1	3.25	0.50	4
by families in my community	Levels 2 and 3			3	1	3.25	0.50	4
	Level 4 and Cross			5	3	3.37	0.52	8
Triple P is easy to use	Level 3 Only			3	1	3.25	0.50	4
	Levels 2 and 3		1	1	2	3.25	0.58	4
	Level 4 and Cross		1	3	4	3.37	0.52	8
I feel supported in my agency in using Triple P	Level 3 Only			2	2	3.5	0.58	4
	Levels 2 and 3			2	2	3.5	0.58	4
	Level 4 and Cross	1		2	5	3.37	1.06	8
I am satisfied with the Triple P materials for parents (i.e. tip sheets,	Level 3 Only			2	2	3.5	0.58	4
videos, and workbooks)	Levels 2 and 3		1	3		2.75	0.50	4
	Level 4 and Cross			4	4	3.5	0.53	8

A vast majority (83%) of Level 4 providers reported a moderate to high level of satisfaction with Triple P. Level 4 providers reported the highest levels, with Primary Care only providers reporting mixed degrees of satisfaction and the only report of dissatisfaction. Figure 6 outlines the satisfaction score by training level.

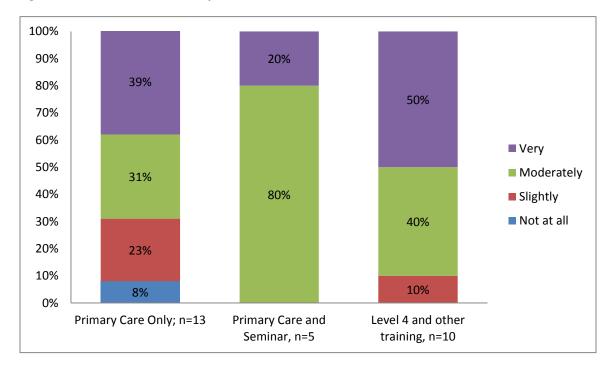


Figure 6. Satisfaction with the Triple P intervention

Community-specific qualitative responses: How satisfied are you with Triple P?

Across all three communities, many providers commented on satisfaction levels with Triple P. Comments are divided by "Positive," "Neutral," and "Negative" to give a sense of the varying features of implementation. There

were many positive comments about the program in general, the materials and how it's structured. Several participants commented that the training is 'empowering' for families and fit for culturally diverse families. Other providers indicated that the program is more difficult to use, especially related to implementation. Some providers commented that it is difficult to get parents engaged in the treatment. One provider questioned the cultural appropriateness of the video and materials.

Providers were generally satisfied with the training and the majority plan to use the intervention at least during the next year.

Omak

- Don't directly use the model (n=2)
- Positive:
 - Meets family challenging behaviors
 - Tip sheets are easy to read and understand
 - (general) satisfied with triple P n=3
 - Parent reporting helpful
 - Parents willing to complete the exercises as prescribed and make an effort have great successes
 - It's a parenting curriculum that tends to fit most of the diverse population in this county.
 I work with all the Hispanic families that come into our agency and Triple P strategies seem to fit fairly well with their cultural values.

- Neutral
 - I like the training, no chance to use
 - o I just stared using the Triple P with a client and will know more in the future.
- Negative:
 - o Triple P requires motivated parents and the majority of our parents are not
 - Difficult to use in a busy primary care clinic
 - limited support in implementation of the program to fidelity (n=2)
 - Triple P has been difficult to fully implement in our community. While its main strength is the different levels and self-referral nature of the program, our social service providers have a difficult time adapting to this different way of referring parents. They are used to 1x/week x 6 weeks x 2 hours each session = completed. Triple P's flexible implementation has left providers with great fear of not implementing the program with fidelity- and so they have been reluctant to adopt it. We have not yet found a full and easy solution to this misunderstanding.
 - o Referral process does not operate efficiently (between community and agency)
 - o It is not an easy program to administer and it seems hard for parents to understand
 - Tip sheets are very word dense and parents don't read them
 - Not enough time in schedule, parents don't make appointments specifically for behavior concerns and when it comes up I don't have time to implement or time in schedule for timely follow-up

Othello

- Don't directly use the model n=3
- Positive
 - (general) Good program for families n=1
 - Great materials and program outline n=2
 - o I believe in the information and the delivery of the information to families
 - Principles are great
- Neutral (no comments provided)
- Negative
 - Family participation
 - Very difficult to have high completion rate n=2
 - Difficulty is getting families to fully participate
 - Don't have time to fit into schedule n=2
 - Intervention model is most difficult to use in my elementary school setting
 - Very complex and time consuming

Ocean Beach

- Don't directly use the model n=2
- Positive
 - (general) Satisfied n=1
 - o Common sense parenting. It is a good curriculum
 - The ideas and concepts are very practical and empowering... n=2
 - o It works, but I most work with older youth
 - Parents who have participated in the programs have good things to say. That means a lot!
 - I believe it is a great program.

- Works at home and work n=2
- Satisfied with materials and the program.
- I really like how interactive it is (especially in the seminars), and the insights that parents get by reflecting

Neutral

 The issue is capturing the population! I believe parents are still skeptical of parenting programs

Negative

- I believe the homework and the graphing/charting can overwhelm parents
- The families I work with do not have custody of their children. I sometimes find it difficult to apply all of PPP's interventions with these families...
- Question cultural or socio-economical connection to the scenarios and people in the videos
- Having parents get involved seems to be the hardest part.

Respondents also reported on their potential use of Triple P in the future (Figure 7). As in the satisfaction reports, Primary Care only providers had the most mixed report of usage. However, the majority (54%) of those providers plan to use Triple P in the next year at least. The majority (60%) of Primary Care and Seminar trained providers plan to use the program in the next year, with 20% planning to use the program over the next 5 years. Level 4 Combined providers project more future use, with 70% planning to use the program in the next year at least. 30% of these Level 4 Combined providers expecting to use the program for the next 5 years. Three of the four providers from the "Primary Care Only" group who indicated "Other" stated that they did not know if they would deliver Triple P in the future or they would try when the situation presented itself. One provider indicated that they plan to get training in Level 4 Standard. Three of the "Level 4 and other training" group who chose "Other" mentioned that they plan to use Triple P as long as there is funding or continue working with families. One mentioned they were not sure at this time.

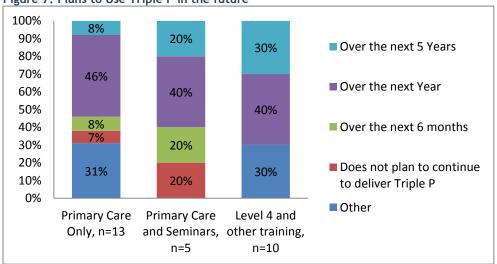


Figure 7. Plans to Use Triple P in the future

The majority of providers (58%) indicated that Triple P was what they expected it to be. This figure is lower than FY 12-13, where 82% said that the reality of Triple P matched their expectation. Below is a chart of response rates when we isolate levels (Figure 8). The total N accounted for in the chart would exceed the N of respondents because some providers had been trained in multiple levels. The match between expectation and

reality seemed to rise with the level trained. It is important to note that providers were not asked to respond to this question in terms of a specific level, if trained in multiple levels.

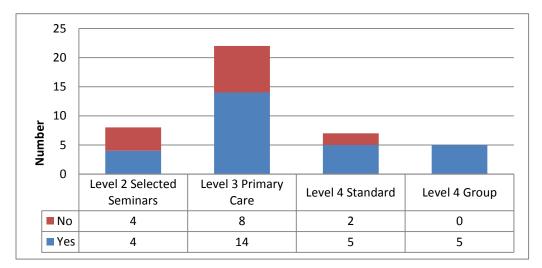


Figure 8. Is the Triple P Program what you thought it would be?

Triple P offers and recommends delivery support services, including a practitioner website and peer-support networks (PSN). Twelve providers (42%) have used the Triple P Network website. Most providers (regardless of level or community) have not utilized PSNs. Nine providers (31%) reported PSN participation. Those nine practitioners provided details about their PSNs. Eight (88%) reported that it is "Somewhat Helpful" and one (12%) reported it as "Very helpful." Qualitative data about why practitioners have not participated in PSNs is included in the appendices. Figure 6 details the practitioners' experience in and with their PSNs.

Community-specific qualitative responses: How Triple P reality was different than expectations?

Two of the three communities had providers who indicated that the realities of implementing Triple P were somewhat different from their initial expectations. Again, a theme emerged around agency support and implementation difficulties. Several commented about the time and difficulty to learn the program.

Omak

- More manualized and pieces of the model are more easily applied to non-parenting counseling topics
- Thought I would be using more often
- Not having agency support n=2
- Thought it would be easier to implement n=2
- Harder to use, timely, I hate the role playing part

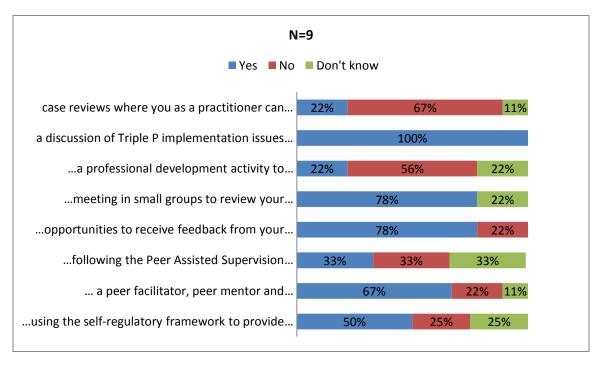
Othello

- Thought parents would be more susceptible to completing the program and encouraged to be involved
- Much more detailed and more work to prepare
- More difficult to present with an interpreter (takes longer)
- Didn't realize the number of sessions... time involved in Level 4
- I didn't think it would go into so much debt, but I do like very much
- More difficult to implement, more complicated

Ocean Beach

None noted

Figure 9. How is your peer support coordinated?



Qualitative comments about peer support

A few providers from one community commented on the peer support network.

Omak

- I have way too many other things to do, spending time on PPP outside of office visit is impossible
- Didn't realize it was available
- Agency not supported participation
- Access does not match co-workers access

Most providers are not using
Peer Support Networks, as
recommended by Triple P

Table 13. Frequency and percentage of the extent to which practitioners have experienced the following scenarios when using Triple P (n=18)

	Training Level	Never	Rarely	Occ.	Almost Every Time	Every Time	Mean	SD	N
made changes to the format of treatment delivery (e.g.,	Level 3 Only	3		1			1.5	1.0	4
delivering it in a group format rather than one-on-one)	Levels 2 and 3	2		1			1.67	1.15	3
	Level 4 and Cross	5	1	1		1	1.88	1.46	8
delivered the program to a different population than originally intended (e.g., teens,	Level 3 Only	1	2	1			2.0	0.82	4
children with developmental disabilities, parents who don't	Levels 2 and 3	1	1			1	2.67	2.08	3
have custody of their child)	Level 4 and Cross	4	1	2		1	2.13	1.46	8
tailored the program to fit local client needs (e.g., modifying language, creating slightly different versions of handouts or homework	Level 3 Only	1	1	1	1		2.5	1.29	4
	Levels 2 and 3	2	1				1.33	0.58	3
assignments, cultural adaptions)	Level 4 and Cross	3	1	3		1	2.38	1.41	8
added materials or activities outside of what is instructed in	Level 3 Only	3		1			1.5	1.00	4
the Triple P manual	Levels 2 and 3	2		1			1.67	1.15	3
	Level 4 and Cross	4	2	1	1		1.88	1.13	8
left out particular elements of the program (e.g. skipping	Level 3 Only	2	1		1		2.0	1.41	4
specific sessions or agenda items within a specific session)	Levels 2 and 3	1	1	1			2.0	1.0	3
	Level 4 and	3	2	2	1		2.13	1.13	8

	Training Level	Never	Rarely	Occ.	Almost Every Time	Every Time	Mean	SD	N
	Cross								
completed the program in a shorter amount of time than prescribed	Level 3 Only	1	2	1			2.0	0.82	4
	Levels 2 and 3	2	1				1.33	0.58	3
	Level 4 and Cross	3	1	3			2.0	1.0	7
completed the program in a longer amount of time than prescribed	Level 3 Only	2	2				1.5	0.58	4
	Levels 2 and 3	1		1		1	3.0	2.0	3
	Level 4 and Cross	2	3	2			2.0	0.82	7

Community-specific qualitative responses

Providers in two of the communities described modifications of the program. Some modifications were to ensure that the program elements would be appropriate for the family circumstance, such as when the identified child is placed outside of the home or the family has literacy issues. Other modifications were made to 'make the most' of the intervention, when family circumstances or the practitioner themselves is unable to deliver the intervention as designed. Below are the specific themes:

Omak

- Parents who do not have custody of their children
 - Remedy: Report back on using the tools during supervised visits with CPS caseworker
- Include the elements e.g., descriptive praise, positive attending, logical consequences, compliance routine, providing engaging activities
 - o Enables use of some tools although worker is unable to implement the whole program.

Othello

- Materials not ideal for lower literacy Spanish speaking families
 - o Remedy: Providing information orally. This makes the intervention take longer
- Parents not seeking parenting advice
 - Remedy: Go over tip sheet during visit and then ask mother if it's something she's willing to try. Then nurse follows up 1-2 weeks later to check.
- Delivering service as an in-home service in a limited number of sessions

Ocean Beach

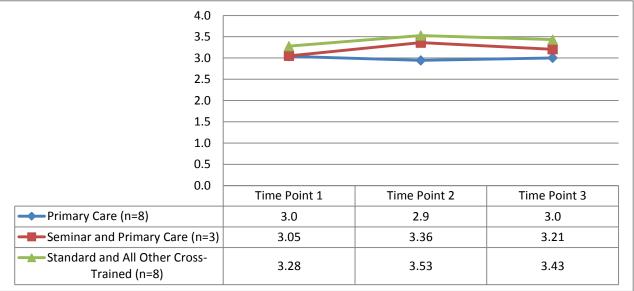
• No need for specific modifications noted

Part 3. Impact of Triple P training

In addition to determining the extent to which Triple P was implemented, and the necessity of any treatment modifications, we wanted to explore the extent to which participation in the initiative may influence provider attitudes towards evidence-based practices more generally, and if there were parts of the Triple P model that were generalizable to other aspects of the providers' work life.

Attitudes towards EBP. Results on provider attitude towards the adoption of evidence-based practices was mixed with no significant findings across time. Primary Care provider attitudes remained stable over time with a small but non-significant decrease at time point 2. All other providers made some modest but non-significant gains in their attitudes towards EBPs (Figure 10).





Generalization of Training Components. The Triple P model contains many distinguishing features. Providers reported how frequently specific elements of Triple P influenced other areas of their work. Providers across levels reported that each element had some impact on other elements of their work. As in FY 12-13, Level 4 Combined providers routinely rated the influence of Triple P components higher than providers trained in lower levels. Level 4 providers identified the framework for discussing problems, offering suggestions rather than prescriptions and behavioral rehearsal. Table 14 providers a detailed breakdown of responses by level.

Table 14. Triple P's influence on Other Areas of Work (n=29)

	Training Level	Never	Rarely	Occ.	Almost Every Time	Every Time	Mean	SD	N
Self-regulatory framework to promote parent's independence, confidence, and future problem	Level 3 Only	2	2	3	3		2.7	1.16	10
solving (e.g., having parents self- assess their strengths and personal goals)	Levels 2 and 3	1		2	1		2.75	1.26	4
	Level 4 and Cross			5	4	1	3.6	0.70	10
Guided participation model to share assessment findings with parents, share the cause of child behavior,	Level 3 Only	4		3	3		2.5	1.35	10
and create a shared understanding of how to address problem areas custody of their child)	Levels 2 and 3		1	2	1		3.0	0.82	4
custour or their clinic,	Level 4 and Cross			5	3	2	3.7	0.82	10
Framework for discussing problem behavior (e.g., asking for specifics	Level 3 Only	1	1	4	3	1	3.2	1.14	10
about the last time something happened)	Levels 2 and 3		1	1	2		3.25	0.98	4
	Level 4 and Cross			2	5	3	4.1	0.4	10
	Training Level	Never	Rarely	Occ.	Almost Every Time	Every Time	Mean	SD	N
Offering suggestions rather than prescriptions	Level 3 Only	1		5	4	1	3.36	1.03	11
	Levels 2 and 3	1			3		3.25	1.50	4
	Level 4 and Cross			2	4	4	4.2	0.79	10
Behavioral rehearsal and modeling	Level 3 Only	4	1	3	2	1	2.55	1.44	11
	Levels 2 and 3	2	1		1		2.0	1.41	4

	Training Level	Never	Rarely	Occ.	Almost Every Time	Every Time	Mean	SD	N
	Level 4 and Cross			2	5	3	4.1	0.74	10
Tracking change in family via monitoring forms and homework	Level 3 Only	5	1	2	2	1	2.36	1.50	11
	Levels 2 and 3	2		1	1		2.25	1.5	4
	Level 4 and Cross	1	2	1	3	3	3.5	1.43	10
Using examples to teach new parent skills	Level 3 Only	2	3	2	3	1	2.82	1.33	11
	Levels 2 and 3	1		1	2		3.0	1.41	4
	Level 4 and Cross		1	1	6	2	3.90	0.88	10
Using diverse examples to generalize skills in different settings	Level 3 Only	3	2	3	3		2.55	1.21	11
	Levels 2 and 3	1		1	2		3.0	1.41	4
	Level 4 and Cross			2	5	3	4.10	0.74	10

Community-Specific Qualitative Responses: How has the training and/or use of Triple P influenced other aspects of your work?

Across all three communities, providers described how the training influenced other parts of their work. Many noted that the skills are broadly applicable for multiple situations. Fewer indicated specific aspects of the program, such as use of assessment tools. Below are the specific themes:

Omak

- Use praise and getting attention with problematic coworkers
- Use of the questionnaires
- Efforts to empower parent as the expert on their child (n=2)
- Provide suggestions rather than prescriptions
- Looking for other information with research-based assistance
- More aware of need for parenting services

Othello

- Broadened scope of practice
- (General) Use in other interactions
- Provide skills to parents that could possibly cause them to be interested in the total training in
 Triple P
- Think about the principles and materials from Triple P whenever a problem arises with a family...
- The assessment can be logged for Parents as Teachers program

Ocean Beach

- At home and work (n=2)
- Helps to be more effective with clients from all walks of life
- Triple P has added dimension to my work with families

Part 4. Providers and Coalition Members - Attitudes and Perceptions

At the beginning and end of the project, Triple-P trained providers and coalition members answered questions about child-serving systems, the behavioral health referral system and the communication between child serving agencies in their communities. The surveys administered to Triple P trained providers contained an additional section about perceptions and utilization of evidence based parenting programs.

Coalition member scores were aggregated as a single group (see Appendix A for demographic information about coalition members). Provider scores were aggregated based on the lowest to highest level of Triple P training as described below and reflected in graphs and charts:

- 1. All providers trained in Level 3 Primary Care only (i.e., "Primary Care" Group)
- 2. Providers trained in both Level 2 Selected Seminar and Level 3 Primary Care (i.e., "Seminar and Primary Care" Group)
- 3. Providers trained solely in Level 4 Standard and all other providers cross trained in a combination that includes Level 4 Standard and/or Level 4 Group (i.e., "Standard and All Other Cross-Trained" Group)

Due to varied response rates across each time points, the following analysis uses three time points for providers and collation members. Forty-two providers (97.7%) completed the baseline survey prior to Triple P training

Minimal change over time was observed in perceptions of communication and collaboration between primary care and behavioral health

(Time Point 1), 34 (89.5%) completed the second follow-up survey at the beginning of FY 13-14 (Time Point 2), and twenty-nine providers (67.4%) completed the final follow-up survey (Time Point 3) at the end of FY 13-14.

Across nearly every Triple P component,

more providers report generalization of

strategies than not. These strategies are

alianed with best practice.

Coalition member responses are looked at across three time points. Forty-three coalition members (56.6%) completed the baseline survey prior to the first Triple P

training in year 1 (Time Point 1), a follow-up survey at the end of FY 12-14 (Time Point 2) with 34 respondents (59.6%), and a final follow-up survey with 43 respondents (48%) at the end of FY 13-14 (Time Point 3). Only providers and coalition members who completed the surveys at those 3 time points have been included in analyses using repeated measures.

Providers trained in both seminar and primary care showed modest gains in their perceptions of communication and collaboration. All other providers had a decrease from time point 1 to time point 3. Coalition members showed a modest but non-significant improvement from time point 1 to 3 (Figure 11). providers and coalition member responses reported that those child-serving agencies sometimes communicate with each other about the behavioral and emotional needs of the children served. This perception increased from time point 1 to 3 for Primary Care providers and Coalition members, with no significant differences found across time. Providers trained in all other levels showed a modest decrease over time, although findings were non-significant across time points (Figure 12). Providers and community members were assessed on the extent to which they felt there are strong referral processes between and within child serving systems. Primary Care providers went from neutral in their responses to moderate disagreement in their time point 3 responses while all other providers stayed neutral throughout. Coalition members showed modest gains and went from disagreement towards neutral at time point 3 (Figure 13). Additional analysis on perceptions of communication and collaboration as well as perceptions of streamlined referral processes are shown in Appendix B.

Figure 11. Perceptions of Communication & Collaboration between Child Serving Agencies and Primary Care from a scale of "1" to "5" with higher scores indicating greater perceptions of communication & collaboration

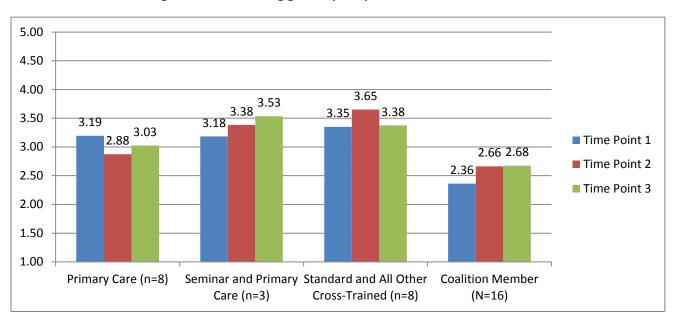


Figure 12. Extent to which participants feel child serving systems communicate about emotional or behavioral health needs of children in their community

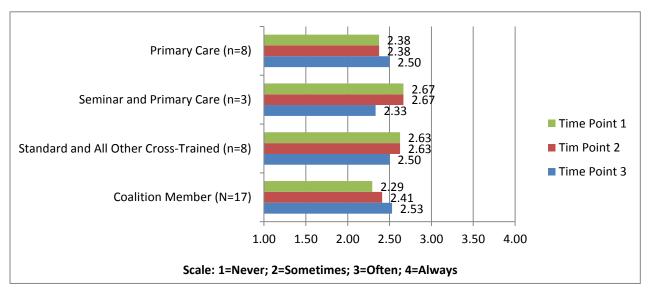
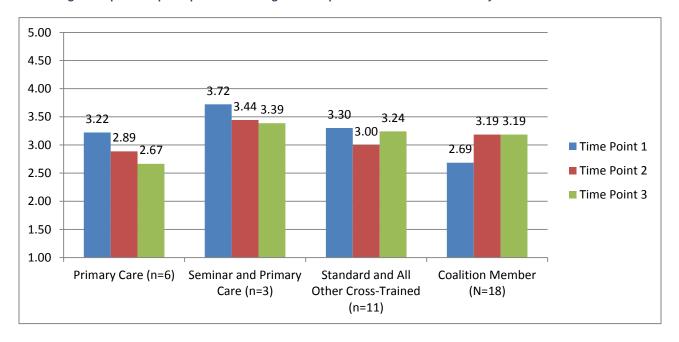


Figure 13. Perceptions of enhanced or streamlined referral process on a scale of "1" to "5" with higher scores indicating more positive perceptions of strong referral processes in their community

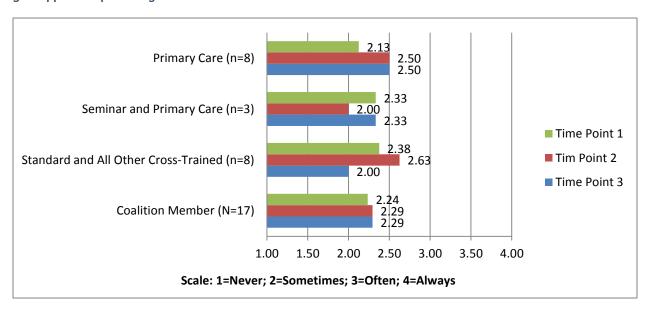


Providers and coalition members also reported on parenting services in their community. Both providers and coalitions reported that parents sometimes know where to get parenting support for parenting children with behavioral or emotional concerns.

A small decrease was observed in provider perceptions of referral processes. Coalition members' perceptions came more in alignment with provider perceptions. There is significant room for improvement in community awareness for parenting support.

Modest gains were made for Primary Care providers and Coalition Members while a small decrease in perceptions occurred for those trained in the higher levels of Triple P of Standard and Standard Group (Figure 14). Providers and Coalition members were asked to report on their perceptions of the extent to which they felt families have access to evidence-based parenting interventions. Over time, providers trained in Primary Care and/or Seminar as well as Coalition Members showed gains in their perceptions of access to EBPs for families in their community. Interestingly, those trained in both Primary Care and Seminar went from indicating that families have access "sometimes" at time point 1 to "often "at time point 3. Providers trained in the higher levels of Triple P stayed in the "sometimes" range (Figure 15).

Figure 14. Participants' ratings of the extent to which they believe families in their community know where to go to get support for parenting children with behavioral or emotional concerns



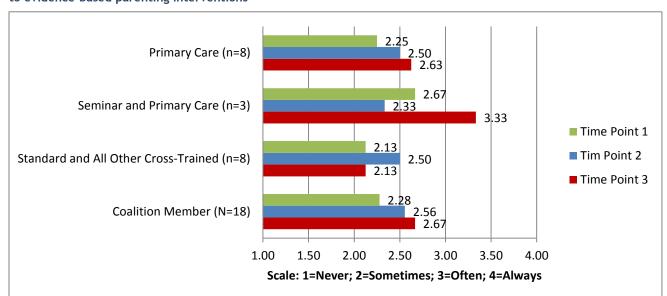


Figure 15. Participants' ratings of the extent to which they believe families in their community currently have access to evidence-based parenting interventions

Triple P Implementation Leadership

Implementation of evidence-based programs requires effective leadership supports. As such, during the final follow-up survey at the end of FY 13-14, Triple P providers and local coordinators were asked to respond to questions related to the implementation support efforts to facilitate Triple P in their community using the Implementation Leadership Scale (Aarons et el, 2014). The 12-item scale, which was modified to include language specific to the implementation of Triple P, contains four subscales representing proactive leadership, knowledgeable leadership, supportive leadership, and perseverant leadership. The four sub-scales were aggregated to make up a total leadership score. Each item was based on a scale from "0" not at all to "4" very great extent. Higher scores indicate high degree to which a leader anticipates and addresses implementation challenges (Proactive), a leader has a deep understanding of Triple P and implementation issues

Community coordinators were viewed as highly supportive and perseverant. Leadership was rated most highly by providers trained in Level 4 and/or cross-trained in Level 2 and Level 3. Room for improvement was noted in the area of proactivity.

(Knowledgeable), their support in the adoption and use of EBPs (Supportive), and finally the leader is consistent, unwavering, and responsive to the implementation of Triple P challenges and issues (Perseverant).

Provider responses were not included if they did not respond to at least 80% of the items from each subscale and total score. Results were grouped by lowest to highest level of training: 1) those trained in Level 2/3 Primary Care only; 2) those cross-trained in Level 2 Seminar and Level 3 Primary Care; and 3) Providers trained in Standard only or cross-trained in either Standard with another lower level or cross trained in Level 4 Group with another lower level. As demonstrated in Figure 16, providers trained in Level 2/3 Primary care reported the lowest levels across all sub-scales. All other provider perceptions of leadership were rated highly across all subscales as well as total score indicating perceptions of strong Triple P implementation support.

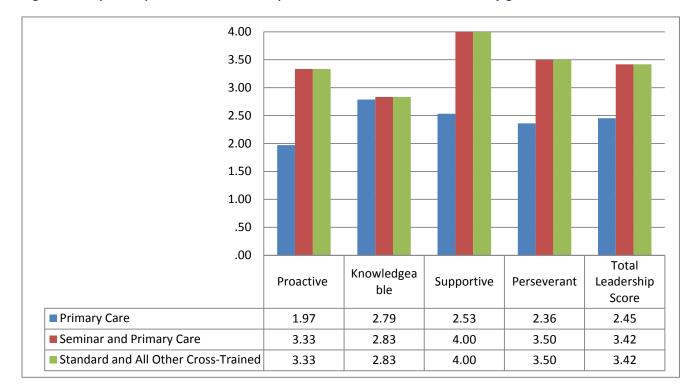


Figure 16. Triple P Implementation Leadership on a scale from 0=Not at all to 4=Very great extent

Coalition Members – Triple P Awareness

Coalition members indicated their awareness level of Triple P at initial implementation and follow-up. By final follow-up, coalition members showed significant improvement knowledge of the Triple P and its activities in their communities. Figure 17 depicts the change in coalition member knowledge over time.

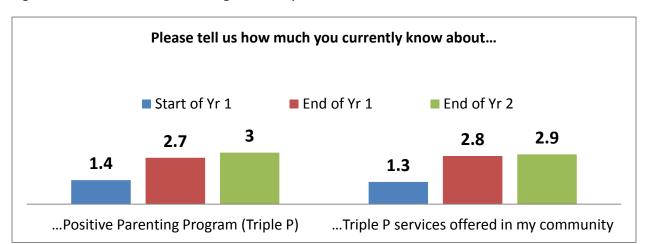


Figure 17. Coalition Member Knowledge about Triple P

Part 5. Analysis of Qualitative findings

Several providers submitted qualitative feedback. Importantly, these responses are reflective of only the practitioners who chose to provide written responses or explanations to their questionnaire items. Responses

are reflective across the final two data collection periods – and represent comments made when Triple P implementation was anticipated to be in the "Full Implementation" stage.

Providers were given a final opportunity to reflect on the Triple P program. The 'verbatim' responses below represent additional thoughts from practitioners. Comments seemed to group around three main themes: Financial considerations, issues related to referral for services, and implementation challenges.

Omak

Financial:

The fact that there is little funding to provide just parenting classes other than having to get families into certain services. It makes it difficult when a family seems to need help on basic behavioral modification ideas to assist their children but due to inability to have parenting classes in this community they seem to fall through the cracks until one of the family members is identified as needing mental health services.

Triple P Workbook. Our agency, thus far, has opted not to purchase workbooks in advance for parents. It has been difficult to deliver Triple P without this resource for parents.

Referral:

The referral process in our community needs to be streamlined. Support from agency that providers are affiliated with is imperative.

I am unaware of any Triple P referrals from area primary care providers to date.

Continue to offer and inform clients of program and benefits it provides for a more stable home life.

Implementation:

I think it has taken nearly a decade for Love and Logic to become a parenting "institution" i.e. accepted model for learning about parenting by ALL of the community. My thoughts are that Triple P might take this amount of time or longer--especially since it isn't as intuitive to teach or learn and doesn't use humor but more of an "expert provider" who knows it all to teach others...

I am excited to continue making efforts to implement Triple P (level 4) successfully as it is desired to be implemented. Again, my supervisor will submit a proposal to our new CEO later this week that, I believe, will help Triple P providers in this agency implement Triple P more successfully.

Our intake process is quite stringent and this agency has struggled to screen for appropriate Triple P candidates that enter our agency. This process has limited clinicians from gathering pertinent information to determine an appropriate Triple P candidate. Hopefully, this barrier can be overcome with the support of our new CEO.

Othello

Financial:

Need more funds to concentrate on implementing in the home visit situation.

Barriers-- billing for triple P is still in the process of being incorporated in the EMR we are using.

Transportation is one barrier and financial

Not having a reimbursement for the time spent makes it more difficult to implement. For Triple P to be widely used in our community it needs to be a billable service, not just for mental health agencies but for health care providers. Intent is there, but if there is no available compensation, it will not be used much.

Implementation:

Some parents are open to anything to have their children behave in the best way possible. They will follow up and be open to suggestions. Some parents are not so clear that they should have a lot of input for the program to work. They rely on children coming in for a visit and go home behaving better. I find that our behavioral health helps me a lot with reinforcing what I suggest in Triple P. They do not go through tip sheets but they walk parent through how to make one and how to implement it.

In my work setting time, availability, and language are the greatest barriers.

The biggest barrier that we see in our community is family (parent) returning to sessions. They may come to one or two, but only want to drop children off and not stay. It is difficult to get a parent to commit to coming back. Within our community we are going to start to focus more on home visits. Transportation and time restraints seem to be an issue.

Many parents don't seem to have the time for recurrent meetings or often even one group meeting. Many have very long work hours. Some have no transportation.

It just seems families are pulled in so many directions and have so many stresses...they become overwhelmed and choose not to participate.

Do not like the Spanish DVD

There are a lot of triple p providers. We recently started the triple p seminar with teen parents but the sessions are too long according to facilitator of group and they don't want to spend the time... Time is an issue for meetings and parent interventions.

time, cost, parental desire to provide effective parenting.

I think it is a good program to implement.

Ocean Beach

Financial:

Financial and capturing the audience. Families are constrained on time and transportation.

Barriers are funding, ability to provide childcare, facility for daytime classes, and reducing the stigma of participating in parenting interventions.

Referrals:

Getting the word out that there are parenting interventions available in the first place. I guess we could call it marketing in a way. Thank you...:o)

Implementation:

Needs more open communication?

Many parents in mild to moderate need of parent skills are not interested in attending a parent class.

Since my work is directly with migrant/Hispanic origin families, in this culture is hard to teach the parents on how to educate their children. They want to grow their children on the same way they were grown. But, on the other hand, the do accepts suggestions and comments about their children's behavior.

Well-Spring is a great organization.

It seems as though communication between organizations and systems is very important and a possible missing link in the equation when attempting to help families.

takes time- years to create change

I believe that Triple P would be a great program to offer in the elementary schools for teachers. Possibly offer it to Parent Groups and have it run school wide and then parents may buy into it. I believe we are raising a very selfish population where children are being given anything they wish so that parents do not have to step up and be parents. The children can do no wrong in the eyes of the parents.

Some strengths are the continued commitment to providing quality parenting interventions, quality providers, strong support system for parents and providers.

The transient nature of our community, high rates of substance abuse and mental health issues are barriers.

Discussion

In this section, we highlight several important 'learnings' from this evaluation. We start with an assessment of community capacity to deliver Triple P services, followed by a summary of broader impacts of the initiative, and concluding with a set of recommendations as the communities move forward with implementation in Year 3. Important successes included increasing the number of providers trained and able to deliver Triple P services, creative solutions to funding and sustainability, and innovative strategies for reaching parents. Communities continue to strategize how to increase the number of families participating in Triple P services and how to address major systems-level issues related to referrals and cross-system communication. As the next year of funding approaches, strategies to ensure that providers remain well supported to deliver the Triple P intervention will be critical.

Capacity

Throughout this second year of implementation, communities have continued to expand their capacity to deliver Triple P services. By the end of the second year, Omak had 8 active primary care providers, 2 active providers able to deliver seminars, 5 providers delivering Level 4 Standard, and 4 providers delivering Level 4 group. Othello had 12 individuals actively providing primary care, 4 providing seminars, 5 providing Level 4 standard, and 3 providing Level 4 Group. Ocean Beach had 9 individuals able to provide primary care, 3 providing seminar, 1 providing Level 4 Standard, and 2 providing Level 4 group. Providers across all communities delivered Triple P services to 235 unique families. This is a significant increase from Year 1. Additionally, there was nearly a 420% increase in the number of families served!

This success is tempered only by the communities still operating below *potential capacity*. Triple P America (TPA) provides estimates for the number of families that a typical provider could be expected to serve. Extrapolating those numbers to the number of providers trained in the initiative, there is the potential for 1562-4695 parents to participate in a given year (high end of the range is based on official Triple P estimates). However, the actual number of families served in the initiative was well below this number – and indicates that providers are operating beneath potential capacity (Table 15).

Table 15. Provider Capacity to Deliver Services to Families by Level

	TPA estimates of # families per	•	ential # of families see in initiative	Actual # families	% Potential Capacity
	practitioner/year	High	Low	seen*	
Seminar	300	2700	900	94	3.5%-10.4%
Primary Care	50	1450	480	65	4.5%-13.5%
Level 4 Standard	25	275	92	49	18%-53%
Level 4 Group	30	270	90	27	10%-30%

^{*}this only represents the number reported to the community coordinators and may be an underrepresentation of the actual number of families served.

It is possible that the estimates provided by TPA are not realistic for Initiative-related practitioners for a variety of reasons, including the small community sizes and the different types of providers trained. Many providers report delivering services in Spanish and with lower-literacy families. Providers report that this takes additional time, so capacity estimates may not be reflective of working with these diverse populations of families. However, even if more conservative estimates are used (the lower estimates in Table 15), there would still be 'unused capacity.' This is particularly evident in the Seminar and Primary Care levels, which arguably have the greatest capacity for potential reach.

There are many plausible explanations for this finding. The seminar training in particular, and the Primary Care intervention to a large degree, are 'non-traditional' service pathways with unclear funding mechanisms. In the Ocean Beach community the community coordinator was able to identify a strategy to fund the seminars. In this community, seminar capacity is the highest – over 10% (the other two communities did not initiate seminars as of this writing).

Importantly, if the current rate of growth observed between Year 1 and Year 2 continues (over 400%), Level 4 Standard and Group providers will be operating around or at full capacity by the end of Year 3. Seminar and Primary Care providers would be operating at about half, or just under half, capacity. Therefore, if implementation supports remain and trends continue, we are encouraged that Level 4 providers may come close to operating at a conservative level of capacity by the conclusion of Year 3. For Seminars and Primary Care services to 'take off,' perhaps some additional approaches may be required.

Summary of Impacts

The strong and positive impact of training on provider self-efficacy to deliver the Triple P intervention was maintained throughout this evaluation year. As indicated in the prior report, provider self-efficacy is a necessary component predicting effective service delivery.

Providers continued to report relatively high levels of satisfaction with the Triple P program. Modest modifications were made when necessary to accommodate for the diverse needs of families. For the most part, the modifications fell within the 'flexible implementation' of Triple P (e.g., modifying language, delivering the program in a longer or shorter period of time), with only a few providers indicating making changes that would call into question the extent to which they are implementing Triple P with fidelity (adding new material, leaving parts out).

There continued to be limited appreciable differences in communication across time for the providers and the overall rating of communication and collaboration between behavioral health and primary care systems remained moderately low, especially for those providers only trained in primary care and coalition members. And, considering child serving systems more broadly, responses were even lower. All responses were below 3 (previous work has demonstrated items scoring under 3 generally are in need of attention). We had recommended targeting cross-system communication during the previous evaluation period. However, no changes were observed during this year.

During Year 2, trends remained consistent regarding impressions of the referral system. Community coordinators offered a possible explanation that this initiative may have shed light onto referral pathways, and especially for primary care providers elucidated that enhancement to those pathways is necessary.

Most providers are not engaged in a Peer Support Network. This delivery support was a strong recommendation at the training and an implementation component that was discussed with local coordinators. It appears that this is an area in need of enhancing and will be a point of focus in Year 3.

Finally, we added a new section during this evaluation period to get a better sense of provider perceptions of the leadership of the community coordinators. Given coordinator turn-over, we asked the questions more

broadly, about initiative leadership. Providers who were cross-trained in primary care and seminar and in Level 4 had very similar ratings of implementation leadership, especially noting the supportiveness and perseverant qualities of their coordinators. Individuals trained only in Primary Care gave relatively lower ratings, only matching the other groups in the area of 'knowledgeable.' This may be reflective of the lower levels of success that these individuals had with implementation and that the Primary Care level of Triple P was more foreign to everybody when the initiative started.

Limitations

There were several limitations to the present evaluation. We relied strongly on self-report measures, and doing so carries inherent demand characteristics and possible response bias. We were not able to collect reliable monthly service delivery information for the vast majority of providers. Therefore, this component of the evaluation yielded limited information. Our overall provider sample was relatively small, limiting our ability to draw definitive conclusions about changes and our confidence in generalizing findings. Additionally, we experienced attrition in providers. These changes may have impacted response rates and possibly even attenuated our findings, as consistent local implementation supports are critical to uptake.

Recommendations

While initiatives such as this have many possible areas for continuous quality improvement, we note four areas of recommended focus given the results above.

Area 1: Peer support

The first priority area is ensuring providers have access to and attend peer support meetings. These meetings serve to support practitioners in delivery of Triple P consistent with fidelity standards. They also provide a forum to problem-solve implementation barriers. Guidance on how to set up effective peer support networks is in the concluding unit of the Participant Notes, distributed at the training events, and on-line on the practitioner network. Note that there can be some flexibility in how these meetings are arranged, including in-person vs. telephone; rotating peer leaders vs. nominating someone for a period of time; presence of implementation support staff vs. only practitioners, etc.

Area 2: Communication and Collaboration between child serving systems (including primary care)

Across all communities, the extent to which child serving systems, including primary care, communicate and collaborate with each other was relatively low. The specific strategies used to enhance this communication and collaboration will need to be tailored to the specific community context. Some ideas from other communities include:

- Creation of a 'core team' that is inclusive of leaders from the different systems
- Creation of a "learning collaborative"
- Participation in joint training events or summits
- Local surveys to identify areas for particular focus
- Provide regular feedback about numbers of families served and referrals/referral sources
- Partnering together on Level 1 Universal media strategies
- Co-locating behavioral health services within schools and primary care

We recommend each community identify strategies that they believe will make a difference for them and engage in 'small tests of change' – to see if there is a positive impact of the strategy.

Area 3: Referrals

All communities reported a desire for increased service delivery. And, despite greater numbers of families served during Year 2, there was little change in the perceptions of a 'streamlined referral pathway' for services. This is particularly pronounced for primary care providers, who reported the lowest ratings of referrals and are operating well below capacity. As above, the solution to this will need to be individualized within each community. Some of the strategies mentioned in "Area 2" may also provide the infrastructural supports to highlight the existence of or make alterations to the referral pathways.

Area 4: Family participation/completion

Communities commented on the challenges associated with getting families to 'complete' their Triple P program. This is particularly evident in Level 4 services, when families are expected to participate for many consecutive weeks. Program dropout is not uncommon in parenting interventions in general. A few ideas are listed here that have evidence of effectiveness:

- Use peer support networks to enhance provider skills using the guided participation model (the parental engagement strategy in Triple P)
- Consider additional clinical supports or trainings
 - o Triple P Clinical Support Day (organize through Triple P America)
 - Engagement training (contact PBHJP for options)
 - Motivational Interviewing (contact PBHJP for options)
- If possible, partner with agencies that can help with childcare and transportation. Consider offering food at Group or Seminar.
- Offer certificates of completion for families (examples are available on the Provider Network)

Works Cited

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research*, 6, 61-74.

Aarons, G.A., Ehrhart, M.G., & Farahnak, L.R. (2014). The Implementation Leadership Scale (ILS): Development of a Brief Measure of Unit Level Implementation Leadership. *Implementation Science*.

American Academy of Child and Adolescent Psychiatry Committee on Health Care Access and Economics Task Force on Mental Health. (January 01, 2009). Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics*, 123, 4, 1248-51.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (January 01, 2009). Population-based prevention of child maltreatment: the U.S. Triple p system population trial. *Prevention Science: the Official Journal of the Society for Prevention Research*, 10, 1, 1-12.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (January 01, 2009). Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health*, *36*, 1, 24-34.

Appendix A. Community Coalition Members - Demographics

Across all time points, 109 unique coalition members across the three communities who were administered the survey. However, there was both attrition and new additions to the local coalition membership in between all four time points. Additionally, during each time-point there were active coalition members who did not respond to surveys. Therefore, the following analysis includes only those members who were active (as indicated by the coalition rosters) during both the pre-training and 18-month final follow-up survey.

Forty-three community coalition members across Omak, Othello, and the Ocean Beach School District participated in the Triple P pre-accreditation (baseline) survey. Response rates for each community are as follows: 45% (14 of 31) of the Ocean Beach School District Coalition members; 75% (24 of 32) of the Omak Coalition members; and 38.5% (5 of 13) of the Othello Coalition members responded to the survey. Forty-three community coalition members across the three communities responded to the Triple P 18-month final follow-up survey with response rates for each community as follows: 42% (19 of 45) of Ocean Beach School District Coalition members, 61% (19 of 31) of Omak Coalition members, and 38% (5 of 13) of Othello Coalition Members. There are a total of 45 unique coalition members were active since the inception of the initiative and continued to be active at the end of the initiative (pre-training and 18-month final follow-up survey) across the three communities for which we have demographic information, as outlined in Table 16. All further analyses include only those members who were active and who completing both pre- and post-assessments.

Across communities, coalition members were typically female, though Ocean Beach School District's coalition was split almost evenly between male and female members. A majority of coalition members have not provided mental health services (71.1%) and were not trained in Triple P (73.3%). Coalition members have served an average of 4.8 years on the coalition.

Table 16. Coalition Member Demographics

	Omak (n= 21)	Othello (n= 8)	Ocean Beach S.D. (n= 16)	Total (N=45)	Missing
Gender					
Male	5 (23.8%)	5 (62.5%)	3 (18.8%)	13 (28.9%)	
Female	16 (76.2%)	3 (37.5%)	13 (81.3%)	32 (71.1%)	
Provided MH services					
Yes	6 (28.6%)	3 (37.5%)	4 (25.0%)	13 (28.9%)	
No	15 (71.4%)	5 (62.5%)	10 (75.0%)	32 (71.1%)	
Was trained in Triple P					15

Yes	4 (23.5%)	1 (50.0%)	3 (27.3%)	8 (26.7%)	
No	13 (76.5%)	1 (50.0%)	8 (72.7%)	22 (73.3%)	
Average no. of years as coalition member (SD)	4.8 (3.14)	5.13 (6.00)	4.56 (3.05)	4.8 (3.67)	1

Appendix B. Additional Analysis

At the request of the local coordinators, additional analysis was conducted for the "Communication & Collaboration" scale, the "Perceptions of Enhanced Streamlined Referral Process" scale, and the "Self-Efficacy" scale to include:

- Version B: analysis excludes Triple P providers who indicated not using Triple P with a family at both time points 2 and 3
- Version C: analysis includes all Triple P providers (regardless of whether they delivered services to families) but excludes Ocean Beach providers

Figure 11 version B. Perceptions of Communication & Collaboration between Child Serving Agencies and Primary Care from a scale of "1" to "5" with higher scores indicating greater perceptions of communication & collaboration

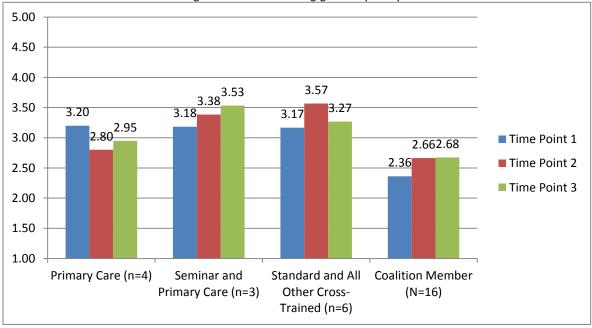


Figure 11 version C. Perceptions of Communication & Collaboration between Child Serving Agencies and Primary Care from a scale of "1" to "5" with higher scores indicating greater perceptions of communication & collaboration

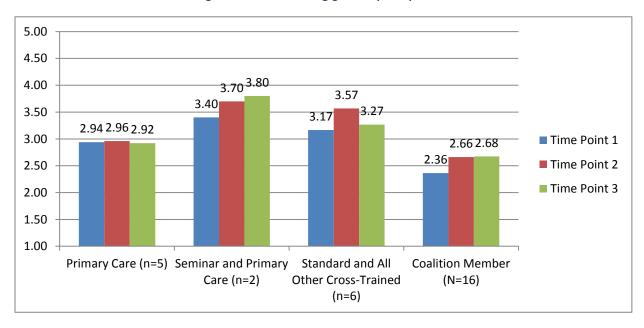


Figure 13 version B. Perceptions of enhanced or streamlined referral process on a scale of "1" to "5" with higher scores indicating more positive perceptions of strong referral processes in their community

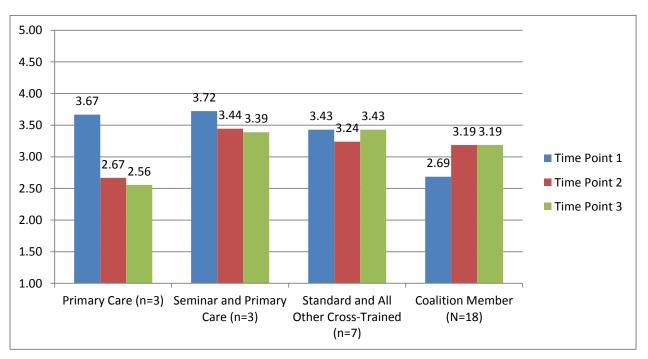
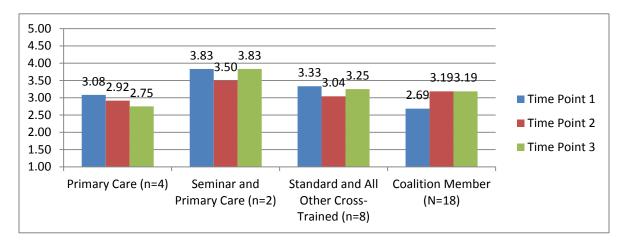


Figure 13 version C. Perceptions of enhanced or streamlined referral process on a scale of "1" to "5" with higher scores indicating more positive perceptions of strong referral processes in their community



Provider Self-Efficacy – Excluding providers who did not serve families

Table 9 version B. Provider Self-Efficacy Mean Scores⁶

Level of Triple P	Time Point	Mean	SD	N
	Pre-Training	4.64	.43	6
Drimanı Cara	Post-Training	5.47	.51	6
Primary Care	Accreditation	5.79	.27	6
	Follow-Up	5.28	1.14	6
	Pre-Training	2.23	1.35	2
Seminar and Primary	Post-Training	3.86	.71	2
Care	Accreditation	4.54	.13	2
	Follow-Up	3.86	.58	2
	Pre-Training	3.99	1.00	7
Standard and All Other	Post-Training	5.62	.41*	7
Cross-Trained	Accreditation	5.62	.34*	7
	Follow-Up	5.54	.40**	7

 $^{^{\}it 6}$ Participants were excluded if they were missing more than 20% of questions on each measure.

Note: ***p < .001, **p<.01; *p<.05

