TRIPLE P CABARRUS SUSTAINABILITY MANUAL



Table of Contents

Triple P Supervisors Corner
- Supervisors Corner

Triple P General Information
- About Triple P
- Triple P at a Glance
- Factsheet
- Triple P Cabarrus Overview – Webcast
- Triple P Overview – Presentation
- Triple P – Information Booklet
- What is Triple P – Program Descriptions
- Triple P Top 10 Tips – English
- Triple P Top 10 Tips – Spanish

Triple P Peer Support & Practitioner Resources
- Provider Directory
- PASS Model One-Pager
- Peer Support Checklist
- Agency Peer Support Contacts
- Q&A with Professor Matt Sanders – Movies
- Triple P Podcasts
- *Attachments:*
  - Provider Directory

Triple P Evaluation
- Level 2 Evaluation
  - Primary Care 0-12 & TEEN Evaluation Manual
  - Caregiver Contact Record
  - Caregiver Satisfaction Questionnaire – English & Spanish
  - Brief Primary Care Session Checklists
- Level 2 Evaluation – Seminar
  - Seminar Sign-In Sheets
  - Seminar Parent Satisfaction Survey
- Level 3 Evaluation – Primary Care
  - Primary Care 0-12 & TEEN Evaluation Manual
  - Caregiver Contact Record
  - Parenting Experience Survey – PRE – English & Spanish
  - Parenting Experience Survey – POST – English & Spanish
  - Caregiver Satisfaction Questionnaire – English & Spanish

Primary Care 0-12 Session Checklists
Primary Care TEEN Session Checklists

Level 3 Evaluation – Discussion Group
0-12 Sign-In Sheet
TEEN Sign-In Sheet
0-12 & TEEN Caregiver Satisfaction Questionnaire

Level 4 & 5 Evaluation
Evaluation Manual
Caregiver Contact Record
PRE & POST Parenting Scale – English & Spanish
PRE & POST Strength & Difficulties Questionnaire Instructions
Caregiver Satisfaction Questionnaire – English & Spanish
Standard – Session Checklists
Group Lifestyle – Session Checklists
Family Transitions – Session Checklists

Triple P Program Promotion

Stay Positive – Product Overview
Stay Positive – Information Booklet
What is Stay Positive? – Movie
Triple P Logo
Triple P Communications – Copyright & Image Use
Stay Positive Provider Website – Troubleshooting
Promote Your Sessions on Brochures
Attachments: Brochures
Brochure – Discussion Group 0-12 – Overprint Template – English & Spanish
Brochure – Group 0-12 – Overprint Template – English
Brochure – Group 0-16 – Overprint Template – English
Brochure – Seminar 0-12 – Overprint Template – English & Spanish
Brochure – Seminar 0-16 – Overprint Template – English & Spanish
Triple P Logo

Triple P Trainings & Resources

Open Enrollment List Serve
Course Summaries*
A Triple P Provider's Guide to Parent Resources
Online Resources – Important Triple P Websites
*Attachments: Order Forms***
Facilitator Kit Resources Order Form FY 15-16
Parent's resources Order Form FY 15-16
Program Resources Order Form FY 15-16

*Note: Triple P reserves the right to make changes to the course summaries including the prerequisites as needed

**Note: Triple P prices change each year, and therefore a new order form is released every July with new pricing. Email orders.us@triplep.net for the most current order form.

Local Funding Opportunities

Local Funding Opportunities

Attachments: Applications

Carolina Panthers Charities – Grant Application

Triple P Research

University of Queensland

Facilitating Practitioner Flexibility Within an Empirically Support Intervention (2010)

Facilitators and Barriers to Implementation of an Evidence-Based Parenting Intervention to Prevent Child Maltreatment (2012)

Population-Based Prevention of Child Maltreatment (2009)

Some Key Research Findings

Professor Matt Sanders

What the Experts Say

Triple P Impact on Top Diagnoses for Medicaid Billing

Triple P Cabarrus APHA Dashboard

Triple P Cabarrus NACCHO Report – LHDs & Child Maltreatment – October 2015

Triple P Cabarrus Evaluation Results – October-December 2015

Triple P Implementation Evaluation (Duke Endowment) – Final Report – January 2016

TRIPLE P SUPERVISORS CORNER

Section Contents:

Supervisors Corner

Supervisors Corner

As a supervisor of Triple P practitioners, you play a valuable role in supporting the implementation of Triple P in your agency. This Sustainability Manual will provide you with all the necessary resources and tools you need to support your staff in implementing and evaluating Triple P services provided within your agency. This Supervisor's Corner section was developed with supervisors of Triple P practitioners in mind to provide a quick reference and overview of key resources and activities required by the funder NC Department of Health and Human Services. Should you still have any questions, please contact Triple P Mecklenburg Coordinator, Cathy Henderson at 980-314-9128 (o), 704-534-3774 (c) or by email at Cathy.Henderson@mecklenburgcountync.gov or Myocia Young-Montgomery at 704-617-2176 or by email at myocia.young-montgomery@mecklenburgcountync.gov.

For New Supervisors

Triple P – Positive Parenting Program is a multi-tiered system of evidence-based education and support for parents and caregivers of children and adolescents. Cabarrus Health Alliance (CHA) was awarded $1.2 million from the NC Department of Health and Human Services to implement Triple P in Cabarrus County beginning in June 2012. Since then, CHA, in partnership with Triple P America (TPA), has trained Cabarrus County's existing workforce to deliver the evidence-based Triple P interventions to parents. Triple P is designed to be incorporated into practitioners' agencies as "business as usual", meaning Triple P will be another tool for their toolbox to be utilized when regularly working with parents on their child's behavioral concerns. The program can be offered in both clinical and non-clinical settings by multidisciplinary sectors including social services, mental health, healthcare, education, and many more. For more information on Triple P, please refer to the Triple P General Information section.

Requirements and Resources

As an agency with a trained Triple P practitioner(s), there are a few things you will want to know to help ensure Triple P services are successfully sustained with your agency. Some of these are deliverables required by the state funder that were outlined in a Memorandum of Understanding (MOU) between your agency and Cabarrus Health Alliance at the time of training. These requirements and resources are briefly explained below.

Evaluation: Evaluation activities are a required part of being a Cabarrus-trained Triple P practitioner. Data collection tools not only provide useful information to the practitioner and parent during the intervention, but also are mandated by the funder for funding purposes. CHA was purposeful in selecting only the minimal number of tools and abbreviated versions in order to minimize the time needed for evaluation efforts. Evaluation is collected on a quarterly basis and requirements are specific to the intervention level. Please refer to the Evaluation section for more information on evaluation requirements and protocols.

Peer Support: Peer support is essential in building practitioners' competence and confidence in their ability to delivery Triple P. It is also a valuable resource for practitioners to learn from one another and problem solve through potential barriers to implementation. Peer support involves a structured feedback process to promote learning of a complex set of consultation skills and enables providers to develop self-regulation skills & to learn from each other by sharing their cases with a group of peer practitioners. It also allows practitioners to discuss challenges, celebrate successes, and receive programmatic updates. As a requirement of our MOU, Triple P providers are to attend one peer support meeting a month. CHA coordinated peer support meetings for practitioners for six months following accreditation, after which practitioners transitioned into peer support groups within their agencies. All practitioners should have a designated peer support group. Please refer to the Triple P Peer Support and Practitioner Resources section for more information.

Provider Network: The Stay Positive website is a Triple P International owned and managed website that was created for both parents and practitioners. The parent site is where caregivers can learn information on Triple P and find a Triple P Provider. The Provider Network is the site created for Triple P practitioners. Following training, practitioners receive login access. This site is where practitioners find clinical tools for those interventions in which they are trained. They can also promote their Triple P services online by posting their agency contact information and listing any Triple P group sessions offered. Contact information provided on the "promote your location" function is how parents connect with a Triple P services through the "Find a Triple P Provider" function on the parent site. Triple P practitioners can also use this information should they want to refer a family to another agency for services or should the family need more intense Triple P services through a practitioner that is trained in a higher level of intervention. This is a great referral source, but only if the information is updated. Please help ensure that families in need of Triple P services can access them by encouraging your Triple P practitioners to keep their information updated on the Provider Network. If contact information changes or should a practitioner leave the agency and perhaps no longer provide Triple P services, it is important they update or remove their contact information to ensure referrals are successful. The Triple P Cabarrus Provider Directory can also be used for referrals, but because Triple P practitioners have the authority to update contact information on the Provider Network, the website has the most current information and should be the primary resource for referrals.

Ordering Parent Resources: Each accredited practitioner received a starter pack of parent resources for each level of intervention in which a practitioner was trained. Many practitioners have found their starter pack has lasted 1-2 years before they had to begin replenishing resources, depending on the type of resources parents have needed throughout the intervention, of course. With state grant funds, CHA was fortunate to be able to provide these starter packs at no cost to practitioners or their agency. However, once resources are exhausted, it is the responsibility of the agency to replenish the supplies. These supplies are essential for the continued implementation of the evidence-based intervention and for the success participating families will achieve in addressing their child's behavior. To order supplies, agencies will need to complete TPA's Program Resources Order Form. This form is not included in the attachments of this manual, but can also be found on your Sustainability Manual USB drive.

CHA website: Many of the resources listed in this manual are also posted on the CHA website. These resources include, but are not limited to, evaluation tools in English and Spanish, parent resource order form, and child behavior monitoring tools. Both practitioners and supervisors may access our Triple P Cabarrus page at www.cabarrushealth.org/153/Triple-P-Positive-Parenting-Program.

Triple P America Contact Information: Your local Triple P Coordinator is your greatest resource for any questions you may have regarding Triple P implementation and should be your first contact while funding continues. Should funding cease, Triple P America is also available to help you with questions regarding ordering additional resources and notifying you of any Open Enrollment training opportunities (these are training opportunities hosted by TPA for a cost and typically held in Columbia, SC or Los Angeles, CA. Refer to the Triple P Trainings and Resources section.)

Triple P America
1201 Lincoln Street, Suite 201
Columbia, SC 29201
(803) 451-2278

TRIPLE P GENERAL INFORMATION

Section Contents:

- About Triple P
- Triple P at a Glance
- Factsheet
- Triple P Cabarrus Overview – Webcast
- Triple P Overview – Presentation
- Triple P – Information Booklet
- What is Triple P – Program Descriptions
- Triple P Top 10 Tips – English
- Triple P Top 10 Tips – Spanish

About Triple P - Positive Parenting Program

The Triple P – Positive Parenting Program is one of the world's most effective parenting programs. It is one of the few based on evidence from ongoing scientific research. Developed by clinical psychologist Professor Matt Sanders and his colleagues at Australia's University of Queensland, Triple P has been proven to work with hundreds of thousands of families through ongoing research over 30 years. More than 230 international trials and studies have shown it works across cultures, socio-economic groups and in many different family structures.

Triple P is designed to give parents the skills they need to raise confident, healthy children and teenagers and to build stronger family relationships. Triple P doesn't tell people how to parent. Rather, it gives parents simple and practical strategies they can adapt to suit their own values, beliefs and needs. The benefits can be dramatic and long-lasting.

"Children who grow up with positive parenting are more likely to develop the skills they need to do well at schoolwork, build friendships, and feel good about themselves," says Professor Sanders.

"They are also much less likely to develop behavioral or emotional problems when they get older. Similarly, parents who use positive parenting skills feel more confident and competent about managing day-to-day family life. They are also less stressed, less depressed and have less conflict with their partners over parenting issues."

Triple P is distinctive in that it is not a "one-size-fits-all" course. Rather, it is a system that offers increasing levels of support to meet parents' different needs. Parents can choose anything from one-off public seminars or self-help books and DVDs to more intensive group courses or individual counseling sessions.

"Some parents may just need a light-touch of Triple P, a few ideas to help them set up a better bedtime routine or manage occasional disobedience," says Professor Sanders. "But others may be in crisis and need greater support. So Triple P is based on the idea that we give parents just the right amount of help they need – enough, but not too much." This Triple P approach guards against over-servicing and over-spending, which is good for parents and good for budgets.

Triple P has also been designed as a population-based health approach to parenting – typically implemented by government bodies or NGOs (non-government organizations) across regions or countries with the aim of reaching as many people as possible. It is often delivered through health, families or education departments.

Practitioners come from a range of professions and include doctors, nurses, psychologists, counselors, teachers, teacher's aides, police officers, clergy, social workers and health support workers. The concept, once again, is to provide easy access, support and choice for parents.

"Parenting is the most difficult job any of us will ever do in our lives, but it's also the one we're least prepared for," says Professor Sanders. "By making parenting information more widely available we're increasing the likelihood that parents will accept or seek out help. Offering Triple P is like immunizing the community. You prepare parents, make families healthier and prevent problems before they happen."

Triple P is now used in more than 20 countries including the USA, Canada, Australia, New Zealand, Belgium, Japan, Iran, Hong Kong, Singapore, the Netherlands, England, Scotland, Ireland, Wales, Germany, Curacao, Switzerland, Austria, Romania, France and Sweden. It has been translated into 18 languages to meet specific country requirements.

Triple P has won numerous international awards, including the Australian Heads of Government National Violence Prevention Award and Professor Sanders has been a consultant to the World Health Organisation and the Council of Europe and to governments in countries including the UK, Canada, Australia, New Zealand, Switzerland, Japan and Iran.

A number of specialist Triple P programs have also been developed. These include Stepping Stones Triple P (for parents of children with a disability), Family Transitions Triple P (for parents going through divorce or separation), Lifestyle Triple P (preventing obesity in children) and Indigenous Triple P (for Indigenous Australian families).

Triple P - Positive Parenting Program
At a glance

- One of the few evidence based parenting programs in the world. Triple P addresses child behavioral and emotional problems by giving parents proven tools and skills to build stronger families.
- Developed by Professor Matt Sanders and colleagues at the University of Queensland.
- Research ongoing for over 30 years, in the US and abroad. This includes the CDC-funded US trial.
- More than 230 evaluation, efficacy and dissemination studies conducted throughout the world proving that Triple P works across cultures, socio-economic groups and family structures.
- Ranked by the United Nations as the world's most extensively researched parenting program.
- Triple P has helped approximately 6 million children and their families. It is used in more than 20 countries and in 27 states of the US. It has been translated into 18 languages.
- More than 55,000 practitioners have been trained in its delivery. There are more than 5,000 practitioners in the US.
- Triple P is typically implemented by government bodies across regions/countries (typically Health, Families, Education).
- Subject of two primetime television series in the UK. *Driving Mum and Dad Mad* followed 10 families as their lives were transformed by Triple P.
- Professor Sanders has consulted and advised governments at senior policy levels in Australia, Canada, the UK, Ireland, Switzerland, New Zealand, Hong Kong, Singapore, Japan, Iran, Germany, France, Sweden, Belgium and the Netherlands. He has been a consultant to the World Health Organisation and to the Council of Europe.
- Has won numerous national and international awards.

www.triplep.net contact.us@triplep.net +1 803 451 2278

Triple P – Positive Parenting Program
Factsheet

What is Triple P?

The Triple P-Positive Parenting Program® (Triple P) is a multi-tiered system of evidence-based education and support for parents and caregivers of children and adolescents. The system works as both an early intervention and prevention model. Triple P may be offered in clinical and non-clinical settings by a multidisciplinary workforce of social service, mental health, healthcare, and education providers. A single practitioner may provide Triple P services to interested parents; or on a larger scale, an entire county or state jurisdiction may implement Triple P as a public health approach. The Institute of Medicine's 2009 Report[1] on prevention of mental, emotional, and behavioral disorders highlighted Triple P as having substantial empirical evidence: Triple P "is noteworthy for being the first [program] to show significant positive effects of a parenting intervention in an entire population."

The overarching aims of Triple P are as follows:

- To promote the independence and health of families through the enhancement of parents' knowledge, skills, confidence, and self-sufficiency.
- To promote the development of non-violent, protective, and nurturing environments for children.
- To promote the development, growth, health, and social competence of young children.
- To reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence.

Triple P is a culturally sensitive intervention being offered in 23 countries and in 27 States in the United States with various materials translated into seventeen non-English languages. As of July 2011, there were over 5200 Triple P practitioners in the US.

What is the evidence base?

Triple P is backed by more than 30 years of research conducted by academic institutions in the US and abroad (UK, CA, DE, NL, BE, SE, CH, IR, TR, HK, JP, AU, NZ). This includes 72 theoretical papers, 65 randomized controlled trials, 22 effectiveness trials, 19 single case studies, 4 meta-analyses, and 2 population-level trials (including the CDC-funded US Trial). Triple P is proven to work across ethnicities, cultures and socio-economic groups. For a complete list, please see:
http://www.pfsc.uq.edu.au/research/evidence/

Who does Triple P benefit?

- **Children, Parents, & Families**
  Triple P interventions increase parents' ability to deal with a full range of behavior problems including those within normal developmental limits to severe problems associated with DSM IV TR diagnoses (e.g. Oppositional Defiant Disorder, ADHD, Conduct Disorder, and Autism Spectrum Disorders).
- **Practitioners and Agency Providers**
  As an evidence based practice, Triple P can stand alone or complement existing services. As a brief and time-limited intervention, practitioners and organizations see significant results (both clinically and statistically) immediately following treatment and at follow-up.
- **Public Health Outcomes and Cost Savings**
  When implemented as a public health approach, Triple P positively impacts key child welfare indicators. The CDC-funded US Population Trial[2], demonstrated reductions in the following annual outcomes (standardized to 100,000 children):
  - 240 fewer out of home placements
  - 60 fewer hospitalizations/ER visits for child maltreatment injuries
  - 688 fewer substantiated child abuse cases

  The trial also demonstrated that Triple P training costs can be recovered in a single year by reducing the number of families where abuse and neglect occurred by 10 in a population of 100,000 families.

  Other economic analyses have yielded similar results:
  - Triple P would only have to divert 1.5 percent of cases of conduct disorder in order to pay for the service delivery of Triple P in to families in the community[3].
  - Washington State Institute of Public Policy (WSIPP) reported that when implemented as a public health approach for parent training, Triple P could save a community $722/participant through the prevention of child abuse and neglect and up to an additional $1,788/participant through the prevention of child mental health disorders[4]. WSIPP calculated the odds of achieving overall cost savings at 92-100%[4].

1. *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and possibilities* - Institute of Medicine. (2009)
2. Prinz, R. J., Sanders, M.R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). *Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial.* Prevention Science, 10(1), 1-12.
3. Mihalopoulos, C, Sanders, MR, Turner, KMT, Murphy-Brennan, M & Carter, R (2007). *Does the Triple P – Positive Parenting Programme provide value for money?* Australian and New Zealand Journal of Psychiatry, vol. 41, no. 3, pp. 239-46.
4. Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012* (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy.

nting - Empowerment - Community

PPP

Triple P Cabarrus



rrus Triple P
Overview

ive Parenting Program

Presenter/Author:

Amy Bartlett

Program Coordinator

Parenting - Empowerment - Community

Triple P Cabarrus



Cabarrus Triple P Overview

Positive Parenting Program

Presenter/Author:

Amy Bartlett

Program Coordinator

December 2014

Purpose

- Purpose: To provide an overview of the Triple P system
- Audience:
  - Agency representatives/supervisors with accredited Triple P providers who want to be more informed of the program their agency offers
  - Agency representatives who are interested in having their staff trained to deliver Triple P
  - Community members who want to learn of the program and how to connect parents to services



Look Familiar?









What is Triple P

- Positive Parenting Program
- Evidence-based intervention
- Multi-level programs of increasing intensity
- Parent-Driven/Empowerment Framework
- NC using a Population-Based Approach
- Looking at parenting as a public health concern



30+ years of research

Triple P: International Dissemination

29 Countries


Australia


New Zealand


Canada


United States


England

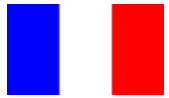

Ireland


Scotland


Switzerland


Wales


Germany


France


Luxembourg


Belgium


Sweden


Austria


Romania


The Netherlands


Caribbean Netherlands (BES Islands)


Curacao


Chile


Iran


Singapore


Hong Kong


Japan


Greece


Portugal

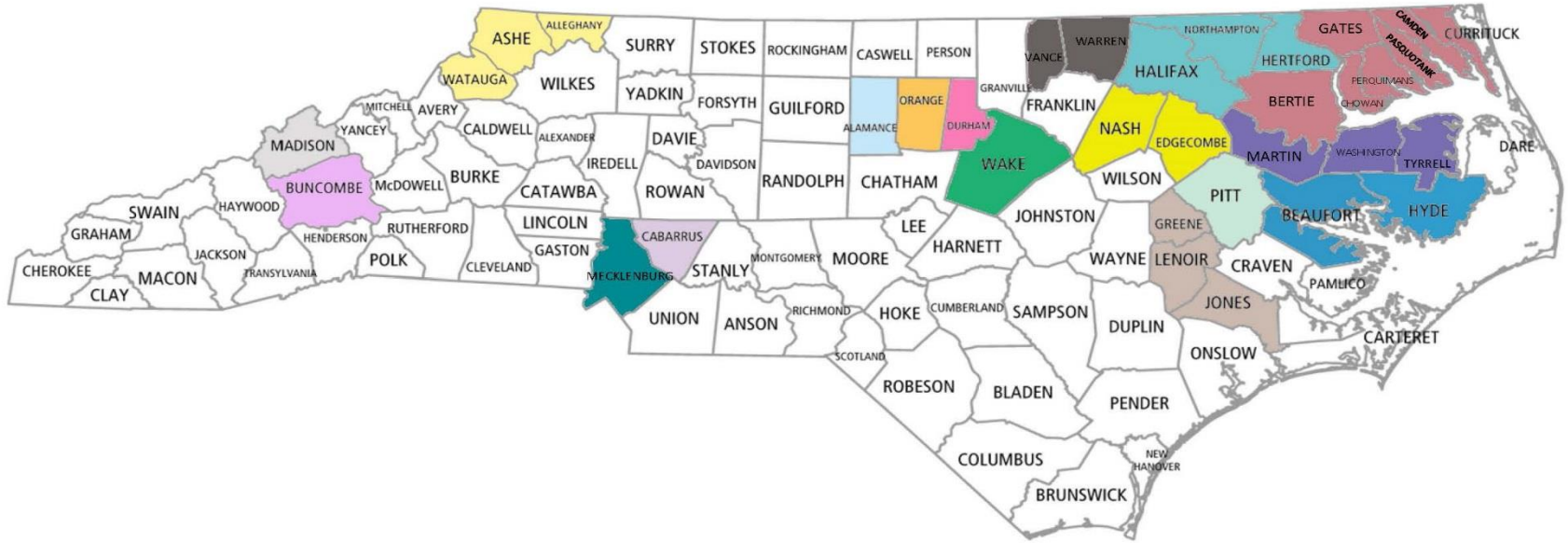

Turkey


Estonia

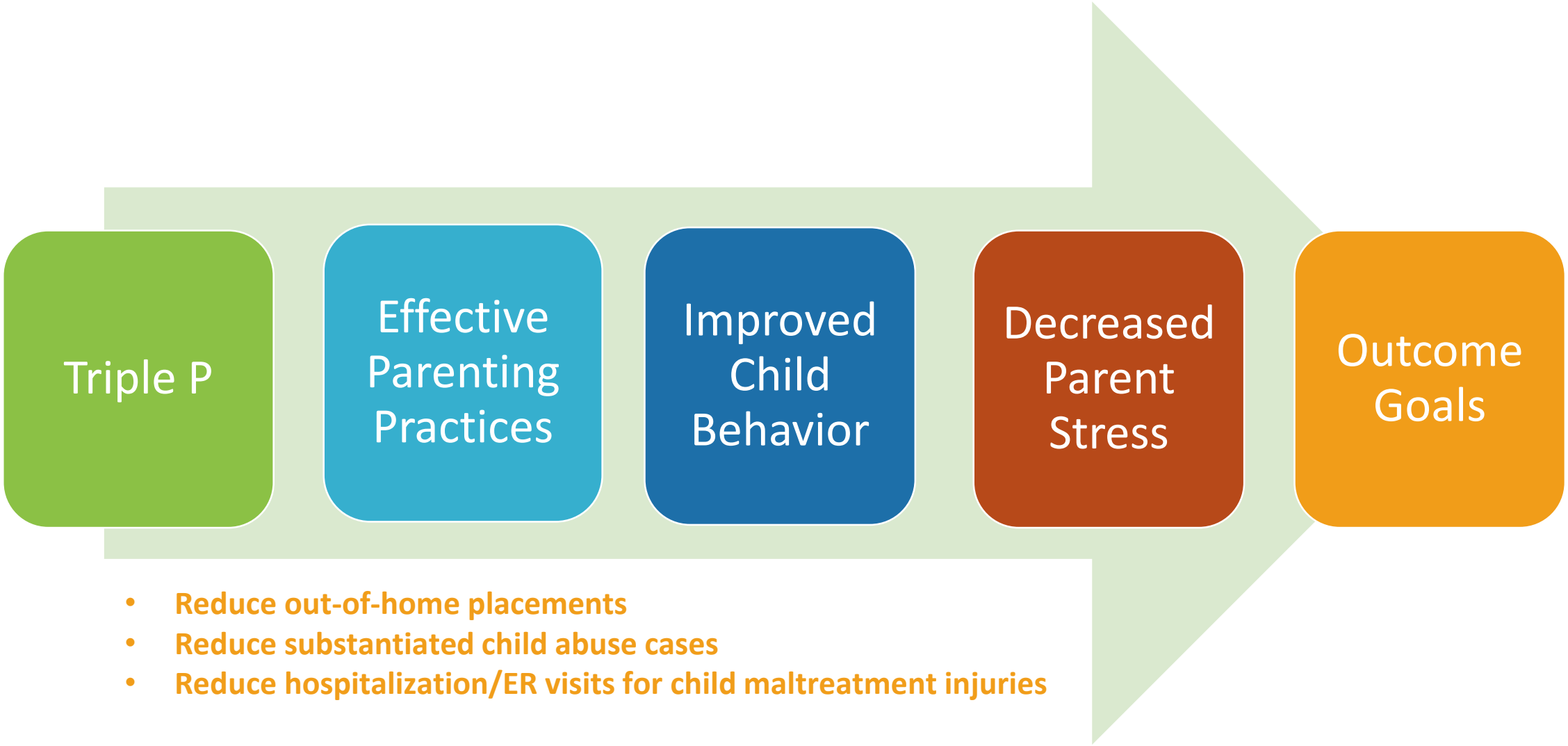

Panama

Triple P in North Carolina

- CHA awarded $1.2 million from NCDHHS until 2016
- 1/3 of state implementing
- Program trains existing workforce

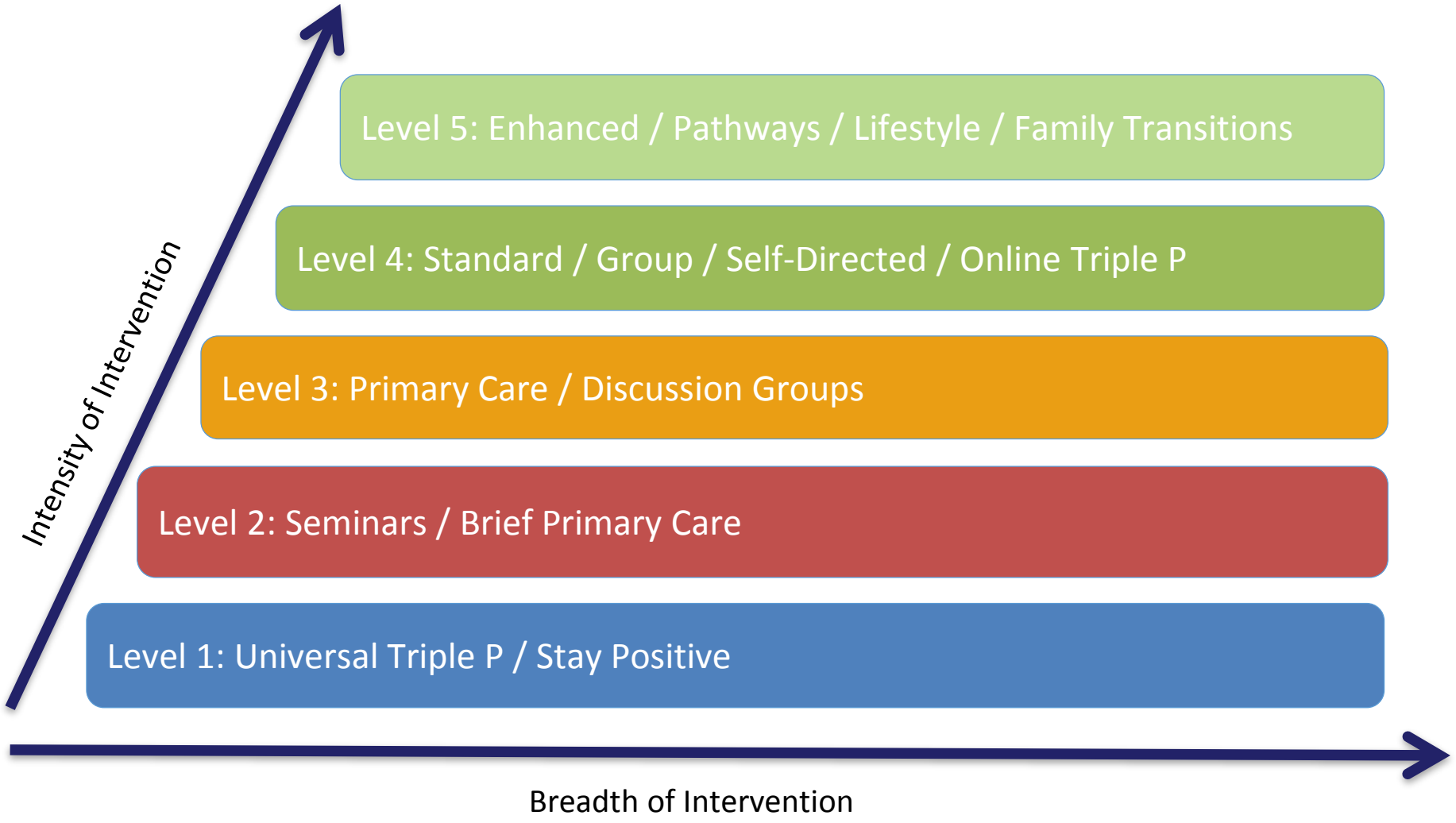


Mechanism of Change

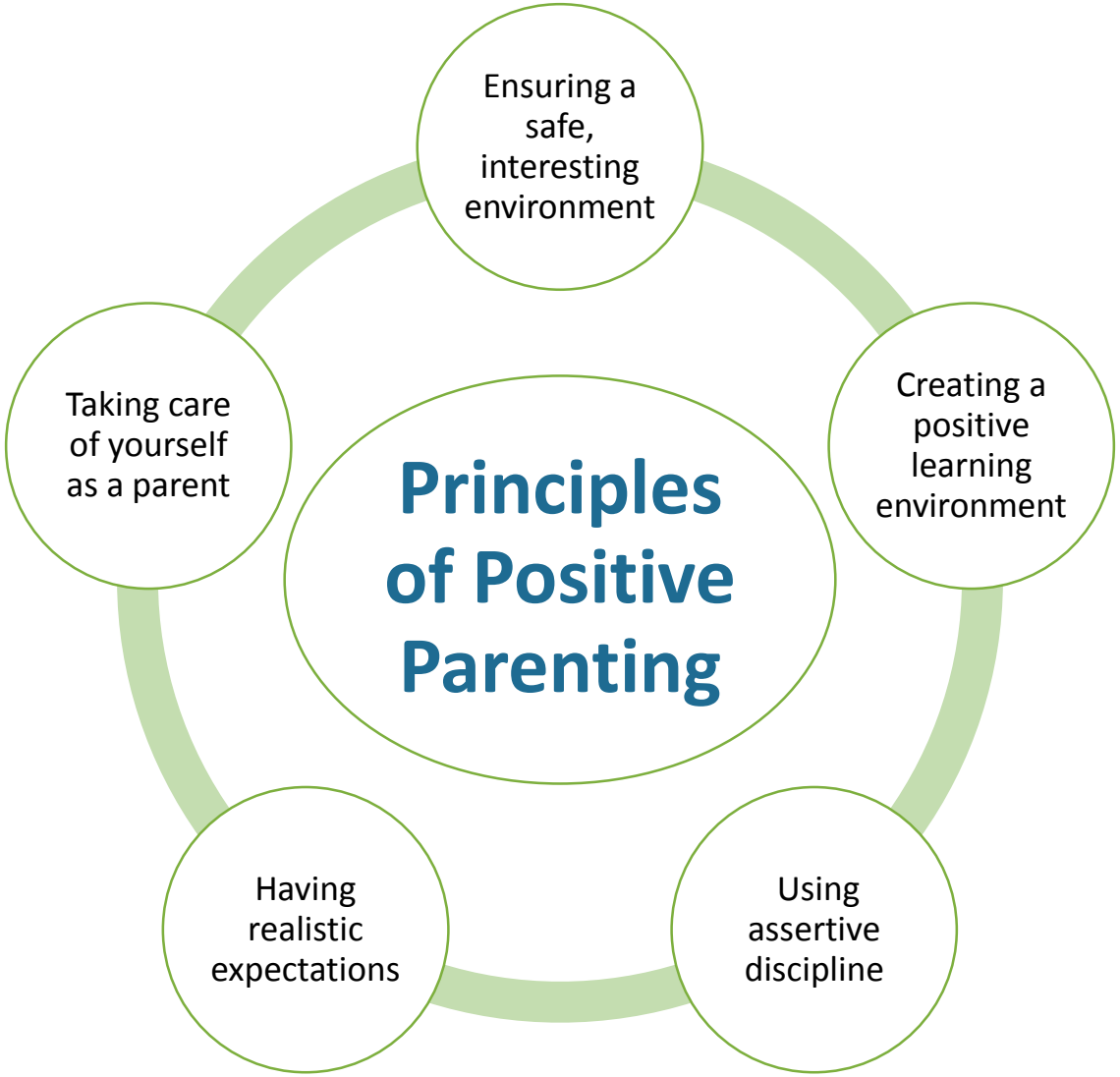


- **Reduce out-of-home placements**
- **Reduce substantiated child abuse cases**
- **Reduce hospitalization/ER visits for child maltreatment injuries**

Levels of Interventions



5 Core Principles



17 Specific Parenting Skills







Promoting a Positive Relationship

- Brief quality time
- Talking to children
- Affection

Teaching New Skills and Behaviors

- Modeling
- Incidental teaching
- ASK, SAY, DO
- Behavior charts

Encouraging Desirable Behavior

- Praise
- Positive attention
- Engaging activities

Managing Misbehavior

- Ground rules
- Directed discussion
- Planned ignoring
- Clear, calm instructions
- Logical consequences
- Quiet time
- Time out

What does a Level 3 Intervention look like?

Session 1

- Initial interview
- Options for intervention
- Keeping track of child's behavior

Session 2

- Review assessment results
- Discuss causes of behavior problems
- Set goals for change
- Develop parenting plan
- Set homework tasks

Session 3

- Review progress
- Refine parenting plan and practice strategies
- Identify and overcome obstacles
- Set homework tasks

Session 4

- Update on progress
- Discuss maintenance



Triple P Trainings in Cabarrus County

Capacity Building/Workforce Development

FY 2013		FY 2014		FY 2015			FY 2016		
MARCH 2013	**JUNE 2013**	**OCTOBER 2013**	**MARCH 2014**	**AUGUST 2014**	**SEPT. 2014**	**SPRING 2015**	**SUMMER 2015**	**FALL 2015**	
Level 3 Primary Care 0-12 (Completed)	**Level 3 Primary Care Teen Extension** (Completed)	**Level 3 Primary Care 0-12** (Completed) **Level 3 Primary Care Teen Extension** (Completed)	**Level 3 Primary Care Stepping Stones 0-12** (Completed)	**Level 4 Standard** (Completed)	**Level 3 Discussion Group** (Completed)	**Level 3 Primary Care with Teen Extension**	**Level 2 Brief Primary Care** **Level 2 Brief Primary Care TEEN**	**Level 3 Discussion Group TEEN**	**Level 5 Family Transitions**

Trainings selected were based on the strategic planning meeting and guidance from the Triple P Coalition, a governing entity that assesses community needs and agency feasibility to implement the identified interventions.

Triple P in Cabarrus County

- Cabarrus County Department of Human Services
  - Trained Foster Care and In-Home staff
  - Strategic/innovative in developing ways to implement



2 From meltdowns to kindy star — Triple P just what the doctor ordered for Penny

5 Simple steps — Five principles to live by

8 Get help — Where to find Triple P near you

Parenting tips and information for every parent

Tippaper No.1

> Triple P, Positive Parenting, Summer 2014 www.triplep-parenting.net

Busy mom stays positive

The Ward household in Asheville wasn't always a great place to be if you were a cat. Every time Malaika Ward's five-year-old daughter Lila would walk past the family pet, she would pester the cat.

For a mum with her hands full managing "But Triple P has given me a way to deal choices including seminars, group courses

Triple P comes to North Carolina

Thirty-three North Carolina counties have joined forces to bring the Triple P – Positive Parenting Program to parents in the state, in a collaboration that aims to make raising children easier.

Triple P is brought to North Carolina by the North Carolina Triple P State Learning Collaborative and is available to eligible parents of children up to 12 years, or parents of children up to 16 years, free or at low cost.

The 33 counties offering Triple P are Alamance, Appalachian District (Alleghany, Ashe and Watauga), Beaufort, Bertie, Buncombe, Cabarrus, Camden, Chowan, Carrituck, Durham, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Madison, Martin, Mecklenburg, Nash, Northampton, Pasquotank, Perquimans, Pitt, Tyrrell, Vance, Wake, Warren and Washington.

Help that works

Raising kids can be fun, infuriating, frightening, wonderful, stressful, exhausting and sometimes, all those things in one day! But it's amazing the difference a little confidence can make to a parent's life. The Triple P – Positive Parenting Program gives parents the skills they need to build better relationships with their children, solve problems and become more confident parents.

And because Triple P is based on more than 30 years' ongoing research with families around the world, you can be confident it can help you too.

Ten minutes with... Chanell Ketchmore

Chanell Ketchmore is a Triple P and Teen Triple P provider with Cabarrus County Human Services. Triple P is available to North Carolina families experiencing all kinds of problems, from simple issues to more complex concerns. Chanell sees parents on-on-one and spoke to us about the challenges that many families face.

What are the most common problems parents talk to you about?

I would say parents have issues with their children following directions, and they constantly have to ask them to do certain things. They get frustrated when the kids don't follow through.

What do you like most about the Triple P program?

I like the "aha" moment parents have. When parents get the outcome they want, that empowers them and lets them know they can do this. When we first start working with families, they're frustrated.



But there are a wide range of strategies for parents to choose from, and these allow them to also focus on their own behavior, and how it affects their child. They see how they can approach things in a different manner and get a different result.

How do parents react when they realize that Triple P is working for them?

They have been very grateful. Grateful in the fact that that they have new or additional skills to work with to help their family. I've had many parents tell me this.

What would you say to someone who thinks they may need some parenting support but is reluctant to go to a program such as Triple P?

I would remind them that they are the parents, so they are the ones who know their child the best. No parent is perfect, and there is no one right or wrong way to approach things, but everyone can benefit from this program.

Are parents happy to ask for parenting help – or do they worry what others will think of them?

We don't have parents coming to us, our agency has already identified families who need some help. Once they get going with the program, they see the benefits of the program and tell us how the strategies make sense. ■

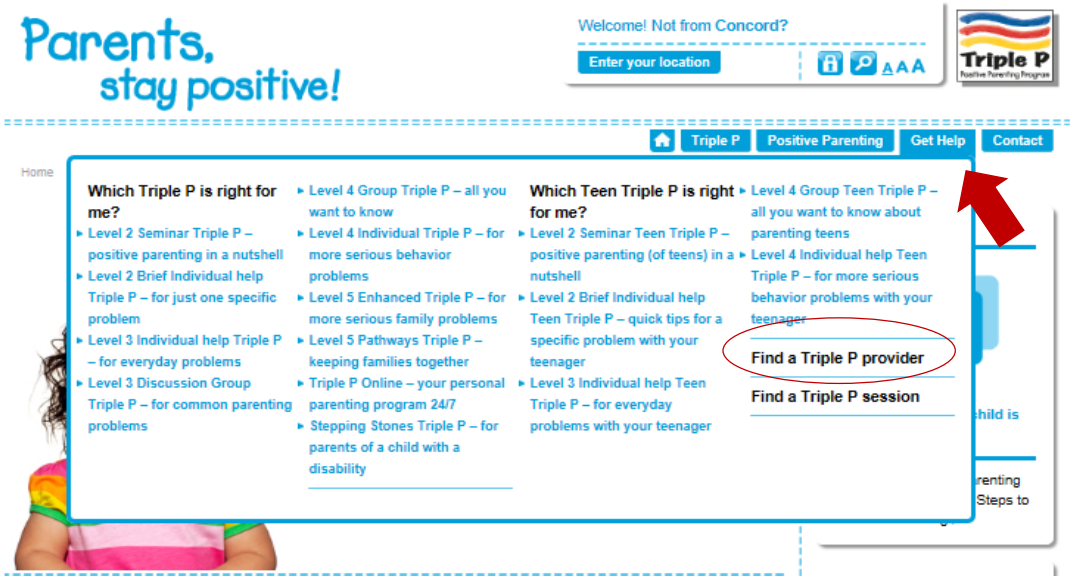
Referrals to a Triple P Provider

Triple P NC Website:

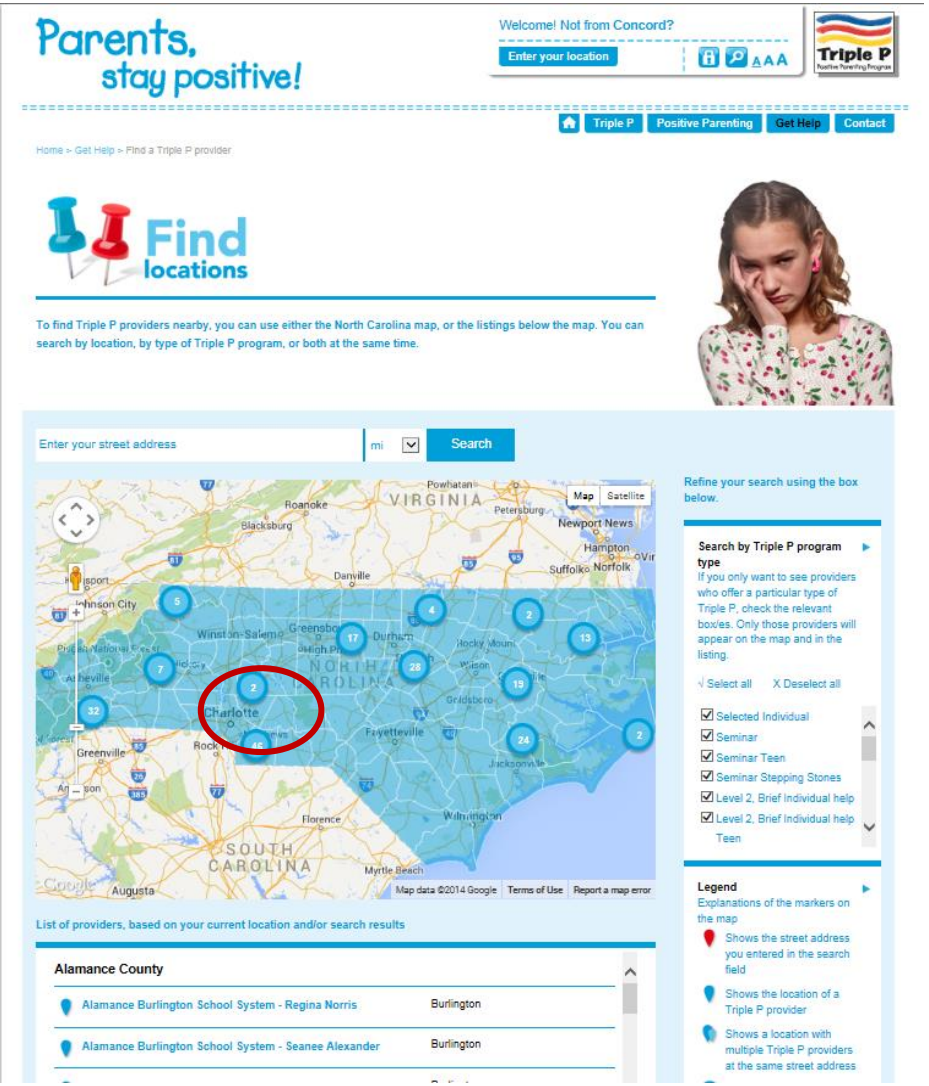
http://www.triplep-parenting.net/nc-en/home

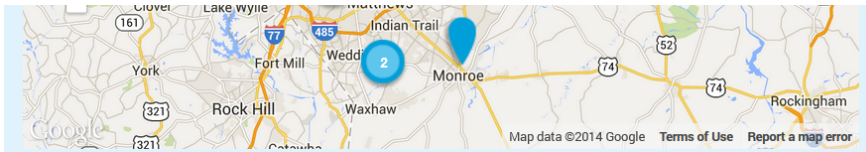
Find a Triple P Provider





Find a Triple P Provider

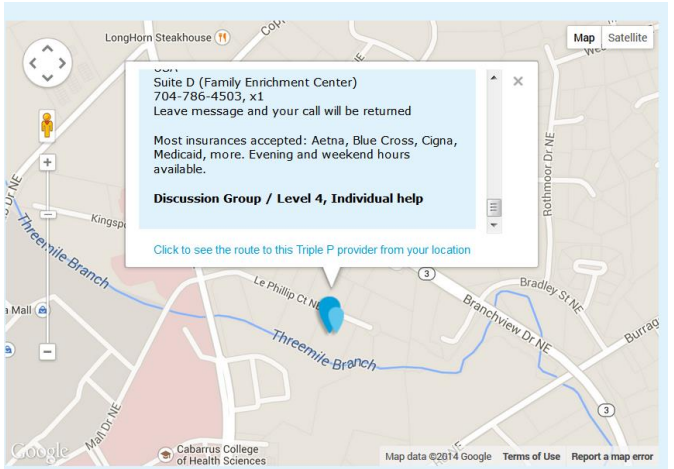




List of providers, based on your current location and/or search results

Cabarrus

Cabarrus Health Alliance - Amy Bartlett	Kannapolis
Cabarrus Health Alliance - Gina Hofert	Kannapolis
Cabarrus Health Alliance - Kermilya Simmons	Kannapolis
Kannapolis City Schools - Donna Gerdes	Kannapolis
CCDHS and Private Sector - Chanell Ketchmore	Cabarrus, Mecklenburg, and Gaston Co.
Cabarrus County Department of Human Services - Hillary Blalock	Kannapolis
Care Coordination for Children - Pamela Eubanks	Kannapolis
Daymark Recovery Services - Jenna K. Hannigan	Concord



List of providers, based on your current location and/or search results

Cabarrus

Sarah Fishback, LPA - Sarah Fishback	Concord

Contact Us

triplep@cabarrushealth.org



References

Information obtained from:

- Triple P America

http://www.triplep.net/glo-en/home/

- Dr. Romney, San Francisco Parent Training Institute

http://www.pti-sf.org/home

Triple P,
Positive Parenting Program



The Triple P – Positive Parenting Program is one of the world's most effective evidence-based parenting systems. With more than 30 years of ongoing research and over 230 international trials and studies, Triple P works across cultures, socioeconomic groups and in many different family structures.

Triple P is designed to give parents the skills they need to raise confident, healthy children and teenagers, and to build stronger family relationships. It provides parents with simple and practical strategies they can adapt to suit their own values, beliefs and needs.

"Children who grow up with positive parenting are more likely to develop the skills they need to do well at school, build friendships, and feel good about themselves."

"They are also much less likely to develop behavioral or emotional problems when they get older. Similarly, parents who use positive parenting skills feel more confident and competent about managing day-to-day family life. They are also less stressed, less depressed and have less conflict with their partners over parenting issues."

Professor Matt Sanders,
founder of the Triple P – Positive Parenting Program

Triple P – Flexible delivery

Triple P is distinctive in that it is not a "one-size-fits-all" course. It is a system that offers increasing levels of support to meet the needs of individual families. Parents can choose anything from single public seminars or self-help books and DVDs, to more intensive group courses or individual counseling sessions.

"Some parents may just need a light-touch of Triple P, a few ideas to help them set up a better bedtime routine or manage occasional disobedience, but others may be in crisis and need greater support. So Triple P is based on the idea that we give parents just the right amount of help they need."

Professor Matt Sanders,
founder of the Triple P – Positive Parenting Program

Triple P – Population based approach

Triple P has been designed as a population-based approach to parenting – typically implemented by government bodies or NGOs (non-government organizations) across regions or countries with the aim of reaching as many parents as possible. It is often delivered through health or education departments. Triple P providers come from a range of professions including doctors, nurses, psychologists, counselors, teachers, teachers' aides, police officers, clergy, social workers and health support workers.



Universal Triple P

Universal Triple P aims to raise awareness of the importance of parenting and destigmatize the idea of asking for parenting help. The communications strategy, Stay Positive, helps ensure the maximum number of parents know about, understand and can easily find the Triple P help they need.

Triple P interventions

All Triple P programs are available for parents of children from birth to 12 years and for parents of teenagers, except where noted.

Selected Seminar Triple P

A series of three 90-minute seminars that tackle common parenting challenges. Parents may choose to do one, two or all three seminars.

Primary Care Triple P

Brief, flexible, consultations for parents of children with mild to moderate behavioral difficulties. Typically provided to parents in up to four sessions (15-30 minutes in duration). Includes active skills training for parents, where necessary.

Discussion Group Triple P

Targets a single specific parenting issue in one two-hour group session. Topics are "dealing with fighting and aggression", "dealing with disobedience", "developing good bedtime routines" and "hassle-free shopping with children". For parents of children birth to 12 years.

Group Triple P

A moderately intensive parent program for moderate to severe behavioral or emotional difficulties. It can also be used as a prevention strategy to promote positive development. Typically delivered to parents as four group sessions of two hours each, followed by three individual phone consultations for each participating family, and concluding with a two-hour group session.

Standard Triple P

Intensive parenting program for moderate to severe behavioral/emotional difficulties. Typically delivered to individual families in 10 sessions. Delivered in a clinic or in parents' homes.

Triple P Online

Eight session web-based course for parents who prefer an electronic medium or who are too busy, reluctant or isolated to attend regular parenting courses. Based on Standard Triple P, Triple P Online introduces parents to Triple P's 17 core parenting skills and includes a mix of

video, worksheets and online activities. Parents can also sign up to receive podcasts, email and texts that recap sessions and goals. For parents of children birth to 12.

Enhanced Triple P

An intensive, individually-tailored program (up to 11 sessions) for families where parenting is complicated by factors such as partner conflict or mental health issues. Enhanced Triple P is used in combination with either Group or Standard Triple P. Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, partner support skills.

Pathways Triple P

A focused intervention for parents at risk of child maltreatment. Pathways Triple P is used in combination with either Group or Standard Triple P. This intervention helps parents understand causes of a child's behavior and develop anger management strategies.

Specialized Triple P Programs

Triple P also offers a range of specialized programs including Stepping Stones Triple P for parents of children with disabilities, Family Transitions Triple P for parents going through divorce or separation, and Lifestyle Triple P for parents of children who are obese or overweight. Check the website for details of these and other specialized Triple P programs.

Triple P – Resources to help parents

Triple P has a broad range of parenting and professional resources including positive parenting booklets, tip sheets and workbooks for parents, as well as DVDs and practitioner kits. Parenting resources are also available in Spanish. Please visit our website and click on Practitioner Resources.



What the research says

The Triple P – Positive Parenting Program is one of the most comprehensive, flexible and extensively evaluated parenting systems in the world. There are now more than 230 efficacy, effectiveness and dissemination studies, with researchers in more than 20 countries.

Some research highlights:

A population level US trial found that communities providing Triple P services had fewer cases of child maltreatment, fewer children removed from their homes, and fewer child hospitalizations or emergency room visits related to maltreatment than similar communities that were not providing Triple P services.
Prinz, R.J. et al (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10(1), 1-12.

A cost analysis based on the US Triple P system population trial found that the costs of equipping a community to provide Triple P services would be recovered in a single year if rates of child maltreatment were decreased by only 10%.
Foster, E.M. et al (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, 30, 493-501.

The Every Family Initiative population trial in Australia found that communities where Triple P services were widely available had fewer children with behavioral or emotional problems than communities where Triple P services were not widely available.
Sanders, M.R. et al (2008). Every Family: A population approach to reducing behavioural and emotional problems in children making the transition to school. *Journal of Primary Prevention*, 29, 197-222.

Many of these articles and numerous other articles, including studies on the effectiveness of individual levels of Triple P and the effectiveness of program variations such as Teen Triple P and Stepping Stones Triple P, can be found at:
http://www.pfsc.uq.edu.au/evidence

Stay Positive – Reaching every parent

One of the greatest strengths of the Triple P – Positive Parenting Program is its ability to cater to every parent, regardless of personal or family circumstances. One of the greatest challenges is ensuring parents know how to reach out for that help. That's why the Stay Positive communications strategy has been created. Stay Positive helps ensure every parent knows about, understands, and can easily find the Triple P help they need.

What is Stay Positive?

Stay Positive is a communications strategy for organizations implementing a population-level Triple P rollout. Materials are designed to raise awareness of parenting issues, destigmatize the idea of asking for parenting advice, and encourage parents to reach out for information and help if they need it. Although Stay Positive is an integrated communications strategy, elements of the campaign may be used in isolation. However program awareness and destigmatization outcomes may be more limited with this approach. Materials include a locally-driven Stay Positive website, television, radio and outdoor creative, banners, brochures, posters, flyers and localized parent newspapers.

Triple P America

Triple P America (TPA) organizes Triple P provider Training Courses for organizations and agencies at their sites around the country. Triple P is offered in 27 states in the United States with various materials translated into seventeen non-English languages. Triple P may be offered in clinical and non-clinical settings by a multidisciplinary workforce of social service, mental health, healthcare and education providers. A single practitioner may provide Triple P services or, on a larger scale, an entire county or state jurisdiction may implement Triple P as a public health approach. Open-enrollment courses are also offered periodically for single practitioners. TPA uses an Implementation Framework with all types of implementation, regardless of scale. The framework supports a successful and sustainable implementation of Triple P.

How to contact us

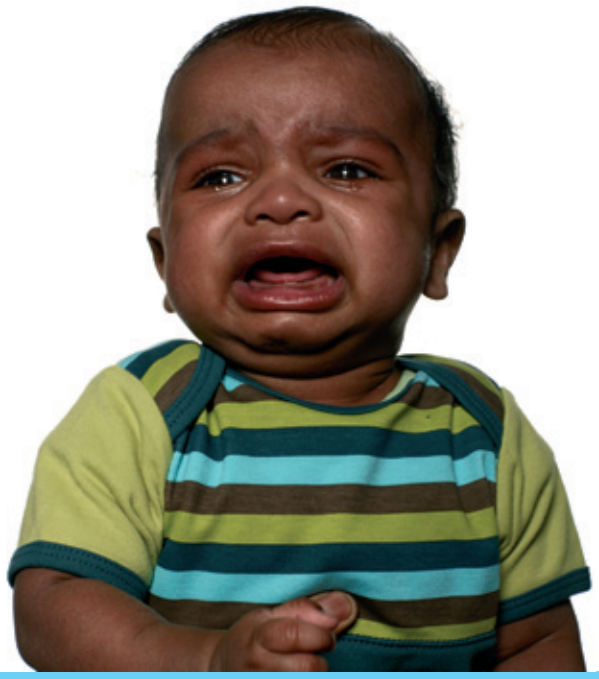
Triple P America

Head Office Address:
1205 Lincoln Street,
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Tel: +1 803 451 2278
contact.us@triplep.net
www.triplep.net

Postal Address:
PO Box 12755,
Columbia, SC 29211
United States









Website: www.triplep.net | Phone: +1 803 451 2278 | E-mail: contact.us@triplep.net

What is Triple P?

Formal Description - One Liner
The Triple P – Positive Parenting Program is an internationally-recognized program that gives parents the skills they need to build strong family relationships, manage misbehavior and prevent problems happening in the first place.

Formal Description - 100 Words
The Triple P – Positive Parenting Program is one of the world's most effective parenting programs.
It gives parents the skills they need to raise confident, healthy children and teenagers, and to build stronger family relationships. It also helps parents manage misbehavior and prevent problems occurring in the first place.

With more than 30 years of ongoing research, Triple P has been scientifically trialed with thousands of families around the world and been found to work – regardless of culture, country or individual situation. Triple P has helped more than six million children and their families in more than 20 countries around the world.

Formal Description - 200 Words
The Triple P – Positive Parenting Program is one of the world's most effective parenting programs.
It is one of the few based on evidence from ongoing scientific research, with more than 230 trials and studies around the world showing it works – regardless of a family's culture, country or situation.

Triple P works by giving parents the skills to raise confident, healthy children and teenagers, and to build stronger family relationships. It also helps parents manage misbehavior and prevent problems occurring in the first place.

But it doesn't tell people how to parent. Rather, it gives them simple and practical strategies they can adapt to suit their own values, beliefs and needs. Triple P is also different because it is not "one-size-fits-all". It's a system that offers increasing levels of support to meet parents' different needs. So parents can choose anything from one-off public seminars or self-help books to more detailed group courses or individual sessions.

Triple P is now used in more than 20 countries including the USA, England, Scotland, Ireland, Wales, Canada, Australia, New Zealand, Belgium, Sweden, Germany, Japan, Iran, Hong Kong, Singapore, the Netherlands, Curacao, Switzerland and Romania. It has been translated into 18 languages.

Informal Description (Second Person) - 110 Words
When you become a parent you're expected to be an instant expert. But all parents struggle from time to time – and that's where the Triple P – Positive Parenting Program can help. Triple P is a world-acclaimed program that gives you the skills you need to manage misbehavior and prevent problems from happening in the first place.

From toddler tantrums to a teenager's defiance, from bedtime dramas to outright disobedience, Triple P helps you sort through the issues that affect families everywhere. And you can be confident that Triple P works. It has more than 30 years' ongoing scientific research to back it up and is now used in more than 20 countries around the world.

Informal Description (Second Person) - 200 Words
When you're a parent, everyone has advice. But with so many conflicting opinions around, how do you know what's best and what works? The Triple P – Positive Parenting Program is a world-acclaimed parenting program that gives you the skills to manage misbehavior and prevent problems from happening in the first place.

From toddler tantrums to a teenager's defiance, from bedtime dramas to outright disobedience, Triple P helps you work through the issues that affect families everywhere. To understand how Triple P works, think of it as a toolbox of ideas. You choose the tools you want to make your family life better. You can adapt Triple P's ideas to suit your culture, beliefs and personal situation, using them to build better relationships with your child, solve problems, become a more confident mom or dad – and give your child the best start to life.

Another great benefit of the Triple P program is that it only gives you the amount of help you really need. So you can choose anything from a one-off seminar to detailed group courses or personal support. And you can be confident that Triple P works. It has more than 30 years' ongoing scientific research to back it up and is now used in more than 20 countries around the world.

Informal Description (Third Person) - 110 Words
Some of the most common parenting problems have very simple solutions – and now, the Triple P – Positive Parenting Program is here to share those solutions. Triple P is a world-acclaimed program that gives parents skills to raise confident, healthy children, manage misbehavior and prevent problems from happening in the first place.

From toddler tantrums to a teenager's defiance, from bedtime dramas to outright disobedience, Triple P helps parents sort through the big and small issues of family life. And the really good news is that Triple P does work. It's got more than 30 years of ongoing scientific research to back it up and is now used in more than 20 countries.

Informal Description (Third Person) - 200 Words
Many of the most common parenting problems have very simple solutions – and now, the Triple P – Positive Parenting Program is here to share those solutions with parents. From toddler tantrums to a teenager's defiance, from bedtime dramas to outright disobedience, Triple P helps parents sort through the issues that affect families everywhere.

Triple P is an internationally-recognized program that gives parents the skills they need to raise confident and healthy children, manage misbehavior and prevent problems happening in the first place. Triple P works like a toolbox of great ideas. Parents choose the tools they need for their own situation – allowing them to create better relationships with their children, solve problems and become a more confident parent.

Also, Triple P gives parents just the right amount of help they need, offering everything from one-off seminars and brief one-on-one sessions with a practitioner to detailed group courses and longer-term personal support. And the really good news is that Triple P does work. It's got more than 30 years of ongoing scientific research to back it up, with studies showing it helps families regardless of their culture, beliefs or personal situation. In fact, Triple P has helped more than six million children and their families in more than 20 countries around the world.

Top ten tips for parents

Triple P
Positive Parenting Program

1. When your child wants to show you something, stop what you are doing and pay attention. It's important to spend frequent, small amounts of time with your child doing things that you both enjoy.

2. Give your child lots of physical affection. Children often like hugs, cuddles, and holding hands.

3. Talk to your child about things he/she is interested in and talk about your day too.

4. Give your child lots of descriptive praise when they do something that you would like to see more of, e.g., "Thank you for doing what I asked straight away."

5. Children are more likely to misbehave when they are bored so provide lots of indoor and outdoor activities for your child, e.g., building blocks, colouring, cardboard boxes, dress ups, play houses, etc.

6. Teach your child new skills by first showing the skill yourself, then giving your child opportunities to learn the new skill. For example, speak politely to each other in the home. Then, prompt your child to speak politely (e.g., say "please" or "thank you") and praise your child for their efforts.

7. Set clear limits on your child's behavior. Sit down and have a family discussion on the rules in the home. Let your child know what the consequences will be if they break the rules.

8. If your child misbehaves, stay calm and give them a clear instruction to stop misbehaving and tell them what you would like them to do instead (e.g., "Stop fighting; play nicely with each other.") Praise your child if they stop. If they do not stop, follow through with an appropriate consequence.

9. Have realistic expectations. All children misbehave at times and it is inevitable that you will have some discipline hassles. Trying to be the perfect parent can set you up for frustration and disappointment.

10. Look after yourself. It is difficult to be a calm, relaxed parent if you are stressed, anxious, or depressed. Try to find time every week to let yourself unwind or do something that you enjoy.

More information: www.triplep-parenting.net

10 Consejos Importantes Para Los Padres

1. Cuando su hijo quiere mostrarle algo, deje de hacer lo que está haciendo y préstele atención. Es importante que pase períodos breves y frecuentes con su hijo, haciendo cosas que ambos disfruten.

2. Dele a su hijo mucho afecto físico: a los niños generalmente les gustan los abrazos, los mimos y que los tomen de las manos.

3. Háblele a su hijo sobre cosas que le interesen y comparta detalles de su día con su hijo.

4. Dele a su hijo elogios descriptivos cuando se comporta de una manera que usted desearía ver más seguido, por ejemplo, "Gracias por hacer de inmediato lo que te pedí".

5. Los niños suelen comportarse mal cuando están aburridos; por lo tanto, proporciónele a su hijo actividades interesantes para realizar en espacios interiores o al aire libre, por ejemplo, juegos con plastilina, libros para colorear, cajas de cartón, disfraces, casitas para niños, etc.

6. Enséñele a su hijo nuevas destrezas de la siguiente manera: primero demuéstrele usted mismo como se hace, luego dele oportunidades a su hijo para aprenderla. Por ejemplo, hable amablemente con las demás persona de la casa. Luego, estimule a su hijo a hablarle a los demás con amabilidad (por ejemplo, a decir "por favor" o "gracias"), y elogie al niño por sus esfuerzos.

7. Establezca límites claros en el comportamiento de su hijo. Reúna a los miembros de su familia y organice una discusión familiar para establecer las reglas de la casa. Explíquele cuáles serán las consecuencias si se rompen las reglas.

8. Si su hijo se comporta mal, mantenga la calma, dele instrucciones claras para que deje de portarse mal y dígale lo que desearía que hiciera en lugar de lo que está haciendo (por ejemplo, "dejen de pelear; jueguen en armonía"). Elogie a su hijo si deja de portarse mal. Si no se detiene, aplique una consecuencia apropiada.

9. Tenga expectativas realistas. Todos los niños se portan mal algunas veces y es inevitable que deba lidiar con situaciones disciplinarias molestas. Intentar ser un padre perfecto puede predisponerlo a frustrarse y sentirse decepcionado.

10. Cuídese. Es difícil ser un padre calmado y relajado si usted está deprimido, estresado o ansioso. Intente encontrar tiempo todas las semanas para relajarse o hacer algo que disfruta.

Estos consejos y más información están disponibles en:

www.triplep-paternidad.net/nc-uses/

TRIPLE P PEER SUPPORT & PRACTITIONER RESOURCES

Section Contents:

- Provider Directory
- PASS Model One-Pager
- Peer Support Checklist
- Agency Peer Support Contacts
- Q&A with Professor Matt Sanders – Movies
- Triple P Podcasts

TRIPLE P CABARRUS

Provider Directory

Please use this directory as a referral resource, not as a resource to distribute to parents.
For the most updated provider information, go to http://www.triplep-parenting.net/nc-en/home/ and find a Triple P Provider near you! Here you can also learn more about specific Triple P courses.

Agency	Provider Name	Triple P Course	Site/School	Office Number	E-mail	Additional Information
Annie E. Vargas Counseling Services	Annie Vargas	Level 4 Standard, Level 5 Family Transitions	Private Practice	(704) 994-5559	anniev.lcsw@gmail.com	Private clinician
Behavioral Assessment Services	Mark Solnick	Level 3 Primary Care Stepping Stones 0-12		(704) 788-8508	solnickm@yahoo.com	Private clinician; works collaboratively with Kim Mork and Developmental Peds
Boys and Girls Club of Cabarrus County	Joe Habina	Level 2 Brief Primary Care TEEN		(704) 721-2582	jhabina@bgclubcab.org	
Cabarrus County DHS	Amanda Prevette	Level 3 Primary Care 0-12 & TEEN		(704) 920-1622	ALPrevette@cabarruscounty.us	
	Cynthia Wilkerson	Level 3 Primary Care Stepping Stones 0-12		(704) 920-1494	CWilkerson@cabarruscounty.us	
	DeShawna Christian	Level 3 Primary Care 0-12 & TEEN		(704) 920-1530	DMChristian@cabarruscounty.us	
	Kesha Grant	Level 3 Primary Care 0-12 & TEEN		(704) 920-1524	KBrant@cabarruscounty.us	
	Quinton Hoskie	Level 2 Brief Primary Care TEEN		(704) 920-1501	QLHoskie@cabarruscounty.us	
Cabarrus County Schools	Alycia Nalbone	Level 3 Primary Care 0-12 & TEEN	CC Griffin	(704) 455-4700	alycia.nalbone@cabarrus.k12.nc.us	If do not see the school the child attends listed: 1. Refer to another agency for Triple P services 2. Complete CCS's survey at the link below and CCS will connect the parent with a Triple P provider. http://www.cabarrus.k12.nc.us//cms/Module/SelectSurvey/TakeSurvey.aspx
	Aronda Dunlap-Elder	Level 3 Primary Care 0-12 & TEEN	Concord High* & Middle; Beverly Hills Elementary	(704) 792-1371	aronda.dunlap-elder@cabarrus.k12.nc.us	
	Bennie Fisher	Level 3 Primary Care TEEN	Concord Middle (retiring 1/29/2016)	(704) 786-4121	bennie.fisher@cabarrus.k12.nc.us	
	Brandi Harris	Level 2 Brief Primary Care TEEN	Opportunity School	(704) 793-1736	brandi.harris@cabarrus.k12.nc.us	
	Brenda McMath	Level 3 Primary Care 0-12	Royal Oaks Elementary	(704) 932-4111	brenda.mcmath@cabarrus.k12.nc.us	
	Christy Clary	Level 2 Brief Primary Care TEEN	Mt. Pleasant Elementary, Middle, and High Schools	(704) 436-8284	christy.clary@cabarrus.K12.nc.us	
	Douglas Carr	Level 2 Brief Primary Care TEEN	Allen, Bethel, C.C. Griffin	(704) 784-5189	douglas.carr@cabarrus.k12.nc.us	
	Jacobia Williams	Level 3 Primary Care 0-12 & TEEN	Weddington Hills Elementary*; Carl Furr Elementary; Winkler Middle School; JM Robinson Middle School	(704) 792-9279	jacobia.williams@cabarrus.k12.nc.us	
	Jaimie Iovacchini	Level 2 Brief Primary Care TEEN	Patriots Elementary School; CC Griffin Middle School; Central Cabarrus High School		jaimie.iovacchini@cabarrus.k12.nc.us	
	John Basilice	Level 3 Primary Care Stepping Stones 0-12 & Level 2 Seminar 0-12	CCS Education Center	(704) 262-6143	john.basilice@cabarrus.k12.nc.us	
	Kaitlyn McEachern (Scipien)	Level 2 Brief Primary Care TEEN	Winecoff Elementary, Royal Oaks Elementary, and Cabarrus-Kannapolis Early College High School	(980) 521-0379	kaitlyn.scipien@cabarrus.K12.nc.us	
	Laura Riley	Level 2 Brief Primary Care 0-12	Mary Frances Wall Center	(704) 782-5712 ex.131	laura.riley@cabarrus.k12.nc.us	
	Lenee Mann	Level 2 Brief Primary Care TEEN	Central Cabarrus High; Rocky River Elementary; Patriots STEM Elementary School	(704) 920-7149	lenee.mann@cabarrus.k12.nc.us	
	Martha Roig	Level 2 Brief Primary Care TEEN	Winkler Middle	(704) 723-9137	martha.roig@cabarrus.k12.nc.us	
	Megan Payne	Level 2 Brief Primary Care TEEN	Harrisburg Elementary, Hickory Ridge Middle and High Schools	(704) 456-6120	megan.payne@cabarrus.k12.nc.us	
	Melissa Gallimore	Level 3 Primary Care 0-12 & TEEN & Level 2 Seminar 0-12	Boeger Elementary, Norwest Middle and High Schools	(704) 618-4617	melissa.gallimore@cabarrus.k12.nc.us	
	Michelle Klein	Level 2 Brief Primary Care TEEN	Concord Middle School, Concord High School, The Opportunity School, and R Brown McAllister Elementary School	(704) 786-4121 ex. 4451	michelle.klein@cabarrus.K12.nc.us	
	Nina Wilkerson	Level 3 Primary Care 0-12	W M Irvin Elementary*; Wolf Meadow Elementary; Coltrane-Webb STEM Elementary	(704) 792-1373	nina.wilkerson@cabarrus.k12.nc.us	
	Sandy Ward	Level 2 Brief Primary Care 0-12	Odell Elementary	(704) 497-5864	sandy.ward@cabarrus.k12.nc.us	
	**These providers are school social workers who reach multiple schools. This school is the home base for each of these staff members.*					
	Amy Potoczny (Bartlett)	Level 3 Primary Care 0-12 & TEEN, Level 3 Discussion Group 0-12, & Level 2 Seminar 0-12, Level 3 Discussion Group TEEN		(704) 920-1281	Amy.Bartlett@CabarrusHealth.org	(Amy is accredited in Level 3 Primary Care 0-12 and TEEN but not through Cabarrus and does not implement those levels. She was trained through the Cabarrus project on Discussion Group and implements that level locally)
	Angie Wallace	Level 2 Brief Primary Care 0-12		(704) 920-1285	Angie.Wallace@CabarrusHealth.org	Spanish available
	Carolina Marquez	Level 2 Brief Primary Care 0-12		(704) 920-1222	Carolina.Marquez@CabarrusHealth.org	Spanish available
	Christina Jones	Level 2 Brief Primary Care 0-12		(704) 920-1242	Christina.Jones@CabarrusHealth.org	
	Clint Cresawn	Level 4 Standard, Level 5 Enhanced, Level 2 Brief Primary Care TEEN, Level 3 Discussion Group TEEN, Level 5 Family Transitions		(704) 920-1330	Clint.Cresawn@CabarrusHealth.org	
	Corey Graham	Level 2 Brief Primary Care TEEN, Level 3 Discussion Group TEEN	KMS; AL Brown; Concord Middle; Concord High - STARS	(704) 920-1289	Corey.Graham@CabarrusHealth.org	Provides services to parents of students participating in the STARS program w/in the schools

Cabarrus Health Alliance	Dr. Valerie Sakach	Level 2 Brief Primary Care 0-12		(704) 920-1000	Valerie.Sakach@CabarrusHealth.org	
	Emma Zelaya	Level 3 Primary Care 0-12		(704) 920-1346	Emma.Zelaya@CabarrusHealth.org	Ages 0-4 years; Medicaid only; Contact Elizabeth Maldonado 704-920-1250 and explain need Triple P services. Spanish available
	Holly Williams	Level 2 Brief Primary Care 0-12		(704) 920-1349	Holly.Williams@CabarrusHealth.org	
	Jenn West	Level 5 Group Lifestyle		(704) 920-1337	Jennifer.West@CabarrusHealth.org	
	Jossie Evans	Level 2 Brief Primary Care 0-12		(704) 920-1338	Jossie.Evans@CabarrusHealth.org	Spanish available
	Katie Dight	Level 3 Primary Care 0-12 & TEEN, Level 3 Discussion Group TEEN	KMS; AL Brown; Concord Middle; Concord High - STARS	(704) 920-1341	Katie.Dight@CabarrusHealth.org	Provides services to parents of students participating in the STARS program w/in the schools
	Kelly Bryant	Level 3 Primary Care, Level 3 Discussion Group	J.M. Robinson, Concord High, Central Cabarrus, Northwest Cabarrus High, Performance Learning Center, Mount Pleasant High, AL Brown	(704) 920-1351	Kelly.Bryant@CabarrusHealth.org	(Kelly was not trained through Cabarrus but currently serves pregnant/parenting students at any school in KCS or CCS)
	Mary Medlin	Level 2 Brief Primary Care 0-12		(704) 920-1271	Mary.Medlin@CabarrusHealth.org	
	Megan Shuping	Level 5 Group Lifestyle		(704) 920-1296	Megan.Shuping@CabarrusHealth.org	(Does not currently implement Group Lifestyle)
	Meghan Charpentier	Level 5 Group Lifestyle		(704) 920-1324	Meghan.Charpentier@CabarrusHealth.org	
	Pam Eubanks	Level 3 Primary Care 0-12		(704) 920-1122	Pamela.Eubanks@CabarrusHealth.org	Ages 0-4 years; Medicaid only; Contact Elizabeth Maldonado 704-920-1250 and explain need Triple P services
	Sonja Bohannon-Thacker	Level 3 Primary Care 0-12 & TEEN		(704) 920-1323	Sonja.BohannonThacker@CabarrusHealth.org	Women/couples, Pregnant, PP women Sliding fee scale, Medicaid
	Susan Horne	Level 3 Primary Care 0-12		(704) 920-1251	Susan.Horne@CabarrusHealth.org	Ages 0-4 years; Medicaid only; Contact Elizabeth Maldonado 704-920-1250 and explain need Triple P services
Cabarrus Rowan Community Health Center	Michelle Wilson	Level 3 Primary Care 0-12 & TEEN	McGill Family Med.; Logan Family Med.; China Grove Family Medicine; Spencer Family Med. (northern Rowan)	(704) 792-2288	mlwilson@crchc.org	Provide support to established patients or parents of patient@ one of four clinics.
Cano Family Services	Angela Cano-Johnson	Level 3 Primary Care 0-12, Level 4 Standard, Level 2 Brief Primary Care TEEN, Level 3 Discussion Group TEEN, Level 5 Family Transitions		(980) 621-8401	Angela.Cano@CanoFamilyServices.com	Angela is accredited in Level 3 Primary Care 0-12, Level 4 Standard and Level 2 Seminar but not through Cabarrus. Also serves Mecklenburg County. Spanish available
Carolina Counseling Inc.	Charlotte Eure	Level 3 Primary Care 0-12 & TEEN, Level 4 Standard 0-12, Level 3 Discussion Groups 0-12, Level 3 Discussion Group TEEN, Level 5 Family Transitions		(704) 721-0000	cci.charlotte@yahoo.com	Cash, Medicaid, and most insurances
	Karissa Krapf	Level 2 Brief Primary Care 0-12, Level 2 Brief Primary Care TEEN, Level 3 Discussion Group TEEN		(704) 721-0000	karissa.krapf.lcsw@outlook.com	
	Sandra Ritter	Level 3 Primary Care 0-12 & TEEN, Level 4 Standard 0-12, Level 3 Discussion Groups 0-12, Level 5 Family Transitions		(704) 721-0000	carolinacounseling@yahoo.com	
	Tonda Childers	Level 2 Brief Primary Care 0-12		(704) 721-0000	tchilders2@liberty.edu	
Carolina Parenting Solutions	Ashley Nordby	Level 2 Brief Primary Care 0-12		(704) 718-8657	ashleyn@carolinaparentingsolutions.com	
	Ashley Schlieper	Level 4 Standard 0-12		(704) 718-8657	ashley@carolinaparentingsolutions.com	Ages 0-8 years
	Diana Torres	Level 4 Standard 0-12		(704) 718-8657	diana@carolinaparentingsolutions.com	Ages 0-8 years; Spanish available
	Janine Denoncourt	Level 4 Standard 0-12		(704) 718-8657	janine@carolinaparentingsolutions.com	Ages 0-8 years
	Jessica Kossick	Level 4 Standard 0-12		(704) 718-8657	jessica@carolinaparentingsolutions.com	
	Tiffany Denoncourt	Level 3 Primary Care Stepping Stones 0-12		(704) 718-8657	tiffanyd@carolinaparentingsolutions.com	All providers accept private insurance and Medicaid.
Carolinas Medical Center - NorthEast (CHS)	Robin Holland	Level 3 Primary Care 0-12 & TEEN	Carolinas Medical Center - NE	(704) 403-3821	Robin.Holland@carolinashealthcare.org	
Community Specialized Services, Inc.	Yaqui Busby	Level 3 Primary Care 0-12 & TEEN		(704) 795-7600 ext. 107	ybusby-cssi@carolina.rr.com	
Concord CDSA	Heather Jacobs	Level 3 Primary Care Stepping Stones 0-12		(704) 786-9181 ext. 239	heather.jacobs@dhhs.nc.gov	Ages 0-3 years
	Tim Truemper	Level 3 Primary Care Stepping Stones 0-12		(704) 786-9181 ext. 220	tim.truemper@dhhs.nc.gov	Ages 0-3 years
Concord Police Department	Kelly Seagraves	Level 3 Primary Care 0-12 & TEEN	School Resource Officer at Concord Middle School	(704) 920-5000	seagrakl@concordnc.gov	
Conflict Resolution Center	Cynthia Seaforth	Level 3 Primary Care 0-12 & TEEN, Level 3 Discussion Group TEEN, Level 4 Standard, Level 5 Family Transitions		(704) 786-1820	ccmctcp@ctc.net	Mediation Center through TEEN Court
	Jennifer Plaster	Level 3 Primary Care TEEN		(704) 786-1820	jplaster@nomoreconflict.org	
	Kathy Walker	Level 3 Primary Care TEEN		(704) 786-1820	4cabcotruancy@nomoreconflict.org	
Cooperative Christian Ministry	Pam Smith	Level 3 Primary Care 0-12, Level 3 Discussion Groups 0-12		(704) 918-1484	psmith@cooperativeministry.com	Mother's and Children's Home
Counseling Center At Concord	Erin Messmer	Level 3 Primary Care 0-12 & TEEN		(704) 507-7360	erin.messmer@outlook.com	Private clinician

Crossroads Church	Tammy Blackburn	Level 2 Brief Primary Care 0-12, Level 2 Seminar 0-12, Level 2 Brief Primary Care TEEN, Level 3 Stepping Stones Primary Care		(704) 707-1170	tammy.blackburn@mycrossroads.co	
Daymark Recovery Services	Anthony St. Louis	Level 3 Primary Care 0-12 & TEEN		(704) 490-3116	LouisnLouis44@yahoo.com	Services available to anyone; diagnosis needed. Accepts insurances and sliding fee
	Ashley Searing	Level 3 Primary Care 0-12 & TEEN		(704) 939-1100	asearing@daymarkrecovery.org	
	Betsy Karas	Level 3 Primary Care 0-12		(704) 939-1100	bkaras@daymarkrecovery.org	
Developmental and Behavioral Pediatrics of the Carolinas (CHS)	Angela Noone	Level 3 Primary Care Stepping Stones 0-12		(704) 403-2693	angela.noone@carolinashealthcare.org	*not accepting outside referrals at this time
	Wes Hatley	Level 3 Primary Care Stepping Stones 0-12		(704) 403-2626	george.hatley@carolinashealthcare.org	
Family Counseling Center	Alisha Cooper	Level 3 Primary Care 0-12 & TEEN		(704) 999-8797	lifeprintscounseling@yahoo.com	Spanish available
	Kim Mork	Level 3 Primary Care Stepping Stones 0-12		(704) 403-2692	hmork@carolina.rr.com	Located within Developmental and Behavioral Pediatrics; not accepting referrals at this time.
Family Enrichment Center	Angie Owen-Killar	Level 3 Primary Care Stepping Stones 0-12	Private Practice	(704) 786-4503	aowenkillar@ctc.net	Private clinician
	Sandy Garmon	Level 3 Primary Care 0-12 & TEEN	Private Practice	(704) 351-2103	sandygarmon@gmail.com	Private clinician
	Sarah Fishback	Level 3 Primary Care 0-12 & TEEN	Private Practice	(704) 467-6603	fishbackpsychservices@gmail.com	Private clinician
Family Support Network of Southern Piedmont	Carol Cranford	Level 3 Primary Care Stepping Stones 0-12		(980) 522-8740	ccranford@fsnsp.org	Serving families within their program
Finding Solutions, Inc.	Melba Finley	Level 4 Group, Level 5 Family Transitions	Private Practice	(980) 428-6696	mfinley@findingsolutionsinc.com	Private clinician
Genesis…A New Beginning	Salvador Callejas	Level 3 Primary Care 0-12 & TEEN, & Level 2 Seminar 0-12		(704) 720-7770	callejas2000@gmail.com	Accepting walk-ins and referrals. Spanish available.
Grace Lutheran Church	LaTisha Young	Level 2 Brief Primary Care TEEN		(704) 782-7620	y.latisha@yahoo.com	
Hope, Heal and Peace Center	Chanell Ketchmore	Level 3 Primary Care 0-12 & TEEN, Level 4 Standard 0-12, Level 3 Discussion Groups 0-12, & Level 2 Seminar 0-12, Level 3 Discussion Group TEEN, Level 5 Family Transitions		(980) 349-0233	ketchmore@gmail.com	Accepting referrals
	Sharon Young	Level 3 Primary Care 0-12 & TEEN		(980) 349-0233	Shaysha269@gmail.com	
	Wandrika Borders	Level 3 Primary Care 0-12 & TEEN, Level 3 Discussion Group TEEN		(980) 349-0233	wsborders75@gmail.com	
Kannapolis City Schools	Brenda Toledano	Level 3 Primary Care Stepping Stones 0-12	KCS Headstart	(704) 932-7433 ext. 229	brenda.toledano@kcs.k12.nc.us	Spanish available
	Claudia Martins	Level 3 Primary Care TEEN		(704) 932-6125 ext. 616	claudia.martins@kcs.k12.nc.us	Spanish available
	Dee Gantt	Level 3 Primary Care Stepping Stones 0-12		(704) 932-7433 ext. 228	dee.gantt@kcs.k12.nc.us	
	Dia Harden	Level 3 Primary Care TEEN	AL Brown High School	(704) 932-4102 ext. 8114	dia.harden@kcs.k12.nc.us	
	Donna Gerdes	Level 3 Primary Care 0-12	Shady Brook Elementary	(704) 933-2434	donna.gerdes@kcs.k12.nc.us	
	Jasmine Goldman	Level 2 Brief Primary Care 0-12	Jackson Park Elementary	(704) 933-2831	jasmine.goldman@kcs.k12.nc.us	
	Kim Cibak	Level 2 Brief Primary Care 0-12	Woodrow Wilson Elementary	(704) 933-2935	kimberly.cibak@kcs.k12.nc.us	
	Krista Chapman	Level 3 Primary Care Stepping Stones 0-12	Behavior Liaison Specialist	(704) 938-3151 ext. 211	krista.chapman@kcs.k12.nc.us	
	LiKina Turner	Level 2 Brief Primary Care TEEN		(704) 932-6125	likina.turner@kcs.k12.nc.us	
	Susan Puckett	Level 2 Brief Primary Care 0-12	Forest Park Elementary	(704) 932-8121	susan.puckett@kcs.k12.nc.us	
Kids Interactive Developmental Services	Darcy Bromley	Level 3 Primary Care Stepping Stones 0-12		(704) 773-2584	dbl0606@hotmail.com	Ages 0-5 years
	Pamela Ragan	Level 3 Primary Care Stepping Stones 0-12		(704) 224-3687	kidsnc@aol.com	
Kids' Korner Child Development Center	Danielle Mauldin	Level 2 Brief Primary Care 0-12		(704) 938-9322	danielle@kidskornercdc.com	
Konikoff Counseling	Randi Konikoff	Level 3 Primary Care 0-12 & TEEN		(704) 200-1787	randikonikoff@yahoo.com	Private clinician
Nazareth Children's Home	Gerhronda Cannady	Level 2 Brief Primary Care TEEN		(704) 279-5556 ext. 114	gcannady@nazch.com	
	Jacqueline Millican	Level 4 Standard 0-12		(704) 636-5522 ext. 124	jmillican@nazch.com	
	Ty Kays	Level 4 Standard 0-12		(704) 636-5522	tykays@ymail.com	
RHA Health Services	Eric Tucker	Level 4 Standard 0-12		(704) 721-5551	etucker@rhanet.org	Intensive in-home services
	Lakesha Shingler	Level 4 Standard 0-12, Level 5 Family Transitions		(704) 721-5551	lshingler@rhanet.org	
	Shakeena Speller	Level 4 Standard 0-12, Level 5 Family Transitions		(704) 721-5551	sspeller@rhanet.org	
Sims Consulting and Clinical Services	Arlana Sims	Level 4 Standard 0-12, Level 5 Family Transitions		(704) 630-6634	asims@simsconsulting.net	
	Barbara Bell	Level 4 Standard 0-12, Level 2 Brief Primary Care TEEN, Level 5 Family Transitions		(704) 630-6634	bbell@simsconsulting.net	
	Jennifer Collins	Level 3 Primary Care 0-12 & TEEN, Level 3 Discussion Group 0-12, Level 4 Standard 0-12, Level 5 Family Transitions		(704) 630-6634	mazdachic95@yahoo.com	
	Siobhan Allen-Terry	Level 4 Standard 0-12, Level 5 Family Transitions		(704) 630-6634	Siobhan_all@yahoo.com	
Suburban Pediatrics Clinic	Kym Selden	Level 2 Brief Primary Care 0-12		(704) 403-7740	kymberly.selden@carolinashealthcare.org	
	Mary Garrison	Level 2 Brief Primary Care 0-12		(704) 403-7740	mary.garrison@carolinashealthcare.org	
	Shelley Houston	Level 2 Brief Primary Care 0-12		(704) 403-7740	shelley.houston@carolinashealthcare.org	
Thompson Child & Family Focus	Sue Aschenbrenner	Level 3 Primary Care 0-12, Level 3 Discussion Groups 0-12		(704) 771-3576	saschenbrenner@thompsoncff.org	Not accepting referrals; Both work with daycare facilities
	Tanisha Jones	Level 3 Primary Care 0-12, Level 3 Discussion Groups 0-12		(704) 309-0534	tjones@thompsoncff.org	
Vision for Life of Kannapolis	Christine Harper	Level 3 Primary Care TEEN		(704) 960-5215	clharper09@gmail.com	

THE PEER-ASSISTED SUPERVISION AND SUPPORT (PASS) MODEL

The Peer-Assisted Supervision and Support (PASS) model has been developed as a workforce development strategy to facilitate the process of peer support among practitioners. It is a structured feedback process to promote learning of a complex set of consultation skills. It is especially useful for less experienced practitioners, but is also useful for those with the same level of experience. The PASS model is intended to be used by practitioners throughout their careers, but is particularly beneficial when they are learning to implement a new intervention, such as the Triple P – Positive Parenting Program®.

Key aspects of the PASS model for communication to practitioners

- Participants are both recipients and providers of peer support.
  - Potential benefits involve having the opportunity to reflect on one's own practice, knowledge, and decision making skills, such as how one relates to parents, how well one communicates with parents, one's knowledge and understanding of Triple P strategies, and techniques for dealing with parental resistance.
  - The PASS process requires collegial and collaborative interactions, as opposed to competitive ones. The goal is that all participants benefit from each other's knowledge, observations, and experiences in delivering Triple P.

- The use of the self-regulatory framework is emphasized.
  - The model promotes practitioners' competent use of the program through fostering independent decision making, clinical reasoning and self-directed learning.
  - Practitioners are encouraged to identify their strengths as well as any challenges or implementation difficulties they face.
  - Practitioners are encouraged to 'own' the process of becoming skilled at parent consultation and to become active problem solvers who can initiate requests for assistance and support after first having attempted to address or resolve the concern or problem themselves.
  - The principle of minimal sufficiency is encouraged in providing feedback; just enough help or hints are provided (i.e. no more than is needed) for the practitioner to solve the problem themselves.

- A PASS session involves three key activities:
  - Case review – practitioners discuss an actual case using pre-recorded footage, audiotape or detailed written case notes to review a Triple P session. A 5 to 10-minute segment of video or audio footage is sufficient.
  - Discussion of implementation issues – using the self-regulatory framework.
  - Professional development activity – a range of activities can be discussed during this period (e.g. review a tip sheet, discuss a scientific article or listen to a podcast by Professor Sanders). This section should be a topic of interest or challenge to the group, such as: using Triple P evaluation tools with low literacy parents; maintaining program integrity; flexible use of Triple P; engaging hard to reach families; cultural diversity; or involving teens within sessions.

THE PEER-ASSISTED SUPERVISION AND SUPPORT (PASS) MODEL

- Practitioners take turns in serving one of three roles:
  - Peer facilitator
    - Prepares the agenda and identifies priority issues.
    - Introduces the session, including setting the agenda, who will be presenting, and the professional development activity.
    - Keeps time and helps group members stay on agenda.
    - Reminds group members about the use of the self-regulatory framework as needed.
    - Keeps note of common or complex problems encountered by practitioners for further discussion, and any resistance being exhibited by practitioners to Triple P or the PASS session.
  - Practitioner
    - Shares their experiences delivering Triple P.
    - Brings along a video or audio segment of a session, or detailed case notes, preferably a section where things went well and another section that didn't go well. (Remember, parent consent is required for audio/videotapes to be used.)
    - Reviews audio/videotape or case notes using the self-regulatory model to identify strengths and areas for improvement.
    - Attempts to problem solve any issues before asking for feedback from the peer mentors.
    - Aims to be willing to receive feedback from peer mentors and incorporate their ideas and observations into future practice.
  - Peer mentor/s (all remaining group members)
    - Guides the practitioner to use the self-regulatory model to review their presented session.
    - Reinforces the practitioner's successes.
    - Helps the practitioner to problem solve any implementation issues using the principle of minimal sufficiency.
    - Offers their own observations or experiences as needed to assist the practitioner, and does so in a way that is objective, non-judgmental, and specifically describes the behaviour or skill demonstrated.
    - Encourages the use of role play to assist the practitioner rehearse a particular skill.

- PASS sessions are conducted in small groups of up to six or eight practitioners, and last about one-and-a-half to two-hours.

- It is recommended that PASS sessions are scheduled with regular frequency leading up to accreditation and while practitioners are acquiring skills. After that time, it is recommended that approximately 10 PASS sessions are held per year.

- Advance preparation will assist in making PASS sessions successful.
  - Preparation may include: ensuring materials and equipment are available (e.g. DVD player, practitioner kits, tip sheets, video footage), selecting a venue, choosing a convenient date and time, promoting PASS sessions among colleagues, selecting and completing any background reading (e.g. for professional development activity), developing an agenda, assigning PASS roles and having someone take notes, obtaining parent consent for use of video/audio footage.
  - These issues should be highlighted during the group discussion.

Peer Supervision & Support Checklist

Click here for the Peer Supervision & Support Checklist in Word format for editing purposes.

Date: _____/_____/_____Start time:_____ End Time: _____

Name of facilitator: _____

Names of practitioners in attendance: _____

_____

CONTENT CHECKLIST:

1. Agenda

Names of practitioners to review aspects of their work: _____

General cases and/or issues/concepts, etc., to be discussed: _____

2. Case presentations (allow about 15 minutes each)

- Practitioner/s *briefly* present an *aspect* of their work they want help with; succinctly summarize in writing or verbally for necessary background
- Prompt practitioner/s to evaluate his/her own work using a self-regulatory framework
    - Ask what worked (at least two positive points)
    - Ask what they would do differently
    - Ask other group participants to provide constructive feedback
    - Encourage practitioner/s to set *specific* goals for what they'll do differently next time
- Repeat this process for each presentation

3. Other issues

Discuss any other general cases/challenges/issues that practitioners want to cover (use minimal prompts to help practitioners solve any problems).

4. Meeting close

Summarize the main points discussed in the meeting.

_____
_____
_____

Are there any unresolved issues to follow up on?

_____
_____

What are the issues for the next agenda?

_____
_____

Identify practitioners (1-3) to review cases at the next meeting.

_____
_____

Facilitator of next meeting:

Next meeting: / /
am/pm

Triple P – Positive Parenting Program

Agency Peer Support Contacts

Agency	Contact Person	Phone
Cabarrus County DHS	DeShawna Christian	704.920.1530
Cabarrus County Schools	Aronda Dunlap-Elder	704.792.1371
Cabarrus Health Alliance – Clinic	Holly Williams	704.920.1349
Cabarrus Health Alliance – FCC/WIC/STARS	Susan Horne/Katie Dight	704.920.1251
Carolina Counseling and Consultation	Sandy Ritter	704.721.0002
Carolina Parenting Solutions	Diana Torres	704.718.8657
Concord CDSA	Heather Jacobs	704.786.9181, x239
Conflict Resolution Center	Cynthia Seaforth	704.786.1820
Daymark Recovery Services	Jenna Daley	704.892.9490
Developmental and Behavioral Pediatrics of the Carolinas (CHS)	Rhonda Hartsell/ Mark Solnick/Kim Mork	704.403.2690
Family Enrichment Center	Sandy Garmon	704.351.2103
Family Support Network of Southern Piedmont		
Hope, Heal and Peace Center	Chanell Ketchmore	980.349.0233
Kannapolis City Schools	Angela Ward	704.932.6125
Kids Interactive Developmental Services		
Nazareth Children's Home	Jacqueline Millican	704.636.5522, x124
RHA Health Services	Shakeena Speller	704.721.5551
Sims Consulting and Clinical Services	Priscilla Cooke	704.630.6634
Thompson Child & Family Focus	Sue Aschenbrenner/Tanisha Jones	704.771.3576

Triple P – Positive Parenting Program

Q&A with Professor Matt Sanders

Dr. Sanders, the founder of Triple P, has created brief (5-10 minutes) videos for practitioners on various topics or questions that practitioners have as they begin to implement Triple P with parents. Examples of videos provided are listed below. These videos are updated monthly and are available to practitioners by logging on to the Provider Network found on the North Carolina Triple P website or by clicking here.

1. What are the traps and hazards of giving children rewards?
2. How can I make Stepping Stones work for different disability groups?
3. What should I do to ensure I'm addressing issues relevant to fathers in mixed gender groups?
4. How do I help a parent deal with sibling conflict?
5. How do I work with a parent to decide which Triple P is best for them?
6. What tips can you share for delivering Triple P with an interpreter?
7. How do I know when a parent is self-regulating and why does it matter?
8. How do I choose observation tasks to catch important parent-child interactions?
9. Does Triple P promote attachment?
10. I've finished training. What now?
11. What is facilitative parenting and how can I teach parents about it?
12. What can I do to support parents who have more than one child with behavior problems?
13. What is sufficient exemplar training?
14. Can parents praise too much?
15. What do I say to parents who think their child's problems are purely genetic/biological?
16. How can I encourage parents to do Triple P?
17. How should I work with parents with low literacy?
18. How can I help parents manage their escalation?
19. How can I select the best homework tasks for parents?
20. How can I avoid running overtime on every group session?
21. What could I do when parents say they are using corporal punishment?
22. How can I make the most of role plays?
23. What are some tips for working with mandated parents?
24. What can I do if a parent brings their child to an individual Triple P session?
25. How could I help parents with problems at schools?
26. What is meant by attributions?
27. How can I work more collaboratively with parents?
28. How do I promote the generalization of parenting skills with parents?

Triple P – Positive Parenting Program

Triple P Podcasts

Triple P's Professor Matt Sanders and Dr. Alan Ralph have developed podcasts on some of the most useful topics in the world of parenting. Some topics include how to effectively use time out, the impact television has on development, how to address bullying, and the importance of positive praise. Visit Radio 612 ABC or click one of the links below to listen to the podcast.

1. Triple P Podcast: Conflict at school - Kids fight - but how do you teach them to resolve their arguments when you're not there to break it up?
2. Triple P Podcast: Unemployment - If you have lost your job, how do you broach it with your children?
3. Triple P Podcast: Chores - It can be one of the most frustrating things about family life - getting everyone to pull their weight with household chores. Everyone helps make the mess, so everyone needs to help clean it up right?
4. Triple P Parenting: Monosyllabic Teens - What to do when your children won't speak to you...when one word says it all
5. Triple P Podcast: Preparing for Prep - Is the first day of school more traumatic for the parent or the child? How can you make your child ready for school?
6. Triple P Podcast: Quality Time - What is most important when it comes to spending time with your kids?
7. Triple P Podcast: Technology in the home - Do you ever find yourself looking at your phone over dinner? Do you spend time on the internet when you could be talking to your kids? How much do communication gadgets intrude on your family life?
8. Triple P Podcast: Comfort toys - Does your child have trouble sleeping without their soft toy or blanket? When should you encourage children to give up their comfort toys?
9. Triple P Podcast: Exams - What can you do to manage stress levels when exam time rolls around? The Positive Parenting Program has some tips for parents and children.
10. Triple P Podcast: Mother daughter relations - How does a mother guide their daughter through the teenage years, but maintain a loving and communicative relationship?
11. Triple P Podcast: Going to the show - The Positive Parenting Program tips on getting the most out of a family day out at the country show.
12. Triple P Podcast: Adolescence - Parents of teenagers don't have it easy, Professor Alan Ralph from the Positive Parenting Program has some tips on keeping your cool.
13. Triple P Podcast: Fears - According to Associate Professor Alan Ralph from the Positive Parenting Program a childhood fear is common.
14. Triple P Podcast: Absences - Whether you work in business, the defense forces or as a fly-in/fly-out worker, absences can add complication to family life.
15. Triple P Podcast: Praise - Praising your children is important, but you need to get the balance right according to Professor Alan Ralph.
16. Triple P Podcast: Emotional regulation - When a child is frustrated and acting out, a parent has an open invitation to teach them a valuable life skill according to Associate Professor Kate Sofranoff.

17. Triple P Podcast: Physical disability - Parenting can be one of the most difficult jobs, but what are the challenges of having a child with a physical disability?
18. Triple P Podcast: Autism - Parenting can be hard at the best of times, but what if your child has challenging behavior?
19. Triple P Podcast: Children and their fathers - How has your father influenced your life? Research suggests a father figure is an important part of any child's development.
20. Triple P Podcast: Pocket money - Teaching you child about financial matters is a skill that will benefit them throughout their life - but when do you start giving pocket money, and how much should you give?
21. Triple P Podcast: Shy children – Dr. Alina Morawska from the Triple P Parenting Program says shyness and social anxiety can prevent a child from doing things they enjoy and make everyday occasions stressful.
22. Triple P Podcast: Competition - Should every child get a ribbon at the swimming carnival, or do winning and losing teach valuable life lessons?
23. Triple P Podcast: Sex - Birds do it, bees do it but how do you talk to your kids about sex?
24. Triple P Podcast: Educational media and children - Do educational toys really do anything to help your child? Can you really teach your baby to read? Dr. Alina Morawska from the Positive Parenting Program says well marketed products won't necessarily help your child develop any faster.
25. Triple P Podcast: children and television - Television surrounds our children, but does the influence help or hinder our children's development?
26. Triple P Podcast: technology - Mp3 players, mobile phones, video games, computers and tablets - technology surrounds our children, but how do you get them to put the devices down and play outside?
27. Triple P Podcast: Delayed gratification - Could the difference between your child eating all their easter eggs at once or savoring them to eat slowly over time be an indicator of their future success?
28. Triple P Podcast: Stress - We all go through situations that make our blood pressure rise, but how do our stress levels affect our children?
29. Triple P podcast: work life balance - How do we get the work/life balance right for our children?
30. Triple P Podcast: meal times - Do you dream of a dinner table where all your children have perfect manners and eat what is put in front of them?
31. Triple P podcast: gifted children - How do you support a gifted child?
32. Triple P podcast: Time out - Practical advice on how to use 'time out' effectively.
33. Triple P podcast: first time away - When a child leaves your care for the first time to go to childcare or school, it can be stressful for child and parent alike.
34. Triple P Podcast: toddler travel - Considering taking a toddler on a trip? Professor Matt Sanders has some practical advice.
35. Triple P Podcast: surviving the silly season - Family get-togethers and children's boredom can put the strain on parents at Christmas time. Professor Matt Sanders from the University of Queensland's Positive Parenting Program (Triple P) shares his survival tips.
36. Triple P Podcast: Being up for the job - parenting - Would you respond to this job ad? One couple to raise a child. No experience necessary. Applicants must be available 24 hours a day, 7 days a week. You must provide food, shelter, clothing and supervision. No training provided. No salary - applicants pay 400-thousand dollars over the next 18 years.
37. Triple P Podcast: Children and loneliness - Professor Matt Sanders from the Positive Parenting Program at the University of Queensland says it is common for parents to worry when their child is seen having trouble with peer relationships.

38. Triple P Podcast: Leaving School - It's the end of an era for grade 12 students across Queensland this week as they pack their school bags for the last time as high school students. Professor Matt Sanders from the Positive Parenting Program says its a transitional time for students and parents.
39. Triple P Podcast: Teenagers and Jobs - What age is appropriate for an after school or holiday job for your teenager?
40. Triple P Podcast: Disciplining another person's child - When is it ok to discipline another person's child? Associate Professor Alan Ralph from the Positive Parenting Program says every family has their own way of disciplining their children, so you have to delicately negotiate the situation.
41. Triple P Podcast: Working parents - Associate Professor Alan Ralph from the Positive Parenting Program says well over half of parents both work outside of the home - so how do working families cope with the demands of home life and work life?
42. Triple P Podcast: Building Self Confidence - Associate Professor Alan Ralph of the Positive Parenting Program says not all children come with 'in-built' optimism and self confidence so it's important to begin building confidence in children from a young age.
43. Triple P Podcast: Teen pregnancy - Pregnancy can be an overwhelming experience at any age, but how do you deal with your teenaged child who comes home and tells you they are expecting a child?
44. Triple P Podcast: Losing a Grandparent - By the laws of nature grandparents won't be around forever. So how do you help a child understand the loss of their grandparents?
45. Triple P Podcast: Losing their virginity - Your teenager tells you they're about to go 'all the way', what do you do?
46. Triple P Podcast: Dealing with suicide - When someone close to your family takes their own life, what's the best way to break the news to the children?
47. Triple P Podcast: Making friends - How to make friends... and keep them.
48. Triple P Podcast: - How do you teach children to problem solve?
49. Triple P Podcast: Habits - From biting nails and sucking thumbs to nose picking, how do we prevent children forming bad habits?
50. Triple P Podcast: Teaching kids stranger danger - When warning children about 'stranger danger', it's important to strike the right balance: warning children to be wary without creating a world of threat and danger.

TRIPLE P EVALUATION

Section Contents:

- Level 2 Evaluation
  - Primary Care 0-12 & TEEN Evaluation Manual
  - Caregiver Contact Record
  - Caregiver Satisfaction Questionnaire – English & Spanish
  - Brief Primary Care Session Checklists
- Level 2 Evaluation – Seminar
  - Seminar Sign-In Sheets
  - Seminar Parent Satisfaction Survey
- Level 3 Evaluation – Primary Care
  - Primary Care 0-12 & TEEN Evaluation Manual
  - Caregiver Contact Record
  - Parenting Experience Survey – PRE – English & Spanish
  - Parenting Experience Survey – POST – English & Spanish
  - Caregiver Satisfaction Questionnaire – English & Spanish
  - Primary Care 0-12 Session Checklists
  - Primary Care TEEN Session Checklists
- Level 3 Evaluation – Discussion Group
  - 0-12 Sign-In Sheet
  - TEEN Sign-In Sheet
  - 0-12 & TEEN Caregiver Satisfaction Questionnaire
- Level 4 & 5 Evaluation
  - Evaluation Manual
  - Caregiver Contact Record
  - PRE & POST Parenting Scale – English & Spanish
  - PRE & POST Strength & Difficulties Questionnaire Instructions
  - Caregiver Satisfaction Questionnaire – English & Spanish
  - Level 4 Standard – Session Checklists
  - Level 5 Family Transitions – Session Checklists
  - Level 5 Group Lifestyle – Session Checklists

Please send all evaluation data to your local Triple P coordinator. Contact Myocia Young-Montgomery by email at myocia.young-montgomery@mecklenburgcountync.gov or by phone at 704-617-2176 for any evaluation questions or concerns.

Evolution tools, including the session checklists can be found here or on the Provider Network under the Implementation tab.

LEVEL 2 TRIPLE P

Evaluation Manual

Dear Cabarrus Triple P Provider,

Thank you for partnering with the Cabarrus Health Alliance (and Mecklenburg County) to demonstrate the impactful work you will continue with families in Cabarrus County. Evaluation activities are a required part of being a Cabarrus-trained Triple P Provider. Data collection tools not only provide useful information to the provider and caregiver during the intervention but also are mandated by the NC Department of Public Health for funding purposes. CHA was purposeful in selecting only the minimal number of tools and shortened versions in order to minimize the time needed for evaluation efforts. Please refer to the Memorandum of Agreement for a description of the evaluation commitment for your agency. Please contact Myocia Young-Montgomery by email at myocia.young-montgomery@mecklenburgcountync.gov or by phone at 704-617-2176 for questions regarding evaluation for Triple P.

Edited 4/25/2016

Triple P Evaluation Manual
LEVEL 2 - BRIEF PRIMARY CARE

CONTENTS

1. Instructions
2. Caregiver Contact Record (CCR)
3. Caregiver Satisfaction Questionnaire (CSQ)
4. Fidelity Adherence Session Checklists

*Electronic versions of these tools available at: http://www.cabarrushealth.org/268/Triple-P-Provider

EVALUATION INSTRUCTION SHEET

Data Collection Schedule

SESSION 1:
• Document session on Caregiver Contact Record
• Complete Session 1 Checklist
SESSION 2: (IF APPLICABLE)
• Document session on Caregiver Contact Record
• Complete Session 2 Checklist
• Collect Client Satisfaction Questionnaire

- ***INTERVENTIONS THAT ONLY HAD <u>ONE SESSION</u> ONLY NEED TO SUBMIT CAREGIVER CONTACT RECORD***

- ***Providers that work in a clinic/medical setting and cannot complete the individual client contact form may submit a printed or electronic document of all clients served during the reporting period. The form/document can be designed to meet the individual needs of the practice as long as it documents the number of clients, dates receiving Triple P intervention, and the Triple P provider. It does not have to contain identifying client information.***

Description of Data Collection Tools

TOOL	COMPLETED BY:	COMPLETED DURING:	INSTRUCTIONS
Caregiver Contact Record (CCR)	Provider	Every session or contact with caregiver. Includes telephone conversations or follow-ups.	• Enter Caregiver(s) name(s), DOB, zip code, county of residence, telephone #, your name, agency, and the intervention level (2 or 3) and type. • Record every date in which contact is made with caregiver. • Record who attended the intervention and their relationship to the primary child. • Provide a brief description of the activity (ex. Session 1, tip sheet, phone conversation, etc.). • Provide estimate of time spent with caregiver. • Maintain copy for your records and turn in a copy to CHA once intervention is completed or no further contact will be made with caregiver for Triple P. • Assign your own identifier if the caregiver does not authorize release of information.
Caregiver Satisfaction Questionnaire (CSQ)	Every caregiver present	Session 2	• Each caregiver present must complete a separate CSQ. • Provider fills out 'Provider Name' and 'Triple P Level' at the top of the sheet. • Stress importance of being honest in order to get an accurate assessment. • Caregiver will need to identify a 'primary child' for whom they are primarily seeking Triple P services. • Original unabridged form is available in multiple languages on Triple P provider network. Triple P Cabarrus form is an abridged version of the CSQ. • Maintain copy for your records and turn in a copy to CHA once intervention is completed or no further contact will be made with Caregiver for Triple P.
Fidelity Adherence Session Checklist	Provider	Every session	• Document Client Information and session data (or date range if session is split up across several dates) • Check if each item was completed; enter 'not completed' if it was not completed

Submission of Data Collection Tools

Timeline

Completed evaluation packets must be submitted to Triple P Mecklenburg for the corresponding reporting period on the following dates each year:

REPORTING PERIOD	DATA SUBMISSION DUE DATE
January 1 – March 31	**April 8**
April 1 – June 30	**July 8**
July 1 – September 30	**October 8**
October 1 – December 31	**January 8**

1. Submission Due Date: **April 8** for interventions completed during **[January 1 – March 31]**
2. Submission Due Date: **July 8** for interventions completed during **[April 1 – June 30]**
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4. Submission Due Date: **January 8** for interventions completed during **[October 1 – December 31]**

NOTE:

- An email reminder will be sent to providers to submit evaluation packets for all Caregivers who have completed the intervention prior to the submission deadline.
- Providers may also choose to submit completed evaluation packets at any time prior to the submission deadline on an on-going basis if they prefer.
- Incomplete interventions only need to submit the Caregiver Contact Record.

Method for Submission

Option 1: Your organization can designate one person to collect all the evaluations and schedule a day for evaluations to be picked up. Contact Myocia Young-Montgomery at 704-617-2176 or myocia.young-montgomery@mecklenburgcountync.gov to arrange for evaluation packet pick-up.

Option 2: You may scan evaluation packets (CCR, CSQ (if applicable), and Session Checklists) and email them to Myocia Young-Montgomery myocia.young-montgomery@mecklenburgcountync.gov

Option 3: You may fax evaluation packets (CCR, CSQ (if applicable), and Session Checklists) to 704-602-6954…. (the fax is confidential)

Option 4: Mail completed evaluation packets (CCR, CSQ (if applicable), and Session Checklists) using pre-paid envelops provided by June 15, 2016 for practitioners desiring to mail in packets. Packets should be mailed to:

Southeast Health Department
ATTN: CATHY HENDERSON, TRIPLE P
249 Billingsley Road
Charlotte, NC 28211

Triple P Provider Name: _____ **Provider Agency:** _____

Triple P Mecklenburg

FAMILY INFORMATION & CAREGIVER CONTACT FORM

Caregiver (First Name, Last Initial): _____ **Caregiver's Year of Birth** _____ **Zip Code:**_____

Caregiver's SEX: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Triple P Service: ☐ Level 3/Primary Care **0-12** ☐ Level 3/Primary Care **TEEN** ☐ Level 3/Stepping Stones ☐ Level 4/Standard

Relationship to child _____ **Number of Children in the home:** ____ **Number of adults in the home:** ___

Child's Presenting Problem:_____

Does the child experience any of the following? (CHECK all that apply) ☐ A vision or hearing impairment
☐ A physical disability ☐ A developmental delay ☐ A restrictive/therapeutic diet prescribed by a health provider
☐ An intellectual/mental disability ☐ A severe chronic illness that results in regular hospitalizations

Pre-test Measures Completed? ☐ **Yes** (Date_____) ☐ **No** (☐ BRIEF TRIPLE P ☐ other_____)

DATE	CAREGIVER(S) RELATIONSHIP	BRIEF DESCRIPTION OF ACTIVITIES	TIME SPENT

Post-Measures Completed: ☐ Yes (Date_____) ☐ Not Applicable ☐ No (Check reason below)
☐ Still providing services ☐ Didn't show for last session ☐ Decided not to return ☐ Measures not given
☐ Lost contact with family ☐ Other: _____

Return to: Triple P Mecklenburg – c/o Cathy Henderson, Southeast Health Department, 249 Billingsley Road, Charlotte, NC 28211

Updated 2-1-16

CAREGIVER SATISFACTION QUESTIONNAIRE

Provider Name and Agency: _____ Triple P Level & Type: _____

Caregiver Name or Client ID: _____ Today's Date: _____

Relationship to Child: _____

INSTRUCTIONS:

This questionnaire will help us to evaluate and continually improve the Triple P parenting program we offer. We are interested in your HONEST OPINIONS about the services you have received, whether they are positive or negative. Please answer all the questions by circling the response that best describes how you honestly feel.

1. **How would you rate the quality of the Triple P parenting program you and your child received?**

1	2	3	4	5	6	7
Poor		Fair		Good		Excellent

2. **Has the Triple P parenting program helped you to deal more effectively with your child's behavior?**

1	2	3	4	5	6	7
No, it made things worse		No, it hasn't helped much		Yes, it has helped somewhat		Yes, has helped a great deal

3. **Has the Triple P parenting program helped you to deal more effectively with problems that arise in your family?**

1	2	3	4	5	6	7
No, it made things worse		No, it hasn't helped much		Yes, it has helped somewhat		Yes, has helped a great deal

4. **If you were to seek help again, would you come back to Triple P parenting program?**

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

5. **In your opinion, how is your child's behavior at this point?**

1	2	3	4	5	6	7
Considerably worse	Worse	Slightly worse	The same	Slightly improved	Improved	Greatly improved

6. **Do you have any other comments about Triple P parenting program?**

_____
_____
_____
_____
_____
_____

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

CUESTIONARIO DE SATISFACCIÓN DEL CLIENTE

Provider Name: _____ Triple P Level & Type: _____

Nombre del padre: _____ Fecha de hoy: _____

Relación al niño: _____

INSTRUCCIONES:
Este cuestionario nos ayudará a evaluar y continuar mejorando el programa que ofrecemos. Estamos interesados en sus opiniones honestas sobre los servicios que recibió, ya sea que hayan sido positivos o negativos. Por favor responda todas las preguntas. Por favor encierre en un círculo la respuesta que mejor describa como se siente.

1. **¿Cómo calificaría la calidad del servicio de Triple P que usted y su hijo recibieron?**

1	2	3	4	5	6	7
Malo		Regular		Bueno		Excelente

2. **¿Le ayudó el programa de Triple P a tratar más efectivamente el comportamiento del niño?**

1	2	3	4	5	6	7
No, dejó cosas peor		No ayudó mucho		Si, ayudó un poco		Si, ayudó mucho

3. **¿Le ayudó el programa de Triple P a tratar más efectivamente los problemas que surgen en su familia?**

1	2	3	4	5	6	7
No, dejó las cosas peor		No ayudó mucho		Si, ayudó un poco		Si, ayudó mucho

4. **¿Si buscara ayuda de nuevo, ¿regresaría al programa de Triple P?**

1	2	3	4	5	6	7
No, definitivamente no		No, creo que no		Sí, creo que sí		Sí, definitivamente

5. **¿En su opinión, ¿cómo es la conducta de su hijo en este momento?**

1	2	3	4	5	6	7
Mucho Peor	Peor	Un poco peor	Igual	Un poco mejor	Mejor	Mucho Mejor

6. **¿Tiene algún otro comentario sobre el programa de Triple P?**

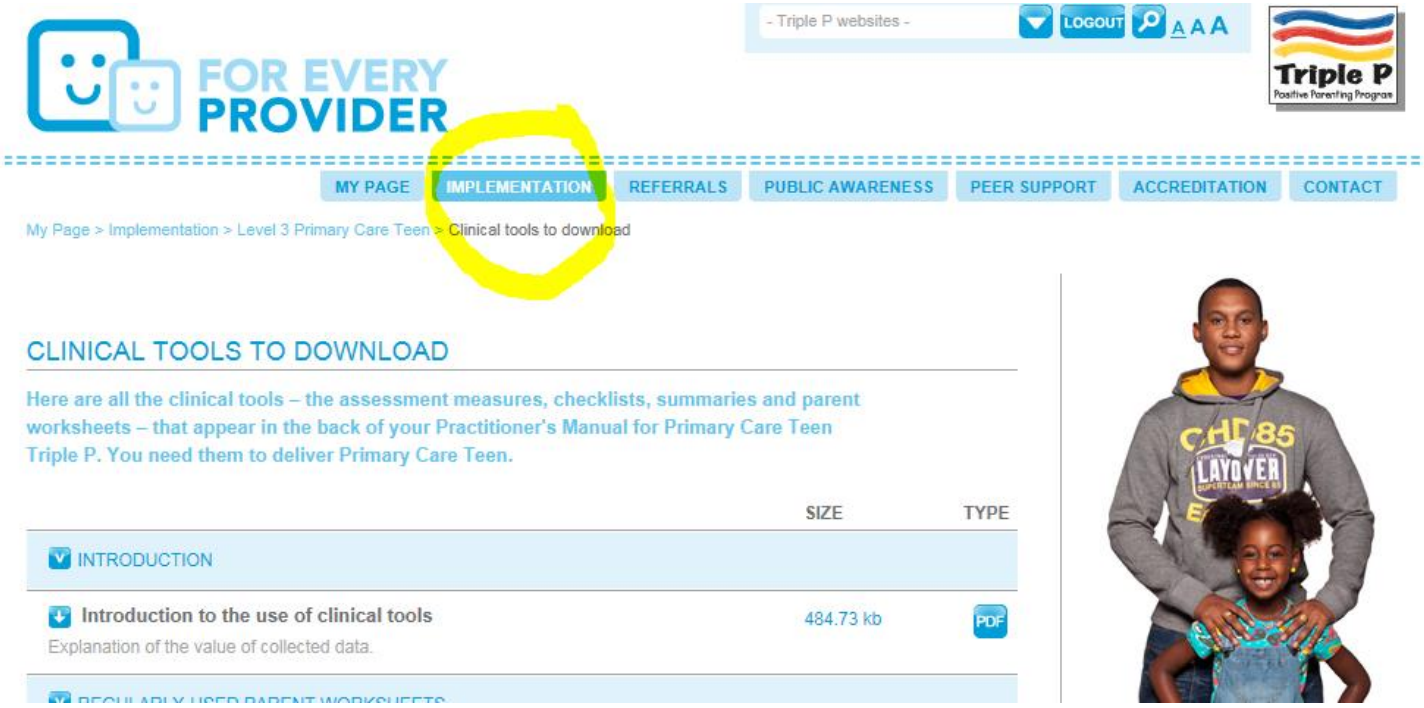
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Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

FIDELITY ADHERENCE SESSION CHECKLISTS

- Complete and turn in “Session Checklists” available from training practitioner handbook or on the Triple P provider network under implementation Tools.



- Tools also available at http://www.cabarrushealth.org/268/Triple-P-Provider
- Session Checklists differ between 0-12 or TEEN interventions
- Below are the session checklist for Level 2 Primary Care 0-12 intervention

Brief Primary Care Triple P Session 1 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave a blank if the item was omitted.

Client number: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

1. Introduction and Assessment

- Introduce self warmly (if not already known to parent)
- Identify parent's immediate need and goals
- Ensure parent is suitable for Brief Primary Care Triple P or refer on as required
- Outline nature of the program (e.g. two 10-minute sessions)

2. Introduce a Parenting Plan ☐

- Introduce a parenting plan from a tip sheet or tailor a plan from a tip sheet for a similar problem or develop a plan using the *Parenting Plan* form
- Outline overall structure of the tip sheet or *Parenting Plan* form highlighting key steps
- Link tip sheet or parenting plan to parent's goals
- Teach key steps of prevention and management routine
- Prompt parent to note key steps on *Parenting Plan* checklist
- Check parent's reaction to the strategies presented
- Check parent's ability to implement the strategy
- Remind parent to check tip sheet if they get stuck
- Check parent understanding and whether information is sufficient

3. Goal Setting ☐

- Encourage parent to set implementation goals
- Teach parent to use the *Goal Achievement Scales*

4. Session Close ☐

- Review key points covered in the session
- Ask parent to complete the *Parenting Experience Survey*
- If necessary, introduce monitoring
- Lend *Every Parent's Survival Guide DVD* for home viewing if needed

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Brief Primary Care Triple P Session 2 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave a blank if the item was omitted.

Client number: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

1. **Agenda (outline proposed session goals and gain consent from the parent/s)** ☐
   - Review of monitoring (if conducted)
   - Review implementation of parenting plan and fine-tune where necessary
   - Overcome obstacles to implementation, if necessary
   - Review progress towards goals
   - Referral and/or closure

2. **Update on progress (review the parenting plan)** ☐
   - Review monitoring, if conducted (try to link changes in child's behavior with parenting strategies used)
     - Review implementation of the parenting plan and/or homework practice goals
     - Ask what worked or what the parent did well (at least two positive points):
     - Ask what the parent/s could have done differently:
   - Fine-tune parenting routine and rehearse strategies as required
   - Check for any obstacles to implementation (things that stopped the parent using any part of the plan) and develop a coping plan to overcome obstacles.
   - Ask the parent what improvements they have seen in their child's behavior and their own behavior since starting the program (refer to original goals and *the Goal Achievement Scales.)*
   - Ask parent what further improvements they would like to see and prompt how they could achieve these goals.

3. **Referral (only if necessary)** ☐
   - Reinforce parent for improvements made to date
   - Discuss referral options for higher-level parenting support (e.g. Level 3, 4, or 5) and the format of these levels
   - Ask parent if they would like further support
   - Provide details of where parent can access additional support

4. **Session Close** ☐
   - Review key points covered in the session
   - Ask parent to complete the *Parenting Experience Survey and Client Satisfaction Questionnaire*
   - Congratulate and thank parent for participating in Triple P.

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Parenting - Empowerment - Community

TRIPLE P LEVEL 2 SEMINAR
POWER OF POSITIVE PARENTING
Sign-In Sheet

Agency/Venue: _____ **Date:** _____

Facilitator: _____ **Topic:** _____

Caregiver Name (First, Last) **Each caregiver must sign in*	**Zip Code**	**How many children live in your home?**

Return to: Triple P Mecklenburg Attn. Cathy Henderson . Southeast Health Department . 249 Billingsley Road . Charlotte, NC 28211

Parenting - Empowerment - Community

TRIPLE P LEVEL 2 SEMINAR
RAISING CONFIDENT, COMPETENT CHILDREN
Sign-In Sheet

Agency/Venue: _____ **Date:** _____

Facilitator: _____ **Topic:** _____

Caregiver Name (First, Last) **Each caregiver must sign in*	**Zip Code**	**How many children live in your home?**

Parenting - Empowerment - Community

TRIPLE P LEVEL 2 SEMINAR
RAISING RESILIENT CHILDREN
Sign-In Sheet

Agency/Venue: _____ **Date:** _____

Facilitator: _____ **Topic:** _____

Caregiver Name (First, Last) **Each caregiver must sign in*	**Zip Code**	**How many children live in your home?**

Parent Satisfaction Survey

Your child's age: ..... Name of seminar: .....

Date of seminar: ..... Presenter's name: .....

01. How would you rate the quality of the seminar presentation?

1	2	3	4	5	6	7
Poor						Excellent

02. Did the seminar provide sufficient opportunities for questions?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

03. Was the seminar interesting to you?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

04. Did the presenter use clear examples to illustrate parenting issues?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

05. Did the presenter provide clear explanations?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

06. Did you gain sufficient knowledge or information to be able to implement the parenting advice you heard about?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

07. Overall, how would you rate the content of the seminar?

1	2	3	4	5	6	7
Poor						Excellent

08. Was the seminar helpful in gaining an understanding of what you can do to help your child learn new skills and behavior?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

Parent Satisfaction Survey

09. Was the parenting tip sheet you received useful?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

10. Do you intend to implement the parenting advice you received?

1	2	3	4	5	6	7
No, definitely not						Yes, definitely

Other comments:

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LEVEL 3 TRIPLE P

Evaluation Manual

Dear Cabarrus Triple P Provider,

Thank you for partnering with the Cabarrus Health Alliance (and Mecklenburg County) to demonstrate the impactful work you will continue with families in Cabarrus County. Evaluation activities are a required part of being a Cabarrus-trained Triple P Provider. Data collection tools not only provide useful information to the provider and caregiver during the intervention but also are mandated by the NC Department of Public Health for funding purposes. CHA was purposeful in selecting only the minimal number of tools and shortened versions in order to minimize the time needed for evaluation efforts. Please refer to the Memorandum of Agreement for a description of the evaluation commitment for your agency. Please contact Myocia Young-Montgomery by email at myocia.young-montgomery@mecklenburgcountync.gov or by phone at 704-617-2176 for questions regarding evaluation for Triple P.

Edited 4/25/2016

Triple P Evaluation Manual
LEVEL 3 - INDIVIDUAL DELIVERY FORMAT INTERVENTION

CONTENTS

1. Instructions
2. Caregiver Contact Record (CCR)
3. Parenting Experience Survey-PRE (PES-PRE)
4. Parenting Experience Survey-POST (PES-POST)
5. Caregiver Satisfaction Questionnaire (CSQ)
6. Fidelity Adherence Session Checklists

*Electronic versions of these tools available at: http://www.cabarrushealth.org/268/Triple-P-Provider

EVALUATION INSTRUCTION SHEET

Data Collection Schedule

SESSION 1 (INITIAL SESSION):
• Document session on Caregiver Contact Record
• Collect Parenting Experience Survey-PRE for each caregiver present
• Complete Session 1 Checklist
SESSION 2:
• Document session on Caregiver Contact Record
• Complete Session 2 Checklist
SESSION 3:
• Document session on Caregiver Contact Record
• Complete Session 3 Checklist
SESSION 4 (FINAL SESSION):
• Document session on Caregiver Contact Record
• Collect Parenting Experience Survey-POST for each caregiver present
• Collect Caregiver Satisfaction Questionnaire
• Complete Session 4 Checklist
ADDITIONAL SESSIONS/FOLLOW-UPS:
• Document session on Caregiver Contact Record

***INCOMPLETE** INTERVENTIONS ONLY NEED TO SUBMIT CAREGIVER CONTACT RECORD*

Description of Data Collection Tools

TOOL	COMPLETED BY:	COMPLETED DURING:	INSTRUCTIONS
Caregiver Contact Record (CCR)	Provider	Every session or contact with caregiver. Includes telephone conversations or follow-ups.	• Enter Caregiver(s) name(s), DOB, zip code, county of residence, telephone #, your name, agency, and the intervention level (2 or 3) and type. • Record every date in which contact is made with caregiver. • Record who attended the intervention and their relationship to the primary child. • Provide a brief description of the activity (ex. Session 1, tip sheet, phone conversation, etc.). • Provide estimate of time spent with caregiver. • Maintain copy for your records and turn in a copy to CHA once intervention is completed or no further contact will be made with caregiver for Triple P. • Assign your own identifier if the caregiver does not authorize release of information.
Parenting Experience Survey-PRE (PES-PRE)	Every caregiver present	Session 1 (Initial In-Person Contact)	• Each caregiver present must complete a separate PES-PRE. • Provider fills out 'Provider Name' and 'Intervention type' at the top of the sheet. • Stress importance of being honest in order to get an accurate assessment. • Caregiver will need to identify a 'primary child' for whom they are primarily seeking Triple P services. • Unabridged survey is available in multiple languages on Triple P provider network. Triple P Cabarrus form is an abridged version of the PRE. • Maintain copy for your records and turn in a copy to CHA once intervention is completed or no further contact will be made with caregiver for Triple P.
Parenting Experience Survey-POST (PES-POST)	Every caregiver present	Session 4 (Final In-Person Contact)	• Each caregiver present must complete a separate PES-POST. • Provider fills out 'Provider Name' and 'Intervention type' at the top of the sheet. • Stress importance of being honest in order to get an accurate assessment. • Caregiver will need to identify a 'primary child' for whom they are primarily seeking Triple P services. • Unabridged survey is available in multiple languages on Triple P provider network. Triple P Cabarrus form is an abridged version of the POST. • Maintain copy for your records and turn in a copy to CHA once intervention is completed or no further contact will be made with caregiver for Triple P.
Caregiver Satisfaction Questionnaire (CSQ)	Every caregiver present	Session 4 (Final In-Person Contact)	• Each caregiver present must complete a separate CSQ. • Provider fills out 'Provider Name' and 'Triple P Level' at the top of the sheet. • Stress importance of being honest in order to get an accurate assessment. • Caregiver will need to identify a 'primary child' for whom they are primarily seeking Triple P services. • Original unabridged form is available in multiple languages on Triple P provider network. Triple P Cabarrus form is an abridged version of the CSQ. • Maintain copy for your records and turn in a copy to CHA once intervention is completed or no further contact will be made with Caregiver for Triple P.
Fidelity Adherence Session Checklist	Provider	Every session	• Document Client Information and session data (or date range if session is split up across several dates) • Check if each item was completed; enter 'not completed' if it was not completed

Submission of Data Collection Tools

Timeline

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October 1 – December 31	**January 8**

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Southeast Health Department
ATTN: CATHY HENDERSON, TRIPLE P
249 Billingsley Road
Charlotte, NC 28211

Triple P Provider Name: _____ **Provider Agency:** _____

Triple P Mecklenburg

FAMILY INFORMATION & CAREGIVER CONTACT FORM

Caregiver (First Name, Last Initial): _____ **Caregiver's Year of Birth** _____ **Zip Code:**_____

Caregiver's SEX: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Triple P Service: ☐ Level 3/Primary Care **0-12** ☐ Level 3/Primary Care **TEEN** ☐ Level 3/Stepping Stones ☐ Level 4/Standard

Relationship to child _____ **Number of Children in the home:** ____ **Number of adults in the home:** ___

Child's Presenting Problem:_____

Does the child experience any of the following? (CHECK all that apply) ☐ A vision or hearing impairment
☐ A physical disability ☐ A developmental delay ☐ A restrictive/therapeutic diet prescribed by a health provider
☐ An intellectual/mental disability ☐ A severe chronic illness that results in regular hospitalizations

Pre-test Measures Completed? ☐ **Yes** (Date_____) ☐ **No** (☐ BRIEF TRIPLE P ☐ other_____)

DATE	CAREGIVER(S) RELATIONSHIP	BRIEF DESCRIPTION OF ACTIVITIES	TIME SPENT

Post-Measures Completed: ☐ Yes (Date_____) ☐ Not Applicable ☐ No (Check reason below)
☐ Still providing services ☐ Didn't show for last session ☐ Decided not to return ☐ Measures not given
☐ Lost contact with family ☐ Other: _____

Return to: Triple P Mecklenburg – c/o Cathy Henderson, Southeast Health Department, 249 Billingsley Road, Charlotte, NC 28211

Updated 2-1-16

PRE

LEVEL 3 TRIPLE P
PARENTING EXPERIENCE PRE-SURVEY

Caregiver Name or Client ID: _____ **Relationship to Child: _____**

Date: _____

Provider and Agency Name: _____

Triple P Intervention Type (ex: Level 3 Stepping Stones 0-12): _____

Below are a list of issues relating to being a parent.
Please circle the number describing the response which best describes how you honestly feel.

1. In an overall sense, how difficult has your child's behavior been over the last 6 weeks?

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

2. To what extent do the following statements describe your experience as a parent in the last 6 weeks?

	Not at all	Slightly	Moderately	Very	Extremely
Parenting is rewarding	1	2	3	4	5
Parenting is demanding	1	2	3	4	5
Parenting is stressful	1	2	3	4	5
Parenting is fulfilling	1	2	3	4	5
Parenting is depressing	1	2	3	4	5

3. In the last 6 weeks, how confident have you felt to undertake your responsibilities as a parent?

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

4. How supported have you felt in your role as a parent over the last 6 weeks?

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

PRE

LEVEL 3 TRIPLE P
PARENTING EXPERIENCE PRE-SURVEY

Nombre del Padre o Client ID: _____ Relación al niño: _____
Fecha: _____
Provider Name: _____

Triple P Intervention Type (ex: Level 3 Stepping Stones 0-12): _____

Debajo esta una lista de temas relacionados con el ser padre.
Por favor circule el número que indica la respuesta que mejor describe cómo se siente usted honestamente.

1. ¿En un sentido general, que tan difícil ha sido el comportamiento de su hijo/a en las últimas 6 semanas?

Para nada	Un poco	Moderadamente	Muy	Sumamente
1	2	3	4	5

2. ¿En qué medida las siguientes afirmaciones describen su experiencia como padre/madre en las últimas 6 semanas?

	Para nada	Un poco	Moderadamente	Mucho	Sumamente
La paternidad es agradable	1	2	3	4	5
La paternidad es exigente	1	2	3	4	5
La paternidad es estresante	1	2	3	4	5
La paternidad es gratificante	1	2	3	4	5
La paternidad es deprimente	1	2	3	4	5

3. ¿En las últimas 6 semanas, que tan confiado se ha sentido usted para asumir sus responsabilidades como padre/madre?

Para nada	Un poco	Moderadamente	Muy	Sumamente
1	2	3	4	5

4. ¿Qué tan apoyado/a se ha sentido usted en su papel como padre/madre en las últimas 6 semanas?

Para nada	Un poco	Moderadamente	Muy	Sumamente
1	2	3	4	5

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

POST

LEVEL 3 TRIPLE P
PARENTING EXPERIENCE POST-SURVEY

Caregiver Name or Client ID: _____ **Relationship to Child:** _____

Date: _____

Provider and Agency Name: _____

Triple P Intervention Type (ex: Level 3 Stepping Stones 0-12): _____

Below are a list of issues relating to being a parent.
Please circle the number describing the response which best describes how you honestly feel.

1. In an overall sense, how difficult has your child's behavior been over the last 6 weeks?

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

2. To what extent do the following statements describe your experience as a parent in the last 6 weeks?

	Not at all	Slightly	Moderately	Very	Extremely
Parenting is rewarding	1	2	3	4	5
Parenting is demanding	1	2	3	4	5
Parenting is stressful	1	2	3	4	5
Parenting is fulfilling	1	2	3	4	5
Parenting is depressing	1	2	3	4	5

3. In the last 6 weeks, how confident have you felt to undertake your responsibilities as a parent?

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

4. How supported have you felt in your role as a parent over the last 6 weeks?

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

POST

LEVEL 3 TRIPLE P
PARENTING EXPERIENCE POST-SURVEY

Nombre del Padre o Client ID: _____ Relación al niño: _____
Fecha: _____
Provider Name: _____

Triple P Intervention Type (ex: Level 3 Stepping Stones 0-12): _____

Debajo esta una lista de temas relacionados con el ser padre.
Por favor circule el número que indica la respuesta que mejor describe cómo se siente usted honestamente.

1. ¿En un sentido general, que tan difícil ha sido el comportamiento de su hijo/a en las últimas 6 semanas?

Para nada	Un poco	Moderadamente	Muy	Sumamente
1	2	3	4	5

2. ¿En qué medida las siguientes afirmaciones describen su experiencia como padre/madre en las últimas 6 semanas?

	Para nada	Un poco	Moderadamente	Mucho	Sumamente
La paternidad es agradable	1	2	3	4	5
La paternidad es exigente	1	2	3	4	5
La paternidad es estresante	1	2	3	4	5
La paternidad es gratificante	1	2	3	4	5
La paternidad es deprimente	1	2	3	4	5

3. ¿En las últimas 6 semanas, que tan confiado se ha sentido usted para asumir sus responsabilidades como padre/madre?

Para nada	Un poco	Moderadamente	Muy	Sumamente
1	2	3	4	5

4. ¿Qué tan apoyado/a se ha sentido usted en su papel como padre/madre en las últimas 6 semanas?

Para nada	Un poco	Moderadamente	Muy	Sumamente
1	2	3	4	5

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

CAREGIVER SATISFACTION QUESTIONNAIRE

Provider Name and Agency: _____ Triple P Level & Type: _____

Caregiver Name or Client ID: _____ Today's Date: _____

Relationship to Child: _____

INSTRUCTIONS:

This questionnaire will help us to evaluate and continually improve the Triple P parenting program we offer. We are interested in your HONEST OPINIONS about the services you have received, whether they are positive or negative. Please answer all the questions by circling the response that best describes how you honestly feel.

1. **How would you rate the quality of the Triple P parenting program you and your child received?**

1	2	3	4	5	6	7
Poor		Fair		Good		Excellent

2. **Has the Triple P parenting program helped you to deal more effectively with your child's behavior?**

1	2	3	4	5	6	7
No, it made things worse		No, it hasn't helped much		Yes, it has helped somewhat		Yes, has helped a great deal

3. **Has the Triple P parenting program helped you to deal more effectively with problems that arise in your family?**

1	2	3	4	5	6	7
No, it made things worse		No, it hasn't helped much		Yes, it has helped somewhat		Yes, has helped a great deal

4. **If you were to seek help again, would you come back to Triple P parenting program?**

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

5. **In your opinion, how is your child's behavior at this point?**

1	2	3	4	5	6	7
Considerably worse	Worse	Slightly worse	The same	Slightly improved	Improved	Greatly improved

6. **Do you have any other comments about Triple P parenting program?**

_____
_____
_____
_____
_____
_____

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

CUESTIONARIO DE SATISFACCIÓN DEL CLIENTE

Provider Name: _____ Triple P Level & Type: _____

Nombre del padre: _____ Fecha de hoy: _____

Relación al niño: _____

INSTRUCCIONES:
Este cuestionario nos ayudará a evaluar y continuar mejorando el programa que ofrecemos. Estamos interesados en sus opiniones honestas sobre los servicios que recibió, ya sea que hayan sido positivos o negativos. Por favor responda todas las preguntas. Por favor encierre en un círculo la respuesta que mejor describa como se siente.

1. **¿Cómo calificaría la calidad del servicio de Triple P que usted y su hijo recibieron?**

1	2	3	4	5	6	7
Malo		Regular		Bueno		Excelente

2. **¿Le ayudó el programa de Triple P a tratar más efectivamente el comportamiento del niño?**

1	2	3	4	5	6	7
No, dejó cosas peor		No ayudó mucho		Si, ayudó un poco		Si, ayudó mucho

3. **¿Le ayudó el programa de Triple P a tratar más efectivamente los problemas que surgen en su familia?**

1	2	3	4	5	6	7
No, dejó las cosas peor		No ayudó mucho		Si, ayudó un poco		Si, ayudó mucho

4. **¿Si buscara ayuda de nuevo, ¿regresaría al programa de Triple P?**

1	2	3	4	5	6	7
No, definitivamente no		No, creo que no		Sí, creo que sí		Sí, definitivamente

5. **¿En su opinión, ¿cómo es la conducta de su hijo en este momento?**

1	2	3	4	5	6	7
Mucho Peor	Peor	Un poco peor	Igual	Un poco mejor	Mejor	Mucho Mejor

6. **¿Tiene algún otro comentario sobre el programa de Triple P?**

_____
_____
_____
_____
_____
_____

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

Primary Care Triple P Session 1 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Introduction (welcome and self-introduction) and Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Assessment of child behavior problems
- Options for intervention
- Keeping track of children's behavior
- Homework tasks

02. Intake Interview ☐

- Discuss each parent's current main concerns about their child's behavior (nature; context; intensity; frequency; duration; onset; course; other carers' approaches)
- Check for any developmental difficulties or health problems
- Check on the child's educational history
- Explore family relationships and interaction

03. Options for Intervention ☐

- Ascertain the appropriateness of Primary Care Triple P for the family
- Discuss continuation of the program if appropriate
- Discuss referral if appropriate

04. Keeping Track of Children's Behavior ☐

- Decide on the target behavior/s to monitor
- Provide a rationale for monitoring children's behavior
- Devise a system for keeping track of the target behavior/s

05. Session Close ☐

- Review the main points covered in the session
- Explain homework tasks (complete the *Family Background Questionnaire, Parenting Experience Survey*, and daily monitoring; review causes of child behavior problems and complete the checklist)
- Schedule the next appointment

Session Notes

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.....*Continued*

Primary Care Triple P Session 1 Summary

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Additional Agenda Items

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Homework Tasks

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Signed: ..... Date completed: .....

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Primary Care Triple P Session 2 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Review assessment information
- Discuss causes of child behavior problems
- Develop specific goals for change *(Goal Achievement Scales)*
- Develop a parenting plan
- Homework tasks

02. Feedback of Assessment Results ☐

- Check the problem is still current and explain the feedback process
- Discuss data from each type of assessment (interview, monitoring, observation)
- Provide an integrating summary
- Check the accuracy of your summary

03. Causes of Child Behavior Problems ☐

- Outline the purpose of discussing causes of child behavior problems
- Ask the parent/s which factors they consider relevant to their child
- Prompt the parent/s to identify other causes
- Share your own observations if necessary
- Provide an integrating summary

04. Goals for Change ☐

- Devise *Goal Achievement Scales*

05. Parenting Plan ☐

- Introduce a parenting plan from a tip sheet, tailor a plan from a tip sheet for a similar problem or develop a plan using the *Planning Ahead* form
- Prompt the parent/s to transfer key steps onto a *Parenting Plan Checklist*
- Rehearse strategies as required

06. Session Close ☐

- Review the main points covered in the session
- Explain homework tasks (continue to monitor target behavior/s; implement parenting plan and monitor on *Parenting Plan Checklist*, practice specific skills)
- Schedule the next appointment

Primary Care Triple P Session 2 Summary

Session Notes

Additional Agenda Items

Homework Tasks

Signed: ..... Date completed: .....

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Primary Care Triple P Session 3 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Review of monitoring
- Review of implementation of the parenting plan and fine-tuning where necessary
- Overcoming obstacles to implementation
- Additional agenda items
- Homework tasks

02. Update on Progress ☐

- Review monitoring of the target behavior/s (try to link changes in child behavior to changes in parenting strategies used)
- Review implementation of the parenting plan

Ask what worked (at least two positive points):

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Ask what the parent/s could have done differently:

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- Fine-tune routines as required
- Provide a model and rehearse specific skills until the parent/s reach a sufficient level of proficiency
- Check for understanding, unhelpful thoughts and other obstacles to implementation of the parenting plan
- Develop a coping plan to overcome identified obstacles

Primary Care Triple P Session 3 Summary

03. Other Issues

- Discuss any other issues the parent/s want to cover, such as developing a new parenting plan for another target behavior (use minimal prompts to help the parent/s solve any problems)

04. Session Close

- Review the main points covered in the session
- Explain homework tasks (continue to monitor target behavior/s; continue to implement parenting plan/s; other personal goals for practice)
- Schedule the next appointment

Session Notes

Additional Agenda Items

Homework Tasks

Signed: ..... Date completed: .....

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Primary Care Triple P Session 4 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Review of monitoring
- Review of implementation of parenting plan/s and fine-tuning where necessary
- Review of progress
- Maintenance of progress made
- Additional agenda items
- Completion of post-intervention assessment forms

02. Update on Progress ☐

- Review monitoring of the target behavior/s (try to link changes in child behavior to changes in parenting strategies used)
- Review implementation of the parenting plan/s and homework goals for practice

Ask what worked (at least two positive points):

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Ask what the parent/s could have done differently:

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- Fine-tune routines and rehearse specific skills as required
- Check for any obstacles to implementation of the parenting plan/s and develop a coping plan to overcome identified obstacles

Primary Care Triple P Session 4 Summary

- Ask the parent/s what improvements they have seen in their child's and their own behavior since starting the program (refer to goals set in Session 2 recorded on the *Goal Achievement Scale Worksheet/s* and note percentage success achieved)
- Ask the parent/s what further improvements they would like to see in their own and their child's behavior and prompt them to think about how to achieve these goals
- Discuss ways of maintaining progress made

03. Other Issues

- Discuss any other issues the parent/s want to cover (use minimal prompts to help the parent/s solve any problems):

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04. Session Close

- Review the session
- Ask the parent/s to complete the *Parenting Experience Survey* and *Client Satisfaction Questionnaire*
- Discuss referral options as appropriate
- Congratulate and thank the parent/s for participating in Triple P

Session Notes

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Additional Agenda Items

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Signed: ..... Date completed: .....

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Primary Care Teen Triple P Session 1 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered, or with a cross ☒ if the item was omitted.

Client name: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Introduction (welcome and self-introduction) and Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Assessment of teenager behavior problems
- Options for intervention
- Keeping track of teenager's behavior
- Homework tasks

02. Intake Interview ☐

- Discuss each parent's current main concerns about their teenager's behavior (nature; context; intensity; frequency; duration; onset; course; other carers' approaches)
- Check for any developmental difficulties or health problems
- Check on the teenager's educational history
- Explore family relationships and interaction

03. Options for Intervention ☐

- Ascertain the appropriateness of Primary Care Teen Triple P for the family
- Discuss continuation of the program if appropriate
- Discuss referral if appropriate

04. Keeping Track of Teenagers' Behavior ☐

- Decide on the target behavior/s to monitor
- Provide a rationale for monitoring teenagers' behavior
- Devise a system for keeping track of the target behavior/s

05. Session Close ☐

- Review the main points covered in the session
- Explain homework tasks (complete the *Family Background Questionnaire, Parenting Experience Survey*, and daily monitoring; review influences on teenager behavior and complete the checklist)
- Schedule the next appointment

Session Notes

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..... *Continued*

Primary Care Teen Triple P Session 1 Summary

Additional Agenda Items

Homework Tasks

Signed: ..... Date completed: .....

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Primary Care Teen Triple P Session 2 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered, or with a cross ☒ if the item was omitted.

Client name: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Review assessment information
- Discuss influences on teenager behavior
- Develop specific goals for change *(Goal Achievement Scales)*
- Develop a parenting plan
- Homework tasks

02. Feedback of Assessment Results ☐

- Check the problem is still current and explain the feedback process
- Discuss data from each type of assessment (interview, monitoring, observation)
- Provide an integrating summary
- Check the accuracy of your summary

03. Influences on Teenager Behavior ☐

- Outline the purpose of discussing influences on teenagers' behavior
- Ask the parent/s which factors they consider relevant to their teenager
- Prompt the parent/s to identify other influences
- Share your own observations if necessary
- Provide an integrating summary

04. Goals for Change ☐

- Devise *Goal Achievement Scales*

05. Parenting Plan ☐

- Introduce a parenting plan from a tip sheet, tailor a plan from a tip sheet for a similar problem or develop a plan using the *Planning Ahead* form
- Prompt the parent/s to transfer key steps on to a *Parenting Plan Checklist*
- Rehearse strategies as required

06. Session Close ☐

- Review the main points covered in the session
- Explain homework tasks (continue to monitor target behavior/s; implement parenting plan and monitor on *Parenting Plan Checklist*, practice specific skills)
- Schedule the next appointment

Primary Care Teen Triple P Session 2 Summary

Session Notes

Additional Agenda Items

Homework Task

Signed: ..... Date completed: .....

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Primary Care Teen Triple P Session 3 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered, or with a cross ☒ if the item was omitted.

Client name: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Review of monitoring
- Review of implementation of the parenting plan and fine-tuning where necessary
- Overcoming obstacles to implementation
- Additional agenda items
- Homework tasks

02. Update on Progress ☐

- Review monitoring of the target behavior/s (try to link changes in teenager behavior to changes in parenting strategies used)
- Review implementation of the parenting plan

Ask what worked (at least two positive points):

.....

.....

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.....

Ask what the parent/s could have done differently:

.....

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- Fine-tune routines as required
- Provide a model and rehearse specific skills until the parent/s reach a sufficient level of proficiency
- Check for understanding, unhelpful thoughts and other obstacles to implementation of the parenting plan
- Develop a coping plan to overcome identified obstacles

Primary Care Teen Triple P Session 3 Summary

03. Other Issues

- Discuss any other issues the parent/s want to cover, such as developing a new parenting plan for another target behavior (use minimal prompts to help the parent/s solve any problems)

04. Session Close

- Review the main points covered in the session
- Explain homework tasks (continue to monitor target behavior/s; continue to implement parenting plan/s; other personal goals for practice)
- Schedule the next appointment

Session Notes

Additional Agenda Items

Homework Task

Signed: ..... Date completed: .....

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Primary Care Teen Triple P Session 4 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered, or with a cross ☒ if the item was omitted.

Client name: ..... Date of session: .....

Start time: ..... Finish time: .....

Content Checklist

01. Agenda ☐

(outline proposed session goals and gain consent from the parent/s)

- Review of monitoring
- Review of implementation of parenting plan/s and fine-tuning where necessary
- Review of progress
- Maintenance of progress made
- Additional agenda items
- Completion of post-intervention assessment forms

02. Update on Progress ☐

- Review monitoring of the target behavior/s (try to link changes in teenager behavior to changes in parenting strategies used)
- Review implementation of the parenting plan/s and homework goals for practice

Ask what worked (at least two positive points):

.....

.....

.....

.....

Ask what the parent/s could have done differently:

.....

.....

.....

.....

- Fine-tune routines and rehearse specific skills as required
- Check for any obstacles to implementation of the parenting plan/s and develop a coping plan to overcome identified obstacles

Primary Care Teen Triple P Session 4 Summary

- Ask the parent/s what improvements they have seen in their teenager's and their own behavior since starting the program (refer to goals set in Session 2 recorded on the *Goal Achievement Scale Worksheet/s* and note percentage success achieved)
- Ask the parent/s what further improvements they would like to see in their own and their teenager's behavior and prompt them to think about how to achieve these goals
- Discuss ways of maintaining progress made

03. Other Issues ☐

- Discuss any other issues the parent/s want to cover (use minimal prompts to help the parent/s solve any problems):

.....

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.....

04. Session Close ☐

- Review the session
- Ask the parent/s to complete the *Parenting Experience Survey* and *Client Satisfaction Questionnaire*
- Discuss referral options as appropriate
- Congratulate and thank the parent/s for participating in Triple P

Session Notes

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Additional Agenda Items

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Signed: ..... Date completed: .....

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Parenting - Empowerment - Community

Triple P Cabarrus

LEVEL 3 TRIPLE P
DISCUSSION GROUP 0-12
Sign-In Sheet

Agency/Venue: _____ **Date:** _____

Facilitator: _____ **Topic:** _____

Caregiver Name (First, Last) **Each caregiver must sign in*	**Zip Code**	**How many children live in your home?**

Parenting - Empowerment - Community

Triple P Cabarrus

LEVEL 3 TRIPLE P
DISCUSSION GROUP TEEN
Sign-In Sheet

Agency/Venue: _____ **Date:** _____

Facilitator: _____ **Topic:** _____

Caregiver Name (First, Last) **Each caregiver must sign in*	**Zip Code**	**How many children live in your home?**

Discussion Group Satisfaction Questionnaire

This questionnaire will help us to evaluate and continually improve the program we offer. We are interested in your *honest opinions* about the services you have received, whether they are positive or negative. Please answer all the questions.

Please circle the response that best describes how you honestly feel.

01. How would you rate the quality of the discussion group?

7	6	5	4	3	2	1
Excellent		Good		Fair		Poor

02. Did you receive the type of help you wanted from the program?

1	2	3	4	5	6	7
No, definitely not		No, not really		Yes, generally		Yes, definitely

03. To what extent has the program met your needs?

7	6	5	4	3	2	1
Almost all needs have been met		Most needs have been met		Only a few needs have been met		No needs have been met

04. How satisfied were you with the amount of help you received?

1	2	3	4	5	6	7
Quite dissatisfied		Dissatisfied		Satisfied		Very satisfied

05. Did you gain sufficient knowledge or information to be able to implement the parenting strategies introduced?

7	6	5	4	3	2	1
Yes, definitely		Yes, generally		No, not really		No, definitely not

06. Do you intend to implement the parenting strategies introduced?

7	6	5	4	3	2	1
Yes, definitely		Yes, generally		No, not really		No, definitely not

07. How satisfied were you with the content of the discussion group?

1	2	3	4	5	6	7
Very dissatisfied		Dissatisfied		Satisfied		Very satisfied

Discussion Group Satisfaction Questionnaire

08. How satisfied were you with the format of the discussion group?

1	2	3	4	5	6	7
Very dissatisfied		Dissatisfied		Satisfied		Very satisfied

09. If you were to seek help again, would you come back to *Triple P*?

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

10. Has the program helped you to develop skills that can be applied to other family members?

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

11. Do you have any other comments about this program?

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LEVEL 4-5 TRIPLE P

Evaluation Manual

Dear Cabarrus Triple P Provider,

Thank you for partnering with the Cabarrus Health Alliance (and Mecklenburg County) to demonstrate the impactful work you will continue with families in Cabarrus County. Evaluation activities are a required part of being a Cabarrus-trained Triple P Provider. Data collection tools not only provide useful information to the provider and caregiver during the intervention but also are mandated by the NC Department of Public Health for funding purposes. CHA was purposeful in selecting only the minimal number of tools and shortened versions in order to minimize the time needed for evaluation efforts. Please refer to the Memorandum of Agreement for a description of the evaluation commitment for your agency. Please contact Myocia Young-Montgomery by email at myocia.young-montgomery@mecklenburgcountync.gov or by phone at 704-617-2176 for questions regarding evaluation for Triple P.

Edited 4/25/2016

Triple P Evaluation Manual
LEVELS 4-5 - INDIVIDUAL DELIVERY FORMAT INTERVENTION

CONTENTS

1. Instructions
    a. Data Collection Requirements
    b. Level 4-5 Evaluation Tools
    c. Submission of Evaluation Packets
2. Caregiver Contact Record (CCR)
3. Parenting Scale
4. Strengths and Difficulties Questionnaire Instructions (SDQ)
5. Caregiver Satisfaction Questionnaire (CSQ)
6. Instructions for completing Fidelity Adherence Session Checklists

*Electronic version of the manual available at: http://www.cabarrushealth.org/268/Triple-P-Provider

EVALUATION INSTRUCTION SHEET

Data Collection Schedule

Providers are asked to:

1. Collect and submit completed evaluation packets (quarterly)
2. Complete a self-report via a link sent by email (quarterly)

LEVEL 4-5 EVALUATION TOOLS

A <u>completed</u> level 4 or level 5 evaluation packet consists of:

1. Caregiver Contact Record
2. Parenting Scale (PRE) + Score Sheet
3. Parenting Scale (POST) + Score Sheet
4. Strengths and Difficulties Questionnaire* - (PRE) + Score Sheet
5. Strengths and Difficulties Questionnaire* - (POST) + Score Sheet

   **or equivalent measure such as CBCL or ECBI*
6. Caregiver Satisfaction Questionnaire
7. Fidelity Session Checklists

Reach and Fidelity: • **CAREGIVER CONTACT RECORD** • **FIDELITY SESSION CHECKLISTS**
• Complete Caregiver Information
• Briefly document each session for fidelity purposes
• Complete Fidelity Session Checklists at each session
Caregiver Level Assessment: • **PARENTING SCALE (PRE & POST)**
• PRE-INTERVENTION: Collect and score Parenting Scale
• POST-INTERVENTION: Collect and score Parenting Scale

Child Level Assessment (choose 1):
• **STRENGTHS & DIFFICULTIES QUESTIONNAIRE (PRE & POST)**
  ○ SDQ: Free download at http://www.sdqinfo.org/
OR
• **CBCL: CHILD BEHAVIOR CHECKLIST (PRE & POST)**
  ○ CBCL: Purchase from http://www.aseba.org/
OR
• **ECBI: EYBERG CHILD BEHAVIOR INVENTORY (PRE & POST)**
  ○ ECBI: Purchase from http://www4.parinc.com/

• PRE-INTERVENTION: Collect and score ONE child level assessment
• POST-INTERVENTION: Collect and score ONE child level assessment
Program Satisfaction: • **CLIENT SATISFACTION QUESTIONNAIRE**
• POST-INTERVENTION: Collect Caregiver Satisfaction Questionnaire

Submission of Data Collection Tools

Timeline

Completed Level 4 or Level 5 evaluation packets consist of 7 tools (CCR, PS-PRE, PS-POST, Child Pre-measure, Child Post-measure, CSQ, and Session Checklists) and must be submitted to Triple P Mecklenburg for the corresponding reporting period on the following dates each year:

REPORTING PERIOD	DATA SUBMISSION DUE DATE
January 1 – March 31	**April 8**
April 1 – June 30	**July 8**
July 1 – September 30	**October 8**
October 1 – December 31	**January 8**

1. Submission Due Date: **April 8** for interventions completed during **[January 1 – March 31]**
2. Submission Due Date: **July 8** for interventions completed during **[April 1 – June 30]**
3. Submission Due Date: **October 8** for interventions completed during **[July 1 – September 30]**
4. Submission Due Date: **January 8** for interventions completed during **[October 1 – December 31]**

NOTE:

- Submit all 7 data collection tools together once the caregiver has completed the entire intervention. The child and caregiver assessments should include the tool and scoring key.
- An email reminder will be sent to providers to submit evaluation packets for all caregivers who have completed the intervention during the corresponding reporting period.
- Providers may also choose to submit completed evaluation packets at any time prior to the submission deadline on an on-going basis if they prefer.
- Incomplete interventions only need to submit the Caregiver Contact Record.

Method for Submission

Option 1: Your organization can designate one person to collect all the evaluations and schedule a day for evaluations to be picked up. Contact Myocia Young-Montgomery at 704-617-2176 or myocia.young-montgomery@mecklenburgcountync.gov to arrange for evaluation packet pick-up.

Option 2: You may scan evaluation packets (CCR, CSQ (if applicable), and Session Checklists) and email them to Myocia Young-Montgomery myocia.young-montgomery@mecklenburgcountync.gov

Option 3: You may fax evaluation packets (CCR, CSQ (if applicable), and Session Checklists) to 704-602-6954…. (the fax is confidential)

Option 4: Mail completed evaluation packets (CCR, CSQ (if applicable), and Session Checklists) using pre-paid envelops provided by June 15, 2016 for practitioners desiring to mail in packets. Packets should be mailed to:

Southeast Health Department
ATTN: CATHY HENDERSON, TRIPLE P
249 Billingsley Road
Charlotte, NC 28211

Triple P Provider Name: _____ **Provider Agency:** _____

Triple P Mecklenburg

FAMILY INFORMATION & CAREGIVER CONTACT FORM

Caregiver (First Name, Last Initial): _____ **Caregiver's Year of Birth** _____ **Zip Code:**_____

Caregiver's SEX: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Triple P Service: ☐ Level 3/Primary Care **0-12** ☐ Level 3/Primary Care **TEEN** ☐ Level 3/Stepping Stones ☐ Level 4/Standard

Relationship to child _____ **Number of Children in the home:** ____ **Number of adults in the home:** ___

Child's Presenting Problem:_____

Does the child experience any of the following? (CHECK all that apply) ☐ A vision or hearing impairment
☐ A physical disability ☐ A developmental delay ☐ A restrictive/therapeutic diet prescribed by a health provider
☐ An intellectual/mental disability ☐ A severe chronic illness that results in regular hospitalizations

Pre-test Measures Completed? ☐ **Yes** (Date_____) ☐ **No** (☐ BRIEF TRIPLE P ☐ other_____)

DATE	CAREGIVER(S) RELATIONSHIP	BRIEF DESCRIPTION OF ACTIVITIES	TIME SPENT

Post-Measures Completed: ☐ Yes (Date_____) ☐ Not Applicable ☐ No (Check reason below)
☐ Still providing services ☐ Didn't show for last session ☐ Decided not to return ☐ Measures not given
☐ Lost contact with family ☐ Other: _____

Return to: Triple P Mecklenburg – c/o Cathy Henderson, Southeast Health Department, 249 Billingsley Road, Charlotte, NC 28211

Updated 2-1-16

Circle: PRE
POST

PARENTING SCALE

Provider Name and Agency: _____ Triple P Level & Type: _____

Caregiver Name or Client ID: _____ Today's Date: _____

Instructions:

At one time or another, all children misbehave or do things that could be harmful, that are "wrong," or that parents don't like. Examples include: hitting someone, whining, throwing food, forgetting homework, not picking up toys, lying, having a tantrum, refusing to go to bed, wanting a cookie before dinner, running into the street, arguing back, coming home late.

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, circle the number that best describes your style of parenting during the past 2 months with your child.

Sample Item

At meal time...

I let my child decide how much to eat. 1 2 3 (4) 5 6 7 I decide how much my child eats.

---

01. When my child misbehaves...
I do something right away. 1 2 3 4 5 6 7 I do something about it later.

---

02. Before I do something about a problem...
I give my child several reminders or warnings. 1 2 3 4 5 6 7 I use only one reminder or warning.

---

03. When I'm upset or under stress...
I am picky and on my child's back. 1 2 3 4 5 6 7 I am no more picky than usual.

---

04. When I tell my child not to do something...
I say very little. 1 2 3 4 5 6 7 I say a lot.

---

05. When my child pesters me...
I can ignore the pestering. 1 2 3 4 5 6 7 I can't ignore the pestering.

---

06. When my child misbehaves...
I usually get into a long argument with my child. 1 2 3 4 5 6 7 I don't get into an argument.

---

07. I threaten to do things that...
I am sure I can carry out. 1 2 3 4 5 6 7 I know I won't actually do.

---

08. I am the kind of parent that...
sets limits on what my child is allowed to do. 1 2 3 4 5 6 7 lets my child do whatever he or she wants.

---

09. When my child misbehaves...
I give my child a long lecture. 1 2 3 4 5 6 7 I keep my talks short and to the point.

10. When my child misbehaves...			
I raise my voice or yell.	1 2 3 4 5 6 7	I speak to my child calmly.
11. If saying no doesn't work right away...			
I take some other kind of action.	1 2 3 4 5 6 7	I keep talking and trying to get through to my child.
12. When I want my child to stop doing something...			
I firmly tell my child to stop.	1 2 3 4 5 6 7	I coax or beg my child to stop.
13. When my child is out of my sight...			
I often don't know what my child is doing.	1 2 3 4 5 6 7	I always have a good idea of what my child is doing.
14. After there's been a problem with my child...			
I often hold a grudge.	1 2 3 4 5 6 7	things get back to normal quickly.
15. When we're not at home...			
I handle my child the way I do at home.	1 2 3 4 5 6 7	I let my child get away with a lot more.
16. When my child does something I don't like...			
I do something about it every time it happens.	1 2 3 4 5 6 7	I often let it go.
17. When there's a problem with my child...			
things build up and I do things I don't mean to do.	1 2 3 4 5 6 7	things don't get out of hand.
18. When my child misbehaves, I spank, slap, grab, or hit my child...			
never or rarely.	1 2 3 4 5 6 7	most of the time.
19. When my child doesn't do what I ask...			
I often let it go or end up doing it myself.	1 2 3 4 5 6 7	I take some other action.
20. When I give a fair threat or warning...			
I often don't carry it out.	1 2 3 4 5 6 7	I always do what I said.
21. If saying "No" doesn't work...			
I take some other kind of action.	1 2 3 4 5 6 7	I offer my child something nice so he/she will behave.
22. When my child misbehaves...			
I handle it without getting upset.	1 2 3 4 5 6 7	I get so frustrated or angry that my child can see I'm upset.
23. When my child misbehaves...			
I make my child tell me why he/she did it.	1 2 3 4 5 6 7	I say "No" or take some other action.
24. If my child misbehaves and then acts sorry...			
I handle the problem like I usually would.	1 2 3 4 5 6 7	I let it go that time.

25. When my child misbehaves...
I rarely use bad language or curse. 1 2 3 4 5 6 7 I almost always use bad language.

26. When I say my child can't do something...
I let my child do it anyway. 1 2 3 4 5 6 7 I stick to what I said.

27. When I have to handle a problem...
I tell my child I am sorry about it. 1 2 3 4 5 6 7 I don't say I'm sorry.

28. When my child does something I don't like, I insult my child, say mean things, or call my child names...
never or rarely. 1 2 3 4 5 6 7 most of the time.

29. If my child talks back or complains when I handle a problem...
I ignore the complaining and stick to what I said 1 2 3 4 5 6 7 I give my child a talk about not complaining.

30. If my child gets upset when I say "No"...
I back down and give in to my child. 1 2 3 4 5 6 7 I stick to what I said.

Note. From "The Parenting Scale: A Measure of Dysfunctional Parenting in Discipline Situations," by D.S. Arnold, S.G. O'Leary, L.S. Wolff and M.M. Acker, 1993, *Psychological Assessment,* 5, p. 140. Copyright 1993 by the American Psychological Association, Inc. Adapted with permission.

Circle: PRE
POST

PARENTING SCALE

SCORING KEY
For provider use only.

Provider Name and Agency: _____ Triple P Level & Type: _____

Caregiver Name or Client ID: _____ Today's Date: _____

Please submit the scoring key as part of the level 4 or 5 evaluation packet to Triple P Cabarrus.

Instructions:

- All 30 items are scored on a 7 point scale, with low scores indicating good parenting and high scores indicating dysfunctional parenting. There are three factors on the Parenting Scale: Laxness (LX), Over-reactivity (OR), and Hostility (HS). There are several items that are not on a factor (NF).
- Items are listed below by factor and it is noted whether the "ideal" anchor is on the left (L) or the right-hand (R) side. If the "ideal" anchor is on the left, the left anchor is scored 1. If the "ideal" anchor is on the right, scoring is reversed and the right anchor is scored 1 rather than 7. For example, item 2 has a right anchor, so if the caregiver circled 6, it would be scored as 2. The total score is the sum of all items divided by 30. To achieve a factor score, sum the items in that factor and divide by the number of items in that factor.

  *You may also use the scoring application from the Triple P Provider website.

The recommended clinical cut-off scores for the revised parenting scale are:

- Mothers: Laxness 3.6, Over-reactivity 4.0, Hostility 2.4; and Total Score 3.2.
- Fathers: Laxness 3.4, Over-reactivity 3.9, Hostility 3.5; and Total Score 3.2.

Sources: The Parenting Scale (PS; Arnold, O'Leary, Wolff, & Acker, 1993); (Rhoades & O'Leary, 2007)

ANCHOR

L = Score item by using the scale on instrument 1-7 from left to right

R = Score item by **reversing the scale** on instrument so that scale is 7-1 from left to right

Right Anchor Items: 2, 3, 6, 9, 10, 13, 14, 17, 19, 20, 23, 26, 27, 30

LAXNESS (LX)

Item	Anchor	Score
12	L	___
16	L	___
19	R	___
21	L	___
30	R	___
LX Sum =		___

Factor Score = ___
(Sum ÷ 5)

OVER-REACTIVITY (OR)

Item	Anchor	Score
3	R	___
6	R	___
10	R	___
14	R	___
17	R	___
OR Sum =		___

Factor Score = ___
(Sum ÷ 5)

HOSTILITY (HS)

Item	Anchor	Score
18	L	___
25	L	___
28	L	___
HS Sum =		___

Factor Score = ___
(Sum ÷ 3)

NO FACTOR (NF)

Item	Anchor	Score
1	L	___
2	R	___
4	L	___
5	L	___
7	L	___
8	L	___
9	R	___
11	L	___
13	R	___
15	L	___
20	R	___
22	L	___
23	R	___
24	L	___
26	R	___
27	R	___
29	L	___

NF Sum = ___

TOTAL SCALE SCORE

Total of Sums (LX Sum + OR Sum + HS Sum + NF Sum) = _____

Total Scale Score = _____
(Total of Sums ÷ 30)

Escala Parental

En un momento u otro, todos los niños se portan mal o hacen cosas que pueden ser dañinas, que están "mal", o que no le gustan a los padres. Como ejemplo de esto se incluye el pegarle a alguien, los lloriqueos, aventar comida, olvidar la tarea, no recoger los juguetes, decir mentiras, hacer berrinches, no ir a dormir, querer una galleta antes de dormir, correr a la calle, discutir, llegar tarde a casa. Los padres tienen muchas formas y estilos para tratar con estos tipos de problemas.

A continuación hay conceptos que describen algunos estilos de paternidad. Para cada concepto, encierre en un círculo el número que mejor describa su estilo de paternidad durante los últimos 2 meses con su hijo.

Concepto de muestra

A la hora de la comida...

Dejo que mi hijo decida cuánto come.	1	2	3	(4)	5	6	7	Yo decido cuánto come mi hijo.

01. Cuando mi hijo se porta mal... Hago algo al respecto de inmediato.	1	2	3	4	5	6	7	Hago algo al respecto después.
02. Antes que haga algo respecto a un problema... le doy varios recordatorios o advertencias a mi hijo.	1	2	3	4	5	6	7	Uso sólo un recordatorio o advertencia.
03. Cuando estoy molesto o bajo presión... Soy caprichoso y ando atrás de mi hijo	1	2	3	4	5	6	7	No soy mas caprichoso de lo usual.
04. Cuando le digo a mi hijo que no haga algo... Digo muy poco.	1	2	3	4	5	6	7	Digo mucho.
05. Cuando mi hijo me está molestando... Puedo ignorar sus molestias.	1	2	3	4	5	6	7	No puedo igrnorar sus molestias.
06. Cuando mi hijo se porta mal... Por lo general tengo una discusión muy larga con mi hijo.	1	2	3	4	5	6	7	No me pongo a discutir.
07. Amenazo con hacer cosas que... Estoy seguro que puedo llevar a cabo.	1	2	3	4	5	6	7	Se que en realidad no haré.
08. Soy el tipo de padre que... Establece límites sobre lo que mi hijo puede hacer.	1	2	3	4	5	6	7	Dejo a mi hijo que haga lo que sea que quiera.
09. Cuando mi hijo se porta mal... Le doy una larga plática a mi hijo.	1	2	3	4	5	6	7	Hablo poco y voy directo al punto.
10. Cuando mi hijo se porta mal... Alzo mi voz o grito.	1	2	3	4	5	6	7	Hablo de manera calmada a mi hijo.

Escala Parental

11.	**Si el decir "no" no funciona de inmediato...**							
	Tomo algún otro tipo de acción.	1	2	3	4	5	6	7	Sigo hablando e intento llegar a mi hijo.
12.	**Cuando quiero que mi hijo deje de hacer algo...**							
	Le digo firmemente a mi hijo que se detenga.	1	2	3	4	5	6	7	Lo engatuso o le ruego para que deje de hacerlo.
13.	**Cuando mi hijo no está a la vista...**							
	A menudo no sé lo que mi hijo está haciendo.	1	2	3	4	5	6	7	Siempre sé lo que mi hijo está haciendo.
14.	**Después de que ha habido un problema con mi hijo...**							
	A menudo me siento resentido.	1	2	3	4	5	6	7	Las cosas regresan a la normalidad rápidamente.
15.	**Cuando no estamos en casa...**							
	Manejo a mi hijo igual que en casa.	1	2	3	4	5	6	7	Dejo que mi hijo haga mucho más.
16.	**Cuando mi hijo hace algo que no me gusta...**							
	Hago algo al respecto siempre que pasa.	1	2	3	4	5	6	7	A menudo lo dejo pasar.
17.	**Cuando hay un problema con mi hijo...**							
	Las cosas se acumulan y hago cosas que no quisiera hacer.	1	2	3	4	5	6	7	Las cosas no se salen de control.
18.	**Cuando mi hijo se porta mal, nalgüeo, abofeteo, agarro o golpeo a mi hijo...**							
	Nunca o raramente.	1	2	3	4	5	6	7	La mayoría del tiempo.
19.	**Cuando mi hijo no hace lo que le digo que haga...**							
	A menudo lo dejo pasar o lo hago yo mismo.	1	2	3	4	5	6	7	Tomo alguna otra acción.
20.	**Cuando le doy una amenaza o advertencia justa...**							
	Por lo general no la aplico.	1	2	3	4	5	6	7	Siempre hago lo que digo.
21.	**Si decir "No" no funciona...**							
	Tomo algún otro tipo de acción.	1	2	3	4	5	6	7	Ofrezco a mi hijo algo bonito para que se comporte.
22.	**Cuando mi hijo se porta mal...**							
	Lo manejo sin molestarme.	1	2	3	4	5	6	7	Me frustro o me enojo tanto que mi hijo puede ver mi molestia.

Escala Parental

23.	**Cuando mi hijo se porta mal…**							
	Hago que mi hijo me diga por qué lo hizo.	1	2	3	4	5	6	7	Digo "No" o tomo otra acción.
24.	**Si mi hijo se porta mal y luego actuamo como si lo siente…**							
	Manejo el problema como siempre lo haría.	1	2	3	4	5	6	7	Lo dejo pasar esa vez.
25.	**Cuando mi hijo se porta mal…**							
	Raramente uso malas palabras o maldigo.	1	2	3	4	5	6	7	Casi siempre uso malas palabras.
26.	**Cuando digo que mi hijo no puede hacer algo…**							
	Dejo que mi hijo lo haga de cualquier manera.	1	2	3	4	5	6	7	Me apego a lo que dije.
27.	**Cuando tengo que manejar un problema…**							
	Le digo a mi hijo que lo siento.	1	2	3	4	5	6	7	No le digo que lo siento.
28.	**Cuando mi hijo hace algo que no me gusta, insulto a mi hijo, digo cosas malas, o le digo nombres…**							
	Nunca o raramente.	1	2	3	4	5	6	7	La mayor parte del tiempo.
29.	**Si mi hijo responde o se queja cuando manejo un problema…**							
	Ignoro la queja y me apego a lo que dije.	1	2	3	4	5	6	7	Platico con mi hijo sobre no quejarse.
30.	**Si mi hijo se molesta cuando digo que "No"…**							
	Retrocedo y hago lo que diga mi hijo.	1	2	3	4	5	6	7	Me apego a lo que dije.

Nota: De "La Escala de Paternidad: Una medida de paternidad disfuncional en situaciones de disciplina," por D. S. Arnold, S. G. O'Leary, L. S. Wolff, & M. M. Acker, 1993, Evaluación Psicológica, 5, pp. 137-144. Copyright 1993 por American Psychological Association, Inc. Adaptada bajo permiso.

Scoring Key Parenting Scale

Child's name: ..... **Client number:** .....
Parent's name: ..... **Date**: .....

All 30 items are scored on a 7 point scale, with low scores indicating good parenting and high scores indicating dysfunctional parenting. There are three factors of the Parenting Scale: Laxness (LX), Over reactivity (OR), and Verbosity (VB).

There are several items that are not on a factor (NF). Items are listed below by factor and it is noted whether the "ideal" anchor is on the left (L) or the right-hand (R) side. If the "ideal" anchor is on the left, the left anchor is scored 1. If the "ideal" anchor is on the right, scoring is reversed and the right anchor is scored 1 rather than 7. The total score is the sum of all items divided by 30. To achieve a factor score, sum the items in that factor and divide by the number of items in that factor.

LX (Laxness)	OR (Over reactivity)	VB (Verbosity)	NF (No Factor)
07-L ☐	03-R ☐	02-R ☐	01-L ☐
08-L ☐	06-R ☐	04-L ☐	05-L ☐
12-L ☐	09-R ☐	07-L* ☐	13-R ☐
15-L ☐	10-R ☐	09-R* ☐	27-R ☐
16-L ☐	14-R ☐	11-L ☐	
19-R ☐	17-R ☐	23-R ☐	
20-R ☐	18-L ☐	29-L ☐	
21-L ☐	22-L ☐		
24-L ☐	25-L ☐		
26-R ☐	28-L ☐		
30-R ☐			

LX SUM	**OR SUM**	**VB SUM**	**NF SUM** .....
Factor Score	**Factor Score**	**Factor Score**	
(Sum ÷ 11)	**(Sum ÷ 10)**	**(Sum ÷ 7)**	

TOTAL (LX + OR + VB + NF)* .....
* Sum all items above, minus scores for Items 7 and 9 (as these load twice on factors)

TOTAL SCALE SCORE (Total ÷ 30) .....

Strengths and Difficulties Questionnaire (SDQ)

Child Assessment Tool

1. **Obtain a free download of the SDQ from:**

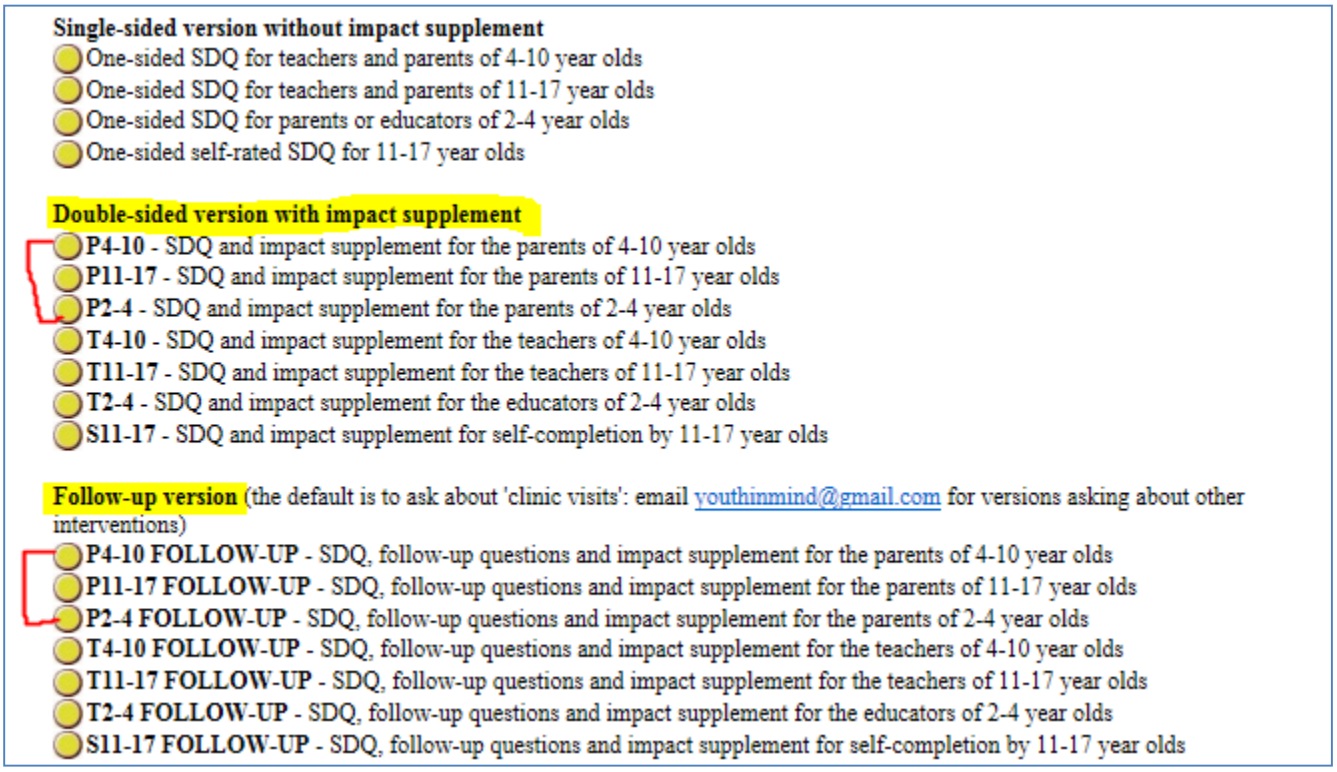
   English Versions: http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(USA)

   Spanish Versions: http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Spanish

Website View Below:

PRE

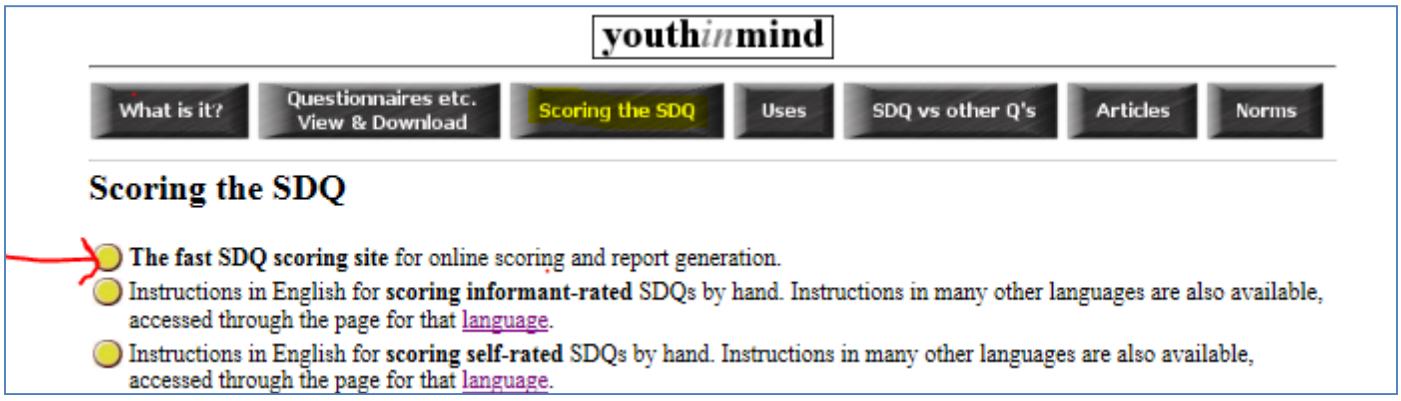
POST



2. **Score using on-line application and submit scoring key:**

   http://www.sdqinfo.org/py/sdqinfo/c0.py

Website View Below:



Circle: PRE
POST

Strengths and Difficulties Questionnaire (SDQ)

SCORING KEY
For provider use only.

Provider Name and Agency: _____ Triple P Level & Type: _____

Caregiver Name or Client ID: _____ Today's Date: _____

Please submit the scoring key as part of the level 4 or 5 evaluation packet to Triple P Cabarrus.

Instructions:

- **Score each subscale and total difficulties using the on-line scoring application and submit a printed copy of the summary report or enter the scores manually using the table below.**
- *The scoring application and ranges for interpretation of scores from the SDQ completed by the **parent** are available from: http://www.sdqinfo.org/py/sdqinfo/c0.py.*

Parent completed SDQ Scores			**Original three-band solution cut-points 4-17 year olds**		
SCALE	**SCORE ↓**		**Normal Range**	**Borderline Range**	**Abnormal Range**
Total Difficulties:	_____		0 – 13	14 - 16	17 - 40
Emotional Symptoms:	_____		0 - 3	4	5 - 10
Conduct Problems:	_____		0 - 2	3	4 - 10
Hyperactivity:	_____		0 - 5	6	7 - 10
Peer Problems:	_____		0 - 2	3	4 - 10
Prosocial Behavior:	_____		6 - 10	5	0 – 4
Impact:	_____		0	1	2-10

CAREGIVER SATISFACTION QUESTIONNAIRE

Provider Name and Agency: _____ Triple P Level & Type: _____

Caregiver Name or Client ID: _____ Today's Date: _____

Relationship to Child: _____

INSTRUCTIONS:

This questionnaire will help us to evaluate and continually improve the Triple P parenting program we offer. We are interested in your HONEST OPINIONS about the services you have received, whether they are positive or negative. Please answer all the questions by circling the response that best describes how you honestly feel.

1. **How would you rate the quality of the Triple P parenting program you and your child received?**

1	2	3	4	5	6	7
Poor		Fair		Good		Excellent

2. **Has the Triple P parenting program helped you to deal more effectively with your child's behavior?**

1	2	3	4	5	6	7
No, it made things worse		No, it hasn't helped much		Yes, it has helped somewhat		Yes, has helped a great deal

3. **Has the Triple P parenting program helped you to deal more effectively with problems that arise in your family?**

1	2	3	4	5	6	7
No, it made things worse		No, it hasn't helped much		Yes, it has helped somewhat		Yes, has helped a great deal

4. **If you were to seek help again, would you come back to Triple P parenting program?**

1	2	3	4	5	6	7
No, definitely not		No, I don't think so		Yes, I think so		Yes, definitely

5. **In your opinion, how is your child's behavior at this point?**

1	2	3	4	5	6	7
Considerably worse	Worse	Slightly worse	The same	Slightly improved	Improved	Greatly improved

6. **Do you have any other comments about Triple P parenting program?**

_____
_____
_____
_____
_____
_____

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

CUESTIONARIO DE SATISFACCIÓN DEL CLIENTE

Provider Name: _____ Triple P Level & Type: _____

Nombre del padre: _____ Fecha de hoy: _____

Relación al niño: _____

INSTRUCCIONES:
Este cuestionario nos ayudará a evaluar y continuar mejorando el programa que ofrecemos. Estamos interesados en sus opiniones honestas sobre los servicios que recibió, ya sea que hayan sido positivos o negativos. Por favor responda todas las preguntas. Por favor encierre en un círculo la respuesta que mejor describa como se siente.

1. **¿Cómo calificaría la calidad del servicio de Triple P que usted y su hijo recibieron?**

1	2	3	4	5	6	7
Malo		Regular		Bueno		Excelente

2. **¿Le ayudó el programa de Triple P a tratar más efectivamente el comportamiento del niño?**

1	2	3	4	5	6	7
No, dejó cosas peor		No ayudó mucho		Si, ayudó un poco		Si, ayudó mucho

3. **¿Le ayudó el programa de Triple P a tratar más efectivamente los problemas que surgen en su familia?**

1	2	3	4	5	6	7
No, dejó las cosas peor		No ayudó mucho		Si, ayudó un poco		Si, ayudó mucho

4. **¿Si buscara ayuda de nuevo, ¿regresaría al programa de Triple P?**

1	2	3	4	5	6	7
No, definitivamente no		No, creo que no		Sí, creo que sí		Sí, definitivamente

5. **¿En su opinión, ¿cómo es la conducta de su hijo en este momento?**

1	2	3	4	5	6	7
Mucho Peor	Peor	Un poco peor	Igual	Un poco mejor	Mejor	Mucho Mejor

6. **¿Tiene algún otro comentario sobre el programa de Triple P?**

_____
_____
_____
_____
_____
_____

Return to: Triple P Mecklenburg
Attn. Cathy Henderson
Southeast Health Department
249 Billingsley Road
Charlotte, NC 28211

Edited 4/25/2016

Standard Triple P Session 1 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Introduction ☐

- Welcome and self-introduction

02. Agenda ☐

- Provide an overview of the session (outline proposed session goals and gain consent from the parent/s)
  - Intake interview (discussion of each parent's main concerns about their child's behavior, factors influencing the child's behavior, and obstacles to change)
  - Keeping track of children's behavior

03. Intake Interview ☐

- Exercise 1: Sharing information

Family Details

- Obtain identifying information

Referral Source

- Establish the source of referral

Diagnostic Information

- Record any available diagnostic information

Child Behavior

- Discuss each parent's main concerns about their child's behavior (nature, context, intensity, onset, course, frequency, duration)
- Use the questionnaires as a prompt if necessary

Parenting Skills

- Explore current parenting strategies

Previous History of Psychological Help

- Ask about any previous help sought for the child

Factors Influencing Child Behavior

- Obtain a developmental history for the child
- Explore the child's educational history

Obstacles to Change

- Discuss family circumstances and history
- Review family relationships and interaction
- Discuss parental adjustment

Health Status

- Review the child's health status
- Review the parent/s' health status

Parent/s' Perception of the Problem

- Discuss each parent's ideas about their child's current behavior problems

Standard Triple P Session 1 Summary

Parent/s' Expectations

- Discuss each parent's expectations for the intervention process

04. Keeping Track of Children's Behavior ☐

- Introduce monitoring of children's behavior
- Decide on the target behavior/s to monitor
- Exercise 2: Choosing what to monitor
- Devise a system for keeping track of the target behavior/s
- Explain the monitoring form/s chosen
- Exercise 3: Keeping track

05. Session Close ☐

- Review the session
- Explain homework tasks
  - Monitor the target child behavior/s
  - Note any important information not discussed in the session
  - Read Session 2 in *Every Parent's Family Workbook* (and, if available, watch *Every Parent's Survival Guide Part 2:* Causes of Child Behavior Problems, Goals for Change) and make a start on the exercises
  - Ensure *Assessment Booklet One* is completed and returned prior to the next session
- Schedule the next appointment (prompt the parent/s to bring their child to the next session)
- Close the session (outline the content of the next session and thank the parent/s for attending)

06. Interview the child's teacher if required (arrange parental permission) ☐

- Explore the child's general adjustment to school
- Ask about classroom and playground behavior
- Review academic achievement
- Discuss peer relationships
- Ask about any assistance to date

Session Notes

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Additional Agenda Items (note any additional content or major deviation from the set program)

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Standard Triple P
Session 1 Summary

Homework Tasks

Signed: ..... Date completed: .....

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Standard Triple P Session 2 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Provide an overview of the session (outline proposed session goals and gain consent from the parent/s)
  - Interview with the child (if appropriate)
  - Brief update and review of homework
  - Observation of parent–child interaction
  - Feedback of assessment results and summary of main areas of concern
  - Causes of child behavior problems
  - Goals for change
  - Intervention negotiation

02. Interviewing the Child ☐

- Ask about the presenting problem
- Check if there are any associated problems
- Talk about social and peer relationships
- Check for any school issues
- Complete a mental status examination
- Provide a summary and thank the child

03. Review ☐

- Obtain a brief update (current family situation, information not covered in previous session)
- Review homework (monitoring, reading/viewing and workbook exercises)

04. Observation of Parent–Child Interaction ☐

- Set up an observation of parent–child interaction
- Exercise 1: Interacting with your family
- Thank the parent/s and child (debrief at completion of observation task)

05. Feedback of Assessment Results ☐

- Formulate hypotheses
- Set the child up with an activity
- Explain the feedback process
- Exercise 2: Sharing assessment findings
- Discuss the data from each information source (interview, questionnaires, monitoring, observation) and keep a record of the baseline rates of the problem behavior/s.
- Provide an integrating summary

Standard Triple P Session 2 Summary

06. Causes of Child Behavior Problems

- Outline the purpose of discussing causes of child behavior problems
- Introduce causes of child behavior problems
- Exercise 3: Identifying causes of child behavior problems
- Share your own observations (if necessary)
- Ask the parent/s for any additional factors not listed
- Provide an integrating summary

07. Goals for Change

- Exercise 4: What skills should we encourage in children?
- Exercise 5: Setting goals for change (note the parent/s' goals)

08. Intervention Negotiation

- Introduce the format of Standard Triple P
- Negotiate an intervention plan

09. Session Close

- Review the session
- Explain homework tasks
  - Monitor the target child behavior/s
  - Read Session 3 in *Every Parent's Family Workbook* (and, if available, watch *Every Parent's Survival Guide* Part 1: What is Positive Parenting? and Part 3: Promoting Children's Development) and make a start on the exercises
- Schedule the next appointment (prompt the parent/s to leave their child with carers for the next session)
- Close the session (outline the content of the next session and thank the parent/s and child for attending)

Session Notes

Additional Agenda Items (note any additional content or major deviation from the set program)

Standard Triple P Session 2 Summary

Homework Tasks

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Signed: ..... Date completed: .....

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Standard Triple P Session 3 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Provide an overview of the session (outline proposed session goals and gain consent from the parent/s)
  - Review of previous session, brief update and review of homework
  - Principles of positive parenting
  - Strategies for promoting children's development (developing positive relationships with children, encouraging desirable behavior, teaching new skills and behaviors)

02. Review ☐

- Recap main points from Session 2 (sharing of assessment findings, causes of child behavior problems, goals for change in child's and own behavior)
- Obtain a brief update (changes in child behavior)
- Review homework (monitoring, reading/viewing and workbook exercises)

03. What is Positive Parenting? ☐

- Introduce the principles of positive parenting
- Exercise 1: What is positive parenting?

04. Promoting Children's Development ☐

- Provide a rationale for strategies for promoting children's development

05. Developing Positive Relationships With Children ☐

- Provide a rationale for developing positive relationships with children
- Introduce quality time and complete Exercise 2: Ideas for quality time
- Introduce conversing with children and complete Exercise 3: Things to talk about
- Introduce showing affection to children and complete Exercise 4: Ways to show affection

06. Encouraging Desirable Behavior ☐

- Provide a rationale for encouraging desirable behavior
- Introduce descriptive praise and complete Exercise 5: How to give descriptive praise
- Introduce giving attention and complete Exercise 6: Ways to give attention
- Introduce engaging activities and complete Exercise 7: Ideas for engaging activities

07. Teaching New Skills and Behaviors ☐

- Provide a rationale for teaching new skills and behaviors
- Introduce setting a good example and complete Exercise 8: Ways to set a good example
- Introduce incidental teaching and complete Exercise 9: Ideas for using incidental teaching
- Introduce Ask, Say, Do and complete Exercise 10: Ideas for using Ask, Say, Do
- Introduce behavior charts and complete Exercise 11: Setting up a behavior chart

Standard Triple P Session 3 Summary

08. Session Close

- Review the session
- Explain homework tasks
  - Practice and monitor use of two strategies for promoting children's development
  - Check ideas for rewards for behavior chart with child
  - Prepare a behavior chart
  - Monitor the target child behavior/s
  - Read Session 4 in *Every Parent's Family Workbook* (and, if available, watch *Every Parent's Survival Guide* Part 4: Managing Misbehavior) and make a start on the exercises
- Schedule the next appointment (prompt the parent/s to leave their child with carers for the next session)
- Close the session (outline the content of the next session and thank the parent/s for attending)

Session Notes

Additional Agenda Items (note any additional content or major deviation from the set program)

Standard Triple P
Session 3 Summary

Homework Tasks

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Signed: ..... Date completed: .....

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Standard Triple P Session 4 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Provide an overview of the session (outline proposed session goals and gain consent from the parent/s)
  - Review of previous session and homework
  - Managing misbehavior
  - Developing parenting routines
  - Finalizing behavior charts

02. Review ☐

- Recap main points from Session 3: principles of positive parenting; promoting children's development by developing positive relationships with children (quality time, talking with children, showing affection); encouraging desirable behavior (descriptive praise, providing attention, selecting engaging activities); teaching new skills and behaviors (setting a good example, incidental teaching, Ask, Say, Do, behavior charts)
- Review homework (implementing two strategies, deciding on rewards, preparing behavior chart, monitoring, reading/viewing and workbook exercises)

03. Managing Misbehavior ☐

- Provide a rationale for strategies for managing misbehavior
- Introduce ground rules and complete Exercise 1: Deciding on ground rules
- Introduce directed discussion and complete Exercise 2: Ideas for using directed discussion
- Introduce planned ignoring and complete Exercise 3: Ideas for using planned ignoring
- Introduce clear, calm instructions and complete Exercise 4: Ideas for giving clear, calm instructions
- Introduce logical consequences and complete Exercise 5: Choosing logical consequences
- Introduce quiet time and complete Exercise 6: Preparing to use quiet time
- Introduce time-out and complete Exercise 7: Preparing to use time-out

04. Developing Parenting Routines ☐

- Introduce the compliance routine and complete Exercise 8: Using the compliance routine
- Introduce the behavior correction routine and complete Exercise 9: Using the behavior correction routine

05. Finalizing Behavior Charts ☐

- Exercise 10: Consequences for behavior charts

Standard Triple P Session 4 Summary

06. Session Close

- Review the session
- Explain homework tasks
  - Decide on and discuss ground rules
  - Practice and monitor use of strategies for managing misbehavior
  - Put behavior chart into practice
  - Monitor the target child behavior/s
  - Read Session 5 in *Every Parent's Family Workbook* and prepare for the practice session
- Schedule the next appointment (prompt the parent/s to have their child with them for the next session)
- Explain the format of practice sessions
- Close the session (thank the parent/s for attending)

Session Notes

Additional Agenda Items (note any additional content or major deviation from the set program)

Homework Tasks

Signed: ..... Date completed: .....

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Standard Triple P Session 5 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Establish an agenda (negotiate the session goals with the parent/s)
  - Practice task
  - Self-evaluation, feedback and goal setting
  - Review of homework
  - Additional agenda items

02. Practice Task ☐

- Review the rules
- Review the parent/s' goals for the practice task as listed in Exercise 1: Setting goals for the practice task
- Check how the parent/s feel
- Prompt the parent/s to complete Exercise 2: Keeping track of what you do, as part of the practice task
- Begin the practice task (on a Practice Session Observation Form, keep a tally and note examples of descriptive and general praise comments, and specific and vague instructions; note strengths and weaknesses in incidental teaching and back-up consequences)

03. Feedback ☐

- Set up to conduct self-evaluation and feedback (prompt the parent/s to set their child up in an activity and to encourage independent play)
- Exercise 3: Reviewing the practice task (use the minimal amount of prompting to help the parent/s identify their strengths and weaknesses, shape the parent/s' skills as appropriate)

04. Goal Setting ☐

- Set goals for behavior change (prompt the parent/s to set specific goals for practice before and during the next session)

05. Homework Review ☐

- Discuss homework tasks (setting ground rules, implementation of behavior chart, use of positive parenting strategies, monitoring)

06. Additional Agenda Items ☐

- Discuss any additional agenda items
- Use minimal prompts to help the parent/s solve problems
- Note any additional content or major deviation from the set program

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Standard Triple P Session 5 Summary

07. Session Close

- Review the session
- Check homework tasks
  - Practice skills as per goals set in this session
  - Reading
  - Monitor the target child behavior/s
  - Prepare for the next practice session (set goals for the practice task and record them in Exercise 1 in Session 6 of *Every Parent's Family Workbook*)
- Schedule the next appointment (prompt the parent/s to have their child with them for the next session)
- Close the session (thank the parent/s for participating)

Session Notes

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Additional Agenda Items (note any additional content or major deviation from the set program)

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Homework Tasks

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Signed: ..... Date completed: .....

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Standard Triple P Session 6 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Establish an agenda (negotiate the session goals with the parent/s)
  - Practice task
  - Self-evaluation, feedback and goal setting
  - Review of homework
  - Additional agenda items

02. Practice Task ☐

- Review the rules
- Review the parent/s' goals for the practice task as listed in Exercise 1: Setting goals for the practice task
- Check how the parent/s feel
- Prompt the parent/s to complete Exercise 2: Keeping track of what you do, as part of the practice task
- Begin the practice task (on a Practice Session Observation Form, keep a tally and note examples of descriptive and general praise comments, and specific and vague instructions; note strengths and weaknesses in incidental teaching and back-up consequences)

03. Feedback ☐

- Set up to conduct self-evaluation and feedback (prompt the parent/s to set their child up in an activity and to encourage independent play)
- Exercise 3: Reviewing the practice task (use the minimal amount of prompting to help the parent/s identify their strengths and weaknesses, shape the parent/s' skills as appropriate)

04. Goal Setting ☐

- Set goals for behavior change (prompt the parent/s to set specific goals for practice before and during the next session)

05. Homework Review ☐

- Discuss homework tasks (skills practiced, monitoring)

06. Additional Agenda Items ☐

- Discuss any additional agenda items
- Use minimal prompts to help the parent/s solve problems
- Note any additional content or major deviation from the set program

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Standard Triple P Session 6 Summary

07. Session Close

- Review the session
- Check homework tasks
  - Practice skills as per goals set in this session
  - Reading
  - Monitor the target child behavior/s
  - Prepare for the next practice session (set goals for practice task and record them in Exercise 1 in Session 7 of *Every Parent's Family Workbook*)
- Schedule the next appointment (prompt the parent/s to have their child with them for the next session)
- Close the session (thank the parent/s for participating)

Session Notes

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Additional Agenda Items (note any additional content or major deviation from the set program)

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Homework Tasks

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Signed: ..... Date completed: .....

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Standard Triple P Session 7 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Establish an agenda (negotiate the session goals with the parent/s)
  - Practice task
  - Self-evaluation, feedback and goal setting
  - Review of homework
  - Additional agenda items

02. Practice Task ☐

- Review the rules
- Review the parent/s' goals for the practice task as listed in Exercise 1: Setting goals for the practice task
- Check how the parent/s feel
- Prompt the parent/s to complete Exercise 2: Keeping track of what you do, as part of the practice task
- Begin the practice task (on a Practice Session Observation Form, keep a tally and note examples of descriptive and general praise comments, and specific and vague instructions; note strengths and weaknesses in incidental teaching and back-up consequences)

03. Feedback ☐

- Set up to conduct self-evaluation and feedback (prompt the parent/s to set their child up in an activity and to encourage independent play)
- Exercise 3: Reviewing the practice task (use the minimal amount of prompting to help the parent/s identify their strengths and weaknesses, shape the parent/s' skills as appropriate)

04. Goal Setting ☐

- Set goals for behavior change (prompt the parent/s to set specific goals for practice before the next session)

05. Homework Review ☐

- Discuss homework tasks (skills practiced, monitoring)

06. Additional Agenda Items ☐

- Discuss any additional agenda items
- Use minimal prompts to help the parent/s solve problems
- Note any additional content or major deviation from the set program

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Standard Triple P Session 7 Summary

07. Session Close

- Review the practice sessions
- Explain homework tasks
  - Practice skills as per goals set in this session
  - Reading
  - Monitor the target child behavior/s
  - Read Session 8 in *Every Parent's Family Workbook* (and, if available, watch the Going Shopping segment of *Every Parent's Guide to Preschoolers*) and make a start on the exercises
- Schedule the next appointment (prompt the parent/s to leave their child with carers for the next session)
- Close the session (provide a rationale for planned activities training, outline the content of the next session and thank the parent/s for participating)

Session Notes

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Additional Agenda Items (note any additional content or major deviation from the set program)

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Homework Tasks

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Signed: ..... Date completed: .....

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Standard Triple P Session 8 Summary

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Client number:..... Date of session:.....

Start time:..... Finish time:.....

Content Checklist

01. Agenda ☐

- Provide an overview of the session (outline proposed session goals and gain consent from the parent/s)
  - Review of practice sessions and homework
  - Update on progress
  - High-risk situations
  - Planned activities routines

02. Review ☐

- Recap main points from the practice sessions
- Review homework (skills practiced, monitoring, reading/viewing and workbook exercises)

03. Update on Progress ☐

- Exercise 1: Reviewing progress

04. High-Risk Situations ☐

- Introduce high-risk situations
- Exercise 2: Identifying high-risk parenting situations

05. Planned Activities Routines ☐

- Provide a rationale for planned activities
- Introduce the steps of the planned activities routine
- Discuss the use of practice sessions
- Use an example to illustrate an entire planned activities routine
- Exercise 3: Developing a planned activities routine
- Summarize planned activities

06. Session Close ☐

- Review the session
- Explain homework tasks
  - Develop and try out planned activities routines for two high-risk situations and monitor the steps completed
  - Monitor the target child behavior/s
  - Prepare for Session 9 (develop a planned activities routine for encouraging independent play and prepare the checklist on page 123 in *Every Parent's Family Workbook*, arrange a fun activity for the session, plan an outing for after the session and note details on page 127)
- Schedule the next appointment (prompt the parent/s to bring their child to the next session)
- Close the session (outline the content of the next session and thank the parent/s for attending)

Standard Triple P
Session 8 Summary

Session Notes

Additional Agenda Items (note any additional content or major deviation from the set program)

Homework Tasks

Signed: ..... Date completed: .....

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Group Lifestyle Triple P Session 1 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Introduction ☐

- Welcome parents and introduce yourself
- Collect completed *Questionnaire Booklet One*
- Provide an overview of Group Lifestyle Triple P

02. Agenda ☐

- Provide an overview of the session

03. Working as a group ☐

- Exercise 1: Setting basic ground rules for the group
- Exercise 2: Getting to know you
- Check questionnaire booklets (return to parent if incomplete)
- Exercise 3: What you would like to get out of the programme

04. What does 'overweight' mean? ☐

- Define 'overweight' and list the associated problems
- Discuss possible causes (genetic versus environmental)

05. How can overweight be treated? ☐

- Explain the importance of making gradual changes in family lifestyle
- Outline the components of Lifestyle Triple P (nutrition, physical activity, positive parenting)

06. Readiness for change ☐

- Exercise 4: Identifying obstacles to change
- Exercise 5: Listing some motivating statements
- Exercise 6: Declaration of commitment

07. Keeping track ☐

- Hand out copies of *Keeping Track Booklet One*
- Exercise 7: Keeping track of food intake and activity

08. Session close ☐

- Review the main issues covered in the session
- Explain why homework is important
- Explain the homework tasks (keeping track of child food intake and activity for 3 days)
- Outline the content of the next session (increasing children's self-esteem, assessing child food intake)
- Thank parents for their participation

Group Lifestyle Triple P Session 1 Checklist

Pre-group assessment (list the names of families still to return *Questionnaire Booklet One*)

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 2 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents and thank them for being ready to start at the agreed time
- Provide an overview of the session

02. Review ☐

- Review Session 1 (what overweight means and how it can be treated, obstacles and benefits to making changes in family lifestyle, keeping track of child lifestyle patterns)
- Check how parents went completing *Keeping Track Booklet One*

03. Increasing children's self-esteem ☐

- Introduce the strategies for increasing children's self-esteem
- Show DVD segments: Spend quality time; Talk to your child; Show affection
- Exercise 1: Ideas for spending time together
- Exercise 2: Thinks to talk about
- Exercise 3: Ways to show affection

04. Changing eating behaviour ☐

- Explain why restrictive diets are not recommended

05. Food groups and nutrients ☐

- Discuss the food groups, the main nutrients within each group, the healthiest options within each group

06. Daily food serves ☐

- Introduce the recommended daily serves
- Exercise 4: Working out daily food serves

07. Nutrition goals ☐

- Exercise 5: Setting nutrition goals
- Remind parents to introduce changes in family nutrition gradually

08. Session close ☐

- Review the main issues covered in the session
- Explain the homework tasks (setting a goal for using one of the strategies for increasing children's self-esteem and keeping track of how it goes)
- Outline the content of the next session (encouraging healthy behaviour, assessing activity levels, increasing incidental activity, reducing sugar intake)
- Thank parents for their participation

Group Lifestyle Triple P Session 2 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 3 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents and thank them for being ready to start at the agreed time
- Provide an overview of the session

02. Review ☐

- Review Session 2 (increasing children's self-esteem, food groups and nutrients, nutrition goals)
- Check how parents went using the strategies for increasing children's self-esteem

03. Encouraging healthy behaviour ☐

- Introduce the strategies for encouraging healthy behaviour
- Show DVD segments: Praise; Attention
- Exercise 1: Praising your child
- Exercise 2: Ways to set a healthy example

04. Trying new foods ☐

- Discuss the ideas for managing fussy eating
- Exercise 3: Getting children to eat vegetables

05. The importance of physical activity ☐

- Discuss the benefits of physical activity
- Introduce the physical activity guidelines
- Exercise 4: Working out your child's activity levels

06. Physical activity goals ☐

- Exercise 5: Setting physical activity goals

07. Increasing incidental activity ☐

- Define 'incidental activity'
- Discuss making family leisure time active
- Discuss using active transport

08. Reducing sugar intake ☐

- Discuss replacing foods high in added sugar
- Discuss providing water as the main drink

Group Lifestyle Triple P Session 3 Checklist

09. Session close

- Review the main issues covered in the session
- Explain the homework tasks (setting four goals for using the Session 3 strategies and keeping track of how it goes)
- Outline the content of the next session (using behaviour charts, reducing fat intake, modifying recipes)
- Thank parents for their participation

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 4 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents to the session
- Provide an overview of the session

02. Review ☐

- Review Session 3 (encouraging healthy behaviour, benefits of physical activity, physical activity guidelines and goals, increasing incidental activity, reducing sugar intake)
- Check how parents went using the strategies from Session 3

03. Motivating children to be healthy ☐

- Introduce behaviour charts
- Show DVD segment: Behaviour charts
- Exercise 1: Planning a behaviour chart
- Exercise 2: Making up a chart

04. Reducing fat intake ☐

- Explain the different types of fat and associated health risks
- Discuss buying low fat foods, using low fat cooking methods, replacing high fat ingredients
- Exercise 3: Modifying recipes

05. The importance of physical activity ☐

- Review the main issues covered in the session
- Explain the homework tasks (making up and using a behaviour chart, writing out a modified recipe)
- Outline the content of the next session (limiting sedentary activity, reading food labels)
- Thank parents for their participation

Group Lifestyle Triple P Session 4 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 5 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents to the session
- Provide an overview of the session

02. Review ☐

- Review Session 4 (using rewards to encourage healthy behaviour, reducing fat intake, modifying recipes)
- Check how parents went implementing a behaviour chart and collect their modified recipes

03. Reducing television and computer time ☐

- Discuss limiting sedentary activity

04. Preventing problem behaviour ☐

- Introduce the strategies for preventing problem behaviour
- Show DVD segments: Establish clear ground rules; Directed discussion
- Exercise 1: Deciding on rules
- Exercise 2: Using directed discussion

05. Understanding food labels ☐

- Explain the steps for reading food labels (ingredient list, nutrition claims, nutrition label)
- Exercise 3: Reading food labels

06. Session close ☐

- Review the main issues covered in the session
- Explain the homework tasks (implementing new rules, finding 3 healthy packaged foods)
- Outline the content of the next session (increasing energetic play) and give a reminder to wear comfortable clothing
- Thank parents for their participation

Group Lifestyle Triple P Session 5 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 6 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents to the session
- Provide an overview of the session
- Hand out copies of the modified recipes collected in Session 5

02. Review ☐

- Review Session 5 (limiting sedentary activities, teaching children to follow rules about food and activity, reading food labels)
- Check how parents went implementing rules and using directed discussion, and ask them to show the group their food packets

03. Increasing energetic play ☐

- Discuss the strategies for increasing energetic play
- Hand out copies of the *Lifestyle Triple P Active Games Booklet*
- Exercise 1: Ideas for active games
- Exercise 2: Setting up and playing an active game
- Exercise 3: Reviewing the game
- Exercise 4: Planning active time
- Exercise 5: Making a games list

04. Session close ☐

- Review the main issues covered in the session
- Explain the homework tasks (setting 2 goals for using the strategies for increasing energetic play and keeping track of how it goes)
- Outline the content of the next session (preventing hunger and overeating, preparing healthy food, increasing involvement in sport)
- Thank parents for their participation

Group Lifestyle Triple P Session 6 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 7 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents to the session
- Provide an overview of the session

02. Review ☐

- Review Session 6 (making games part of your child's daily routine, playing an active game with your child for a few minutes every day)
- Check how parents went using the Session 6 strategies

03. Preventing hunger and overeating ☐

- Discuss how to set up eating routines
- Exercise 1: Setting times for meals and snacks
- Discuss the glycemic index

04. Preparing healthy food ☐

- Discuss the importance of preparing healthy foods
- Hand out copies of the *Lifestyle Triple P Recipe Booklet*
- Exercise 2: Providing healthy meals and snacks
- Exercise 3: Planning healthy packed lunches

05. Increasing involvement in sport ☐

- Discuss children's involvement in sport

06. Session close ☐

- Review the main issues covered in the session
- Explain the homework tasks (researching a suitable sport, trying out the planned packed lunches)
- Outline the content of the next session (managing problem behaviour)
- Thank parents for their participation

Group Lifestyle Triple P Session 7 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 8 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents to the session
- Provide an overview of the session

02. Review ☐

- Review Session 7 (preventing hunger and overeating, preparing healthy food, increasing involvement in sport)
- Collect contact information for local sports and check how parents went trying out their ideas for packed lunches

03. Managing problem behaviour ☐

- Provide a rationale for the strategies for managing misbehaviour
- Introduce planned ignoring
- Show DVD segments: Planned ignoring; Clear, calm instructions; Logical consequences
- Exercise 1: Using planned ignoring
- Introduce clear, calm instructions
- Exercise 2: Giving clear, calm instructions
- Introduce logical consequences
- Exercise 3: Choosing logical consequences
- Introduce quiet time and time-out
- Show DVD segments: Quiet time; Time-out
- Exercise 4: Getting ready to use quiet time
- Exercise 5: Getting ready to use time-out

04. Developing parenting routines ☐

- Introduce the start routine
- Exercise 6: Using the start routine
- Introduce the stop routine

05. Preparing for the weekly telephone sessions ☐

- Explain the purpose and format of the weekly telephone sessions
- Exercise 7: Choosing a time

06. Session close ☐

- Review the main issues covered in the session
- Explain the homework tasks (trying out the strategies for managing misbehaviour, keeping track of time-out)
- Remind parents to plan ahead for their telephone session
- Thank parents for their participation

Group Lifestyle Triple P Session 8 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 9 Checklist

Use this as a guide to deliver the session, and a record of how it went. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted. Use the space provided to summarise what was discussed.

Date: ..... Group: .....

Facilitator's name: .....

Parent's name: .....

Start time: ..... Finish time: .....

Summary of Contact (note the details of any appointment changes or unsuccessful attempts to contact the parent)

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Content checklist

01. Introduction ☐

- Telephone the parent at the scheduled time
- Check that the parent is available for the session
- Remind the parent of the purpose of the weekly telephone sessions

02. Agenda ☐

- Prompt the parent to set the agenda:

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Group Lifestyle Triple P Session 9 Checklist

03. Feedback of assessment results ☐

- Recap the results of the measurement session and summarise the questionnaire data:

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- Check for the parents' reaction and ask if there has been any changes:

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04. Review ☐

- Review Session 8 (managing problem behaviour):

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05. Update on progress ☐

- Ask the parent to list their homework tasks:

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Group Lifestyle Triple P Session 9 Checklist

- Ask what worked (identify at least two things they did well):

- Ask what didn't work (find out exactly what happened):

- Ask what they could have done differently (use minimal prompts to help the parent solve any problems):

06. Other issues ☐

- Discuss any other items on the agenda:

Group Lifestyle Triple P Session 9 Checklist

07. Session close

- Ask the parent to review the main issues discussed in the session:

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- Prompt them to set homework tasks:

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- Thank the parent for their participation

Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 10 Checklist

Use this as a guide to deliver the session, and a record of how it went. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted. Use the space provided to summarise what was discussed.

Date: ..... Group: .....

Facilitator's name: .....

Parent's name: .....

Start time: ..... Finish time: .....

Summary of Contact (note the details of any appointment changes or unsuccessful attempts to contact the parent)

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Content checklist

01. Introduction ☐

- Greet the parent warmly

02. Agenda ☐

- Prompt the parent to set the agenda:

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03. Update on progress ☐

- Ask the parent to list their homework tasks:

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Group Lifestyle Triple P Session 10 Checklist

- Ask what worked (identify at least two things they did well):

- Ask what didn't work (find out exactly what happened):

- Ask what they could have done differently (use minimal prompts to help the parent solve any problems):

04. Other issues ☐

Group Lifestyle Triple P Session 10 Checklist

05. Session close ☐

- Ask the parent to review the main issues discussed in the session:

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- Prompt them to set and note down homework tasks:

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- Outline the content of the next session (planning ahead)
- Thank the parent for their participation

Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 11 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Agenda ☐

- Welcome parents to the session
- Provide an overview of the session
- Hand out copies of the sports organisations collected in Session 8

02. Review ☐

- Discuss how the weekly telephone sessions went
- Ask each parent to review their homework

03. Family survival tips ☐

- Introduce the family survival tips
- Show DVD segment: Family survival tips
- Exercise 1: Taking care of yourself

04. High-risk situations ☐

- Define 'high-risk situation' and give examples
- Exercise 2: Identifying high-risk situations

05. Planned activities ☐

- Provide a rationale for planned activities
- Explain the steps (using a variety of examples)
- Exercise 3: Developing a planned activities routine
- Discuss parents' comments about using planned activities

06. Preparing for the fortnightly telephone sessions ☐

- Explain the format of the final three sessions
- Exercise 4: Choosing a time

07. Session close ☐

- Review the main issues covered in the session
- Explain the homework tasks (designing and implementing 2 planned activities routines)
- Remind parents to plan ahead for their telephone session
- Thank parents for their participation

Group Lifestyle Triple P Session 11 Checklist

Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 12 Checklist

Use this as a guide to deliver the session, and a record of how it went. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted. Use the space provided to summarise what was discussed.

Date: ..... Group: .....

Facilitator's name: .....

Parent's name: .....

Start time: ..... Finish time: .....

Summary of Contact (note the details of any appointment changes or unsuccessful attempts to contact the parent)

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Content checklist

01. Introduction ☐

- Telephone the parent at the scheduled time
- Check that the parent is available for the session
- Remind the parent of the purpose of the fortnightly telephone sessions

02. Agenda ☐

- Prompt the parent to set the agenda:

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Group Lifestyle Triple P Session 12 Checklist

03. Progress review

- Ask the parent to list their homework tasks:

- Ask what worked (identify at least two things they did well):

- Ask what didn't work (find out exactly what happened):

- Ask what they could have done differently (use minimal prompts to help the parent solve any problems):

Group Lifestyle Triple P Session 12 Checklist

04. Other issues ☐

- Discuss any other items on the agenda:

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05. Session close ☐

- Ask the parent to review the main issues discussed in the session:

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- Prompt them to set and note down homework tasks:

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- Thank the parent for their participation

Group Lifestyle Triple P Session 12 Checklist

Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 13 Checklist

Use this as a guide to deliver the session, and a record of how it went. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted. Use the space provided to summarise what was discussed.

Date: ..... Group: .....

Facilitator's name: .....

Parent's name: .....

Start time: ..... Finish time: .....

Summary of Contact (note the details of any appointment changes or unsuccessful attempts to contact the parent)

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Content checklist

01. Introduction ☐

- Greet the parent warmly

02. Agenda ☐

- Prompt the parent to set the agenda:

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03. Progress review ☐

- Ask the parent to list their homework tasks:

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Group Lifestyle Triple P Session 13 Checklist

- Ask what worked (identify at least two things they did well):

- Ask what didn't work (find out exactly what happened):

- Ask what they could have done differently (use minimal prompts to help the parent solve any problems):

04. Other issues ☐

- Discuss any other items on the agenda:

Group Lifestyle Triple P Session 13 Checklist

05. Session close

- Ask the parent to review the main issues discussed in the session:

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- Check that the parent has a copy of *Keeping Track Booklet Two* and knows how to complete it
- Prompt them to set and note down any additional homework tasks:

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- Outline the content of the next session (progress review, keeping up the good changes)
- Discuss arrangements for the group celebration
- Thank the parent for their participation

Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Group Lifestyle Triple P Session 14 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick ☑ if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of participants: .....

Start time: ..... Finish time: .....

Content checklist

01. Introduction ☐

- Welcome parents to the final session
- Collect completed *Questionnaire Booklet Two*

02. Agenda ☐

- Provide an overview of the session

03. Review ☐

- Discuss how the fortnightly telephone sessions went
- Check how parents went completing *Keeping Track Booklet Two* (and any additional homework)

04. Progress review ☐

- Exercise 1: Identifying changes since the beginning of the programme
- Check questionnaire booklets (return if incomplete)
- Exercise 2: Comparing daily food serves
- Exercise 3: Comparing activity levels
- Exercise 4: Reviewing goals

05. Keeping up the healthy changes ☐

- Provide a rationale for addressing maintenance
- Discuss slip-ups and the importance of staying motivated
- Exercise 5: Staying motivated
- Discuss planning ahead, holding regular reviews, acting quickly, trying new ways

06. Problem solving for the future ☐

- Exercise 6: Planning for future high-risk situations
- Exercise 7: Identifying future high-risk times
- Exercise 8: Independent problem solving

07. Satisfaction with the programme ☐

- Exercise 9: Completing the Client Satisfaction Questionnaire

08. Programme close ☐

- Review the main issues covered in the session
- Discuss any additional agenda items and prompt parents to set their own homework tasks
- Thank parents for their participation in the programme and congratulate them on their achievements

Group Lifestyle Triple P Session 14 Checklist

Post-group assessment (list the names of families still to return *Questionnaire Booklet Two* or participate in a measurement session)

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Session notes (include items that were omitted, any additional content, issues you would like to follow up in the next session)

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Self-evaluation (note something that you did well, anything you would do differently next time, issues you would like to discuss in supervision)

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Signature: ..... Date completed: .....

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Family Transitions Triple P Session 1 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of Participants: .....

Start time: ..... Finish time: .....

Content checklist

1. Introduction ☐

   - Welcome and self-introduction
   - Congratulate parents on making the commitment to participate
   - Provide an overview of Family Transitions Triple P

2. Agenda ☐

   Working in groups

   - Exercise 1 – Setting basic ground rules
   - Exercise 2 – Getting to know you
   - Exercise 3 – What you would like to get out of the group sessions

3. What is a positive transition through divorce? ☐

   Discuss the challenges of divorce
   - Write words on whiteboard to describe divorce
   - What are the challenges for parents going through divorce?

   Five key principles of positive transitions through divorce

   Mention these will be looked at in detail in:
   - Managing intense feelings – Session 2
   - Co-parenting – Session 3
   - Communicating with children – today
   - Setting up life as a single parent – Session 4
   - Taking care of yourself – each week

   Ask parents if they think there is anything else that is important for a positive transition for children following divorce
   - Exercise 4: Making a family transition

4. Introduce parent traps ☐

   Ask parents to turn to page 7 in their workbooks to mark off factors influencing their own child as it is discussed

   This is a lengthy exercise so stop after each section
   - Ongoing relationships
   - Conflict
   - Parenting
   - Burdening children with adult concerns
   - Exercise 5: Identifying causes of impact of behaviour on children
   - Exercise 6: Understanding how children are affected by parent behaviour

5. Talking to your child about divorce ☐

- What children need to know
- Discuss challenges parents may have with this
- How parents can help
- Discuss challenges parents may have with this

6. Helping children manage emotions ☐

- Introduce characteristics of emotions in children
- Discuss helping children manage their emotions routine
- Exercise 7: How to deal calmly with children's emotions
- Have parents role-play strategy

7. Set goals for change ☐

- Encourage parents to reflect back over the 5 principles and factors impacting on children and set some goals for changes they may want to make
- Exercise 8: Goals for change

8. Session close ☐

- Keeping track
- Review the session
- Explain tasks to be completed
- Monitor behaviour that parent has set as a goal to change
- Mention what we will do in the next session
- Thank parents for their participation and attendance

Session notes

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Additional agenda items (note any additional content or major deviation from the set program)

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Signature: ..... Date completed: .....

Family Transitions Triple P Session 2 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of Participants: .....

Start time: ..... Finish time: .....

Content checklist

1. Agenda ☐
    - Provide an overview of the session
2. Review of Session 1 ☐
    - Ask parents what was the most important thing they learned in the last session. *Why was that important to you?... has anyone got any other comments?... I'm glad the session gave you some food for thought*
    - Review session content
    - Review homework
    - Go around the group and have each person say what their target behaviour was and how they went monitoring it and what did they learn
3. Unpleasant emotions ☐
    - Introduce unpleasant emotions
    - Exercise 1: Common triggers
    - Exercise 2: Recognising unpleasant emotions
    - Discuss each emotion (stress, anxiety, anger, depression) and then prompt parents to do Exercise 2 as a large group after each section
    - Exercise 3: How does anger affect my co-parenting relationship?
    - Exercise 4: Linking thoughts to feelings
4. How emotions affect parenting ☐

    Coping with unpleasant emotions
    - Without introduction, do the sultana exercise
    - Exercise 5: Reactions to the sultana exercise
    - Introduce Exercise 6: Mindfulness of breath and automatic pilot
5. Relaxation overview ☐
    - Practise Exercise 7: Abdominal breathing
    - Practise Exercise 8: Progressive muscle relaxation
    - Practise imagination visualisation
    - Ask parents what they have found useful and why
    - Discuss indications for each type of relaxation
    - Exercise 9: Relaxation to manage anger
    - Exercise 10: Imagination
    - Discuss common problems with mindfulness and relaxation practise
    - Exercise 11: Setting goals for practise

6. Pleasurable and mastery activities ☐

- Have parents generate their own pleasurable activities
- Explain activity scheduling

7. Session close ☐

- Review the session
- Explain tasks to be completed
- Select mindfulness/relaxation task to complete daily
- Prompt and problem-solve problems to practicing
- Mention what we will do in the next session
- Thank parents for their participation and attendance

Session notes

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Additional agenda items (note any additional content or major deviation from the set program)

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Signature: ..... Date completed: .....

Family Transitions Triple P Session 3 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of Participants: .....

Start time: ..... Finish time: .....

Content checklist

1. Agenda ☐

   Provide an overview of the session

2. Review of Session 2 ☐

   - Ask parents what was the most important thing they learned in the last session. *Why was that important to you?... has anyone got any other comments?... I'm glad the session gave you some food for thought*
   - Review session content
   - Review homework
   - Go around the group and have each person say what their target behaviour was and how they went monitoring it and what did they learn

3. How emotions work ☐

   - Discuss how emotions work
   - Exercise 1: Linking thoughts to feelings

4. Catching unhelpful thoughts ☐

   - Introduce unhelpful thoughts
   - Introduce coping statements; prompt parents to turn to page 30 in workbook
   - Exercise 2: How to monitor your thoughts

5. Coping statements ☐

   - Introduce coping statements and their applicability
   - Exercise 3: Developing your own coping statements
   - Exercise 4: Preparing for high-risk situations
   - Ask parents to monitor their use of coping statements to register

6. Getting ready to challenge unhelpful thoughts ☐

   - Provide rationale for challenging unhelpful thoughts
   - Suggestions for questioning automatic thoughts

7. Common thinking errors ☐

   - Describe each common thinking error and prompt parents to illustrate each situation with a divorce related example

8. Steps for challenging automatic thoughts ☐

- Review steps for challenging automatic thoughts
- Exercise 5: Getting ready to challenge unhelpful thoughts
- Ask parents next week to challenge automatic thoughts to register

9. Taking care of yourself ☐

- Provide rationale for taking care of yourself
- Exercise 6: Taking care of myself

10. Preparing for high-risk times ☐

11. Session close ☐

- Review the session
- Explain tasks to be completed
- Select mindfulness/relaxation task to complete daily
- Prompt and problem-solve problems to practicing
- Complete daily record of helpful thoughts
- Mention what we will do in the next session
- Thank parents for their participation and attendance

Session notes

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Additional agenda items (note any additional content or major deviation from the set program)

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Signature: ..... Date completed: .....

Family Transitions Triple P Session 4 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of Participants: .....

Start time: ..... Finish time: .....

Content checklist

1. Agenda ☐
   - Provide an overview of the session
2. Review of Session 3 ☐
   - Ask parents what was the most important thing they learned in the last session. *Why was that important to you... has anyone got any other comments?... I'm glad the session gave you some food for thought*
   - Review session content
   - Review homework
   - Go around the group and have each person say what their target behaviour was and how they went monitoring it and what did they learn
3. Introduction Session ☐
   - Introduce the need for a constructive way to deal with conflicts
   - Emphasise that learning new skills takes time
4. Model of conflict ☐
   - Introduce and explain model of conflict
   - Exercise 1: Conflict styles
5. Importance of communication skills ☐
   - Ask parents what are common sources of conflict following separation or divorce
   - Discuss the characteristics of passive, aggressive and assertive communication; have parents demonstrate aspects
   - Exercise 2: Communication styles
   - Exercise 3: Using assertive communication to solve a problem
   - Exercise 4: Managing anger
6. Problem-solving process ☐
   - Define steps for problem-solving
   - Work through an example as a group
   - Exercise 5: Practising using problem-solving
   - Group debrief

7. Parenting plan ☐

- Why have a parenting plan?
- Suggested content for a parenting plan
- Refer parents to page 93 for guidelines relating to child age

8. Session close ☐

- Review the session
- Explain tasks to be completed
- Use assertive communication
- Develop parenting plan
- Continue with relaxation/mindfulness practise
- Mention what we will do in the next session
- Thank parents for their participation and attendance

Session notes

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Additional agenda items (note any additional content or major deviation from the set program)

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Signature: ..... Date completed: .....

Family Transitions Triple P Session 5 Checklist

Use this as a guide and as a record of what you covered in the session. Indicate with a tick (✓) if the item was covered. Leave blank if the item was omitted.

Date: ..... Number of Participants: .....

Start time: ..... Finish time: .....

Content checklist

1. Agenda ☐

   Provide an overview of the session

2. Review of Session 4 ☐

   - Ask parents what was the most important thing they learned in the last session. *Why was that important to you?... has anyone got any other comments?... I'm glad the session gave you some food for thought*
   - Review session content
   - Review homework tasks
   - Go around the group and have each person say what their target behaviour was and how they went monitoring it and what did they learn

3. Balancing work, family, and play ☐

   - Introduce the challenges facing divorced parents
   - Exercise 1: Assessing the balance

4. Building a new family identity ☐

   - Building a new family identity
   - Exercise 2: What is going well in my life?

5. Social support ☐

   - Discuss the influence of social support following divorce
   - Exercise 3: Assessing social support
   - Exercise 4: People who have a negative effect

6. Making changes ☐

   - Exercise 5: Deciding what you want your new life to look like
   - Exercise 6: Setting priorities

7. Planning for change ☐

   - Making changes

8. Balancing work and family ☐

   - Discuss strategies on pages 118–119

9. Developing a new family identity ☐

- Group discussion about strategies
- Exercise 7: Setting personal standards

10. Session close ☐

- Review the session
- Explain tasks to be completed
- Mention what we will do in the next session
- Thank parents for their participation and attendance

Session notes

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Additional agenda items (note any additional content or major deviation from the set program)

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Signature: ..... Date completed: .....

TRIPLE P PROGRAM PROMOTION

Section Contents:

- Stay Positive – Product Overview
- Stay Positive – Information Booklet
- What is Stay Positive? – Movie
- Triple P Logo
- Triple P Communications – Copyright & Image Use
- Stay Positive Provider Website – Troubleshooting
- *Attachments: Promote Your Session*
  - Brochure – Discussion Group 0-12 – Overprint Template – English
  - Brochure – Discussion Group 0-12 – Overprint Template – Spanish
  - Brochure – Group 0-12 – Overprint Template – English
  - Brochure – Group 0-16 – Overprint Template – English
  - Brochure – Seminar 0-12 – Overprint Template – English
  - Brochure – Seminar 0-12 – Overprint Template – Spanish
  - Brochure – Seminar 0-16 – Overprint Template – English
  - Brochure – Seminar 0-16 – Overprint Template – Spanish
  - Triple P Logo

Triple P, Stay Positive Product Overview
Reaching every parent

With the launch of Triple P, Stay Positive, a suite of communication materials is now available to support your work as a practitioner. This product overview is a quick and easy reference to explain how materials work and when/where they may work best.

Program awareness and destigmatization

The Stay Positive communications campaign features a range of materials such as posters, brochures and flyers to help raise awareness of parenting issues and aims to destigmatize the process of asking for parenting help. The campaign materials offer information and tips for everyday parenting issues and also direct parents to the Triple P interventions offered within the local community.

Campaign images depict everyday situations, familiar to most parents. Striking images such as a tantrum-throwing toddler, a pouting pre-schooler and a crying infant are designed to capture parents' attention and reassure them they're not alone. All the campaign elements work to create an environment where it's normal for parents to discuss their concerns and ask for help, if they need it.

Campaign materials and their benefit

In any advertising campaign it is important the target is impacted a number of times for the message to break through and be recalled. This is especially true for busy parents. Posters, brochures and flyers help spread the word about Triple P courses and clearly direct parents to the website for more information and details. The more visible you can make the materials to parents, the more impact they will have, the more familiar Triple P will become, and the faster it will work to destigmatize asking for help.

You'll be provided with a quantity of brochures, flyers and posters to help promote Triple P and the courses offered in your area. This guide provides an overview of what you will receive and some suggestions for how to get the most out of your Stay Positive materials.

We hope you find Triple P, Stay Positive campaign elements practical and user friendly and that the campaign supports and enhances your work with parents and carers.

"The single most important thing we can do, at a population level, to prevent serious behavioral and emotional problems and abuse of children is to increase the confidence, skills and knowledge of parents in the task of raising children."

Prof. Matthew R. Sanders, founder of the Triple P – Positive Parenting Program University of Queensland, Brisbane, Qld, Australia.



Triple P, Stay Positive Product Overview
Reaching every parent

Campaign posters

Small (Tabloid) and large (16 × 24 inch) size campaign posters help raise awareness of parenting issues and direct parents to the website for information on the courses available in their local area. Posters feature children from a range of ethnic backgrounds to ensure widespread appeal and visualize common parenting problems such as temper tantrums, crying, aggression and sleeping problems.

Goal:

- To make parents aware of Triple P, Stay Positive
- To promote the key benefit of Triple P – 'Triple P takes the guesswork out of parenting'
- To direct parents to where they can get more information - the website www.triplep-staypositive.net

How best to use it:

Place the poster in high-traffic, visible locations such as the entrance and waiting room of your institution, primary schools and public libraries, child care centers and supportive shopping areas; basically anywhere parents would normally pass by, visit or spend time. Refresh the poster from time to time especially if you have more than one poster to feature.



Campaign poster

"Five steps" flyer

The Triple P program is based on five basic principles. These principles, on a handy size flyer, suggest simple routines and small changes that can make a big difference for every parent.

Goal:

To introduce parents to the basic principles of Triple P and reassure them with simple steps.

How best to use it:

Display them at your institution or center and hand them out when you talk to parents to help stimulate interest in Triple P. Provide the flyer to supporting organizations where parents often come (such as schools, child care centers etc).



Basic principle flyer

Triple P, Stay Positive Product Overview
Reaching every parent

General brochure

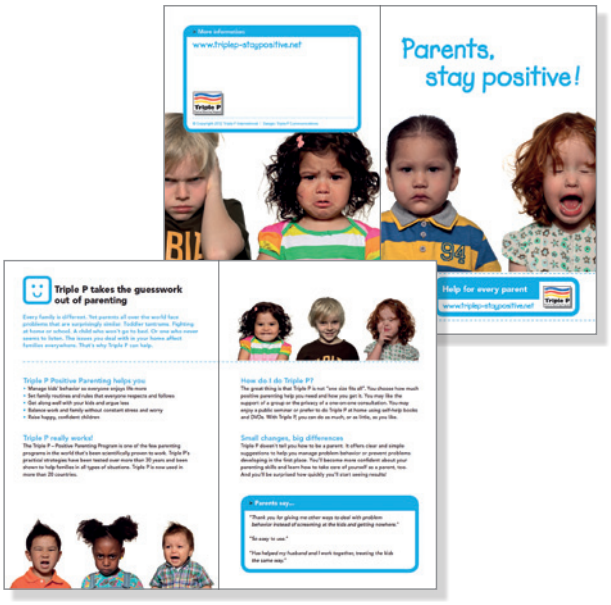
The general brochure informs parents about the Triple P program and the range Triple P offers, such as group sessions, a seminar or individual advice. The general brochure directs parents to the website and potentially to the institutions within their local community.

Goal:

Inform parents of the different options within Triple P and stimulate parents to inquire about Triple P.

How best to use it:

Place this brochure in places parents visit, such as child care centers, schools or medical practices. You may wish to provide a quantity to public libraries or nearby shopping malls. A space is provided on the back of the brochure where you can place a sticker with the contact details of your organization.



General brochure

Brochures for Triple P levels

A brochure has been created for each Triple P intervention to inform parents about the range of Triple P help available in their community.

Goal:

- Inform parents about the range of Triple P program options available
- To provide specific information about the Triple P level a parent is participating in or being referred to.

How best to use it:

Use Triple P course brochures once parents are referred to the most appropriate level of Triple P. A space is provided on the back of the brochure where you can place a sticker with the contact details of your organization. You may have the option of over-printing session times/dates (using your own laser printers) on Group, Discussion Group and Seminar brochures. Triple P suggests practitioners take a small quantity of brochures for higher levels of Triple P interventions to Discussion Group and Seminar sessions to let parents know that more help is available should they have further concerns. It's also good to make brochures available to doctors' surgeries for distribution by GPs.



Brochure for Triple P levels

Triple P, Stay Positive Product Overview
Reaching every parent

Tippapers

A newspaper-style publication dedicated to talking openly and positively about parenting concerns and challenges, and how Triple P can help. These are a very successful way to destigmatize the idea of asking for parenting help and to show local parenting success stories and engagement with the Triple P interventions. Each Tippaper is locally tailored, covering Triple P basic principles, with many stories written specifically for your market. It also includes lively general (non Triple P) feature stories to create the feeling of a local mainstream parenting magazine.



Tippaper

Goal:

- To encourage and destigmatize the conversation surrounding parenting concerns
- To introduce Triple P and provide information about how Triple P can help
- To demonstrate local success stories
- To provide local contact details on how to find a Triple P Provider.



Tippaper

How best to use it:

Tippapers should be placed in prominent positions where parents may look for something to read eg. practice waiting rooms, libraries, school receptions, etc as well as any environment where an interested parent may pick one up eg. childcare centers, child health centers, selected cafes or meeting places. Pass it to appropriate neighboring businesses that may support your efforts or associated health professionals. Your local coordinator may also have a distribution strategy organized for your region.

Stay Positive News

This is a series of single page newsletters, specifically for smaller regions with extremely low levels of adult literacy. Each newsletter includes an easy-to-read snippet of Triple P information – for example, a very basic tip from within the program – along with a testimonial from a local parent who has already enjoyed Triple P success, and a paragraph about what Triple P is or where it can be sourced locally. The type face is large, with clear headings and minimum words.

In dual language areas, an alternate translation can be printed on the second side of the newsletter.

Triple P, Stay Positive Product Overview
Reaching every parent

Goal:

- To provide easy-to-read, regular Triple P information in areas with extremely low literacy
- To destigmatize the idea of parenting help
- To show the practicality of Triple P ideas
- To guide parents to local delivery of Triple P
- To highlight a local parent's success with Triple P

How best to use it:

Printed in US letter-size, Stay Positive News is a great handout for parents at kindergartens, day care centers, schools etc. Your region may have a distribution plan, or you could liaise with your local kindergarten or day care center to organize regular distribution to parents.

You could also place some in your center's reception area, doctors' waiting rooms, cafes or other spaces where parents may have time to read.



Stay Positive News

Parent website
www.triplep-staypositive.net

The Stay Positive parent website is the information and referral hub for the campaign. The website is locally tailored for your area/region. Parents can read news, tips and parent's own stories. Plus, through a handy search function, parents can find out course dates, times and venues, while a Google Maps module highlights the addresses of institutions where Triple P is offered in their neighborhood.

Goal:

- Normalize the idea of asking for parenting help and let parents know that many parents struggle from time to time. Importantly the website enables parents to seek information at a time that suits them, and can be a reasonably private source of information if they wish.
- The website keeps parents up-to-date with Triple P in their region, and offers interesting news, tips and local information about parenting.

How best to use it:

Refer parents to the website where they can find information about Triple P, as well as details on where to access local Triple P practitioners.



Parent website



Parent website

Triple P, Stay Positive Product Overview
Reaching every parent

Provider website:

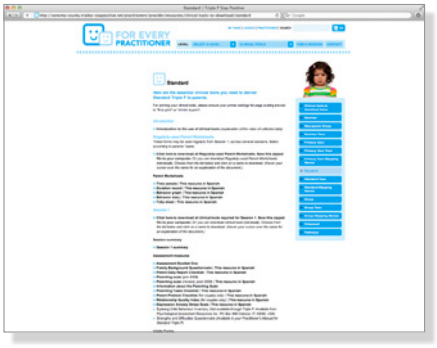
Stay Positive also supports practitioners with a regionally-tailored secure website for Triple P practitioners. The login-accessed site acts as a community network for local Triple P practitioners. It provides Stay Positive-designed clinical tools such as worksheets and checklists, and promotional materials such as posters, brochures and flyers. Practitioners can use the convenient Promote your Sessions and Promote your Location functions to post their own practice details and Triple P session times directly to the parent website. Professionally-written promotional copy is available for download and can be used on practice or institutions' websites. Short Triple P tips columns can be given to local newsletters or magazines to create ongoing interest in parenting issues. The provider website is a community hub for practitioners, helping them stay in touch with their professional community.



Provider website



Provider website



Provider website

Goal:

- To assist practitioners in the delivery of Triple P
- To keep practitioners up-do-date with program development and local initiatives, and provide an easy-to use system to order promotional materials.
- To provide practitioners with an easy means to promote their own practice and Triple P sessions on the parent website.

How best to use it:

As a practitioner you can download the materials you need for your course delivery and to support parents. The materials are there to make your job easier, and to help you effectively reach out to parents. Visiting the practitioner website on a regular basis will keep you up-to-date with Triple P and enable you to stay in touch with fellow Triple P practitioners.

Support materials to pre-promote Triple P

Recent Stay Positive research highlights the importance of creating awareness of positive parenting and Triple P, before promoting upcoming course dates and times. Some good ways to do this include establishing or using existing relationships with key organizations to enlist their help to publish newsletter tips to parents, distribute brochures and flyers and place posters in high-traffic locations. We've supplied some single sheet "What is Triple P" materials that you could give to these organizations as a quick and easy way to explain Triple P and its benefits.

Here's a selection of the material you can use:

- A template letter which introduces you and Triple P to supporting organizations and explains the way an organization may be able to help. The template letter can be used as a first step to let schools, early childhood centers, playgroups, hospitals, churches and GPs know what Triple P can do to help parents and what materials you can provide for an organization to display and distribute.

- One page info sheets which introduce Triple P to supporting organizations:
  - What is Triple P – media release
  - Triple P in a nutshell – bullet points highlighting main features and benefits of Triple P
  - Biography of Professor Sanders – a background on the Triple P system's founder
  - What the research says – one page document highlighting the breadth of research and evidence-base of Triple P
  - What the experts say – the opinions of the world's leading authorities working and researching in the field of parenting

- A general Power Point presentation on Triple P is available, if needed

- Newsletter snippets – Triple P newsletter tips columns can be provided to community newsletters, local newspapers, local parent magazines, school newsletters, library newsletters etc.

Triple P, Stay Positive
The importance of promotion

Promoting your Triple P course – a few simple steps

- **Choose a target group**
  Schools, child care centers, playgroups, community centers, particular groups eg. single parents, teen moms, parents caring for child with a disability.

- **Lay the groundwork**
  Raising the profile of Triple P and explaining the benefits to parents will help make parents feel more comfortable about attending a session. It would be very helpful to enlist the support of institutions and organizations that have direct contact with parents, to help you build awareness of Triple P and parenting issues. Make a list of institutions and organizations that may be prepared to support you and contact them via a letter and/or phone call. Offer them regular updates plus general brochures, flyer and posters. Check with your coordinator what may be appropriate for your area.

- **Practical consideration to suit parents**
  Decide the time and venue for your course. Key considerations include choosing times to suit parents' lifestyles (eg. weekend, evening, after school/kindergarten drop off or before pick up) and considering whether there is a need to choose a venue within easy access to public transport, or which has parking available. You may also consider offering free childcare and/or tea and coffee depending on the circumstances of the parents you are trying to reach.

- **Overprinting session times and dates**
  Brochures for Group/Discussion Group and Seminar may have been provided to you on a paper suitable to go through your own laser printer. If so, you can download an easy overprinting template tool from your provider website which will enable you to put in your own session times and dates and promote upcoming sessions.

- **Use the parent website**
  Make sure your own details are included on the google map on the parent website. Also post all of your upcoming Group/Disccusion Group and Seminar times, dates and details to the parent site. You can do this via your provider network's Promote your Sessions and Promote your Location tools.

- **Promote success**
  See if parents might be prepared to "tell their success story" through the Stay Positive parent tippaper and website, or through a story in the local newspaper or on local radio/TV. Some parents are very open to this and are keen to tell other parents about their great experience. A permission slip can be provided by your coordinator for parents who agree to be interviewed. With the explosion of technology you may feel confident recording some of these comments and stories yourself. If you have parents interested in telling their stories, please contact your coordinator who will assist with the publicity. In the future we'll be adding social media functions to your login practitioner site so you can tell other practitioners, via the website, what worked well in promoting your course!

Triple P, Stay Positive
Reaching every parent



Triple P
Positive Parenting Program

One of the greatest strengths of the Triple P – Positive Parenting Program is its ability to cater to every parent, regardless of personal or family circumstances. One of the greatest challenges is ensuring parents know how to reach out for that help. That's why the Stay Positive communications strategy has been created. Stay Positive helps ensure every parent knows about, understands and can easily find, the Triple P help they need.

What is Stay Positive?

Stay Positive is a communications strategy for organizations implementing a population-level Triple P rollout. Stay Positive uses striking materials to raise awareness of parenting issues and destigmatize the process of asking for parenting help. The campaign offers information and tips for everyday parenting issues and directs parents to the Triple P interventions offered within the local community. Campaign materials include a locally-tailored Stay Positive website, brochures, posters, flyers, parent newspapers, outdoor artwork and TV and radio concepts and scripts. Further materials can be developed for a tailored media mix.

Does it work?

Stay Positive is simple and it works. It's comprehensive, it's consistent, it's eye-catching and it cuts through the advertising clutter.

> *"The single most important thing we can do to prevent serious behavioral and emotional problems and abuse of children is to increase the confidence, skills and knowledge of parents in the task of raising children at a population level."*
>
> Prof. Matthew R. Sanders, founder of the Triple P – Positive Parenting Program
> University of Queensland, Brisbane, QLD, Australia

Parents can't miss Stay Positive

After the launch of Stay Positive in Amsterdam, independent researchers from the Netherlands' Trimbos Institute gauged parents' reactions to the first "awareness" phase of the campaign, which included the website, posters, brochures and TV spots[1]. After the first phase, 77% of Amsterdam parents recognized the Stay Positive campaign.

Visitors spent more than twice as much time on the Stay Positive site compared to time spent on similar parenting websites. Google Analytics tracking showed parents read the basic parenting tips and sought information about how to get help (figure 1).

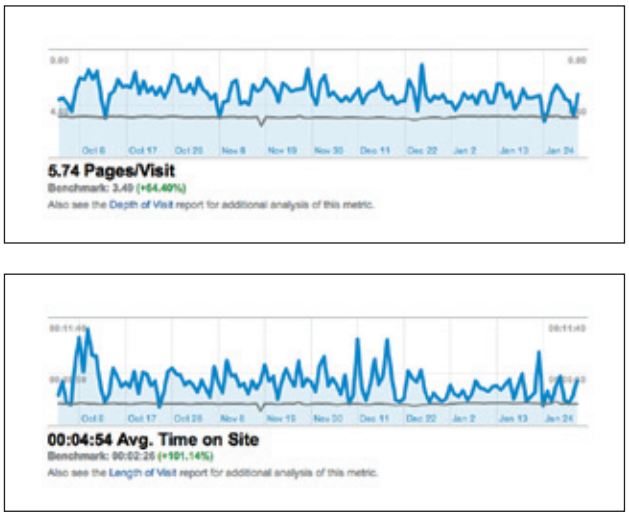


Figure 1; benchmark comparing Stay Positive to other parenting-related sites indicate parents find Stay Positive informative.



[1] *Kielstra, C, Goossens, F.X. 'Campaign Stay Positive' (org: 'Campagne Positief Opvoeden'), Trimbos Instituut, 2009.*

Stay Positive makes it OK to reach out

Parenting programs can sometimes be seen as an admission of failure – the last resort for "bad" parents. Stay Positive works to change this perception. The images connect with parents and depict everyday situations that reassure parents they're not alone. Stay Positive creates an environment where it's natural for parents to discuss their concerns and ask for help if they need it.

In fact, Stay Positive's success in destigmatizing parenting issues is now clearly quantifiable through the results of the Trimbos Institute's research. See the graph showing attitudes after phase one (2008) and attitudes after the end of the second phase of the campaign in 2010 (figure 3).

"When starting a Triple P Seminar session, I always ask the parents if they have seen Stay Positive. Most of the time they did; it made them curious and that's why they came."

Josje Burghard, Parenting Consultant
SO&T, Amsterdam, The Netherlands

Why does it work?

Trimbos Institute research also showed positive parent attitudes to the campaign, rating Stay Positive as more "striking" and "believable" than other government campaigns[2] (figure 2).

The campaign features regular moms, dads and kids from a range of demographic and ethnic backgrounds. Parents identify with the scenarios including a tantrum-throwing toddler, a pouting pre-schooler, a crying infant or a defiant pre-teen. And they're presented with solutions to show that Triple P help can make a big difference to a family's life.

Figure 2; ratings measured on a 5 point scale

	Stay Positive Phase 1	Stay Positive Phase 2	PB 51 (national campaign)
Stands out (execution)	3.7	3.5	3.2
Credible (informative)	3.9	3.6	3.4
Appealing (relevance)	3.4	3.5	3.2

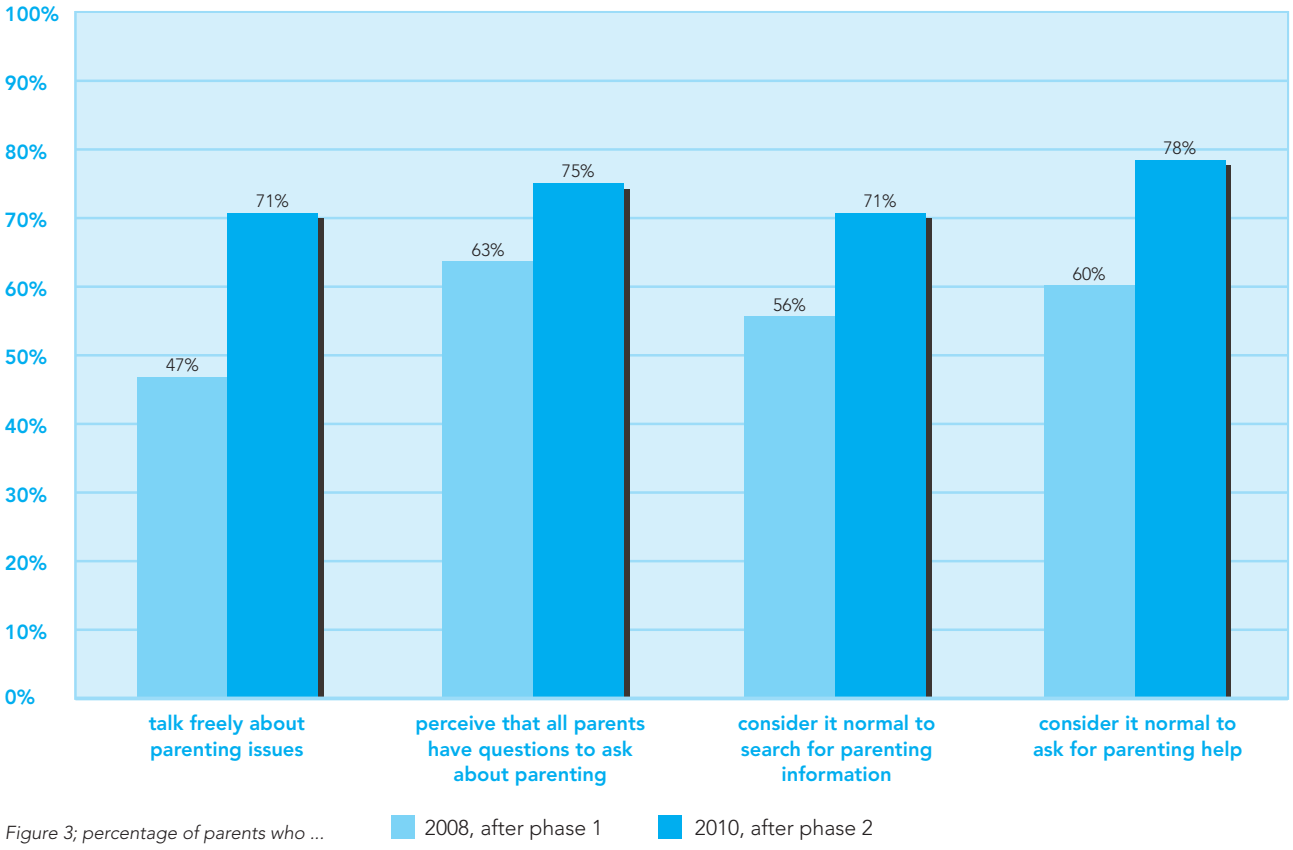


Figure 3; percentage of parents who ...

[2] *Postbus 51 (PB 51) is the main communications and information channel of the Netherlands' central government*

Stay Positive makes referrals simple

Stay Positive maximizes the number of parents who know about Triple P. The consistent message clearly points parents to the agencies and practitioners offering Triple P and, in turn, parents are well-informed about what to expect when they walk through the door.

"With Stay Positive, practitioners felt like they were part of something really big. When they told people they were delivering Triple P, they didn't have to explain any further. Parents would come to them, asking them for Triple P. Practitioners said they felt supported and proud and were relieved they didn't have to convince parents that it was OK to ask for parenting help."

Carine Kielstra, Project Leader, Triple P Universal SO&T, Amsterdam, The Netherlands



And Stay Positive offers personal support to practitioners

Stay Positive also supports practitioners with a regionally-tailored secure website for Triple P practitioners. The login-accessed site acts as a community network for local Triple P practitioners. It provides Stay Positive-designed clinical tools and promotional materials, with professionally-written editorials and copy that can be provided to support websites and used in newsletters and other communications.

There are localized news pages and peer support information and sessions. There are facilities to access referral forms and guidelines, a searchable database of practitioners delivering Triple P, a searchable calendar to locate local Triple P seminars and groups and an online form to ask professional questions about Triple P and its delivery. Updated FAQs, regular video blogs and news updates keep the site timely and relevant.

A fully developed and tested communications strategy

Stay Positive is a four-phase communications strategy. Although the phased campaign is recommended for population implementations, it is possible to select individual campaign components. However, program awareness and destigmatization outcomes may be more limited with this approach.

"We hope this multi-media approach will combine to create a rainbow effect so that when parents do get information in a school bag or from a health visitor, Triple P is not completely new and they feel a little bit more comfortable with the concept."

Ally McLaws, Director of Corporate Communications NHS Greater Glasgow and Clyde, Scotland, UK

Frequently Asked Questions about the Stay Positive Campaign

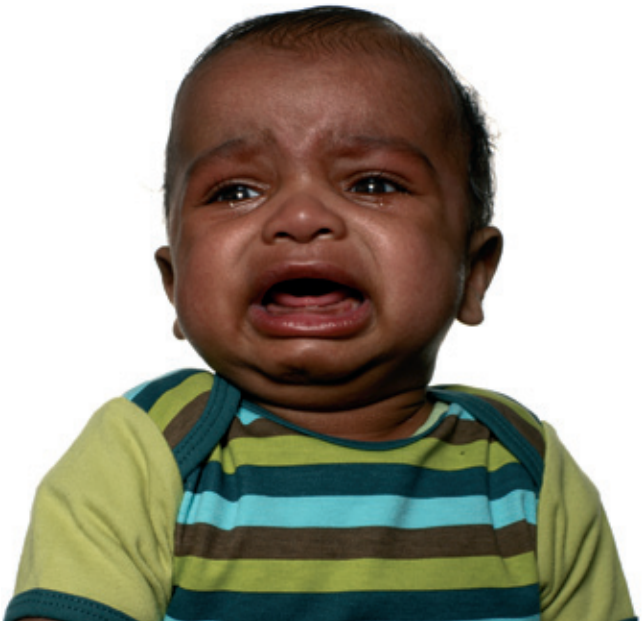
Why do we need a website in addition to our local authority's/healthcare program's site?

Local government programs and associated websites usually cover a range of healthcare solutions and information, however the Triple P – Positive Parenting Program is designed to specifically enhance parent's knowledge, skills and confidence in parenting.

The Stay Positive website, which is the center-piece of the campaign, provides a locally-administered Content Management System (CMS) to help organizations create a solid peer support network for local practitioners. The site also includes centrally-administered pages that are regularly refreshed to remain dynamic and invite repeat visits.

Can an organization incorporate its identity into the Stay Positive campaign?

A local authority's/organization's logo and corporate website link is added to their local Stay Positive website. An XML link may also be used to incorporate specific Stay Positive creative and content into a local government/ organization corporate website. This means parents can click through to their local Stay Positive website from the government/organization corporate site and vice-versa, allowing a seamless flow of information.



The Stay Positive campaign uses images of children crying or screaming. Why use pictures that seem negative?

The Stay Positive campaign is designed to cut through the mass of health and family messages and speak to parents in an informal, personal and colloquial way. Research indicates that parents identify with the images as everyday parenting situations they've faced themselves. The pay-off tells parents: 'Stay Positive - help is near with Triple P'. This is supported by the copy, the bright colors, the smiley icon, and the resolution of the stories and scenarios on the website and posters and in brochures and parent newspapers.

Our organization has a great deal of expertise in communicating with our residents. How can Stay Positive know how to best reach our community?

Research shows Stay Positive is an effective creative execution, however local expertise is essential to ensure the methods used to reach the local community are effective and cost-efficient. For a successful launch, local authorities use their own public relations professionals and local media buyers where applicable. Triple P will assist here if needed. Based on the local targets set, Triple P Communications works with the authority and its agencies to create a campaign that will reach the greatest number of parents.

How does an organization implement Stay Positive?

The campaign strategy questionnaire is the starting point. This helps establish the organization's objectives and targets, and determines whether the organization requires any additional creative to be costed. It's an important collaboration, because although Stay Positive has been designed to relieve an organization of the demands and risks of an untried campaign, the media mix needs to be planned to fit the local community.

Brochures, flyers and posters can be custom designed with government/organization logo, and photos can be mixed and matched for specific age range and ethnicity. Generic brochures, flyers and posters are also available and are a more cost-effective alternative where customization is not a priority. Generic brochures are designed to reflect major ethnicities and age ranges.

The website is licensed for a minimum of three years.

Costs can be reduced by joining with neighboring counties and organizations.

A local media buyer may need to be engaged to recommend a media schedule to meet agreed objectives. Triple P Communications (TPC) and the organization agree to the package, budget and timing. Triple P produces and delivers the materials: the printed flyers/brochures/posters/Tippapers, copy for TV/radio and artwork for outdoor.

The parent newspaper, the Tippaper, is also a collaborative effort. TPC provides the brief which outlines the themes of the stories. Local stories about parents, practitioners, the local rollout and the organization's involvement are written by a local journalist, recommended by the organization. Triple P sub edits this copy for program integrity and editorial style and generates the generic Triple P copy. TPC organizes production and printing and delivers the Tippaper to the organization to distribute.

With the Stay Positive website, Triple P gives a Content Management System (CMS) manual to the organization so it can tailor and manage its own local pages (e.g. posting news, seminar or group session times, success stories from local parents and practitioners and multi-media content). Meanwhile, Triple P looks after the updates and management of the general Triple P pages.

The organization also has its own local Peer Support and Referrals pages on the Practitioner section of the Stay Positive website. This gives the organization the opportunity to inform and update practitioners about peer support and referral opportunities, contacts and procedures and acts as a community hub for practitioners.

And finally, Triple P provides google analytics information on website visits, time spent on the site, pages visited and comparisons with comparable sites.

Implementing Triple P in the community is a considerable investment. Why do we need to spend money on a communications strategy?

Funding a parenting intervention is only part of the equation. The other part is ensuring the population knows about it and is ready to accept it. An evidence-based parenting intervention and an integrated communications strategy, which destigmatizes asking for parenting help and reaches parents via a range of communications materials provides the complete solution and the best return on investment.

For more information

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Columbia, SC 29211
United States

To see the Stay Positive websites in action and get first-hand experience on the many features, visit demo.triplep-staypositive.net

Triple P International



The four phases of Stay Positive

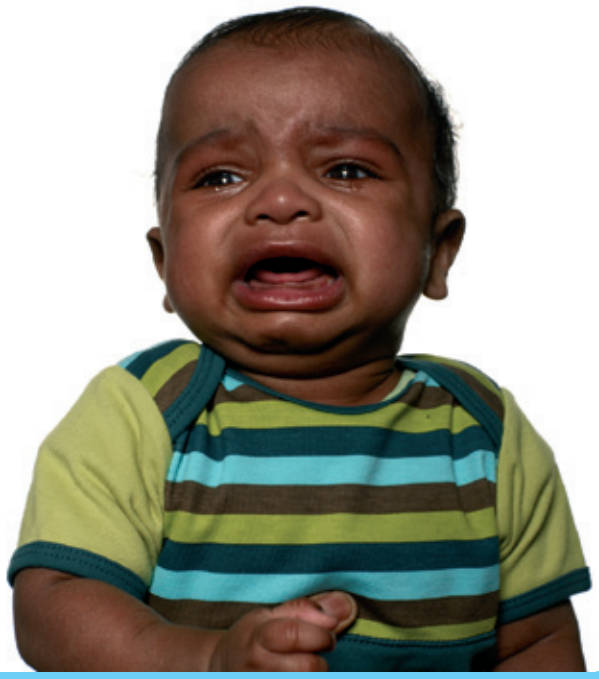
Triple P Stay Positive is a four-phase communications campaign. Each stage builds upon the previous stage to ensure parents are aware of and informed about the Triple P interventions available in their local community. That way, whenever they're ready to reach out, Triple P will be the program they turn to. Please note that materials listed beside the headings Information, Referral and Destigmatizing support that specific campaign phase.

Phases

Delivery formats

Four stages of Stay Positive	Phase 0 Providing materials	Phase 1 Name/program awareness	Phase 2 Destigmatizing parenting issues	Phase 3 Active referral towards sessions and courses
	This phase starts about four weeks before campaign launch. Local Triple P-trained practitioners and stakeholders are informed about Stay Positive and materials are distributed to practitioners, schools, kindergartens, libraries, clinics etc.	Parents discover what's available to them and begin to feel positive about Triple P. They relate to the campaign's featured parent stories, which highlight everyday problems and situations. Parents are directed to the website for more information.	Materials with more detailed information reinforce how common parenting problems are, and how helpful Triple P can be. Normalizes the idea of parenting courses and encourages parents to feel comfortable reaching out.	Parents are now very familiar with the Triple P options available to them and may seek out parenting advice if needed. Use of referral information to practitioners and services. Active referral also relies on the organization's network to maximize distribution of materials.
Information	• Brochures per level • Posters	• Website • Brochures per level • Posters • PR/launch • Press kit	• Website	• Website
Referral	• Triple P Session poster (in-printable) • Triple P Session brochure (in-printable)	• Basic principles poster • Basic principles flyer		• Basic principles poster • Basic principles flyer • Triple P Session poster • Triple P Session brochure (in-printable)
Destigmatizing		• Localized marketing communications strategy • Outdoor signs and/or posters • Newspaper ads • Television ad • Radio ad • PR	• Localized marketing communications strategy • Outdoor signs and/or posters • Newspaper ads • Television ad • Radio ad • Tippaper Triple P basic principles	• Localized marketing communications strategy • Outdoor signs and/or posters • Newspaper ads • Television ad • Radio ad • Tippaper Triple P basic principles







Triple P - Positive Parenting Program
demo.triplep-staypositive.net

More information on Stay Positive?
Scan the code!

Stay Positive Movie




Triple P
Positive Parenting Program
for every parent

Triple P Communications

For any questions you run into about Triple P Communications – particularly regarding copyright, intellectual property, and use of Triple P images and logos – contact:

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Web: www.triplep.net

Stay Positive Provider Website – Troubleshooting around login

1. If you haven't received any emails from Triple P.

The emails could be getting blocked by your organization's spam filter, or they may be sitting in your personal junk mail. So, we'd suggest you add **SUPPORT@TRIPLEP-PARENTING.NET** to your Safe Senders list and check with your Internal IT support person to see whether there is a super spam filter that could be blocking our emails. If an organization has blocked the Triple P emails a new email will be sent once we have been advised the address is safe.

2.Forgotten your password?

- You can go to the provider website and apply for a password straight away. Here's the link:

  http://www.triplep-parenting.net/provider/provider_login

- Just click on the link that says "Forgotten your password or need a new password?" Fill out the email address with which you are registered with TPI, and it will send you a password straight away to that email account.

3.Email address change

If you change email address after doing Triple P training our emails will not be getting through. Make sure Triple P know if a provider changes their email address. Keep accurate records.

Triple P – Positive Parenting Program

Promote Your Sessions on Brochures

You can customize your brochures for Level 2 Seminar Triple P, Level 3 Discussion Group Triple P and Level 4 Group Triple P, to tell parents the times, dates and locations of your upcoming sessions. You can print your own details on the back page, using the simple overprint template below.

1. First, you will need to have the brochures ready. See what's available in our Promotional resources to order section. To find out how to order more promotional resources, contact your local Triple P coordinator.
2. Once you have your brochures, click on the corresponding brochure link below. This will open the template. As this is an interactive pdf, it requires an Adobe Reader version 9.0 or higher. Updating your Adobe Reader is free of charge and will enable you to use the templates.
3. Then, simply click your cursor into the template and type over the example details. (Session title, time, day, month, year etc.) If you have fewer than five sessions to enter, please make sure you delete the remaining examples.
4. When you're satisfied you have everything you want entered into the template, load your brochures into your laser printer and print. Your sessions will print in the space on the back of your brochures.

See what's available in our Promotional resources to order section and get copies of these Triple P brochures. To find out how to order more promotional resources, contact your local coordinator.

See attachments for the following Overprint Template Brochures:

- Discussion Group 0-12 – English
- Discussion Group 0-12 – Spanish
- Group 0-12 – English
- Group 0-16 – English
- Seminar 0-12 – English
- Seminar 0-12 – Spanish
- Seminar 0-16 – English
- Seminar 0-16 – Spanish

TRIPLE P TRAININGS & RESOURCES

Section Contents:

- Open Enrollment List Serve
- Course Summaries*
- A Triple P Provider's Guide to Parent Resources
- Online Resources – Important Triple P Websites
- *Attachments: Order Forms***
  - Facilitator Kit Resources Order Form FY 15-16
  - Parent's resources Order Form FY 15-16
  - Program Resources Order Form FY 15-16

*Note: Triple P reserves the right to make changes to the course summaries including the prerequisites as needed

**Note: Triple P prices change each year, and therefore a new order form is released every July with new pricing. Email orders.us@triplep.net for the most current order form.

Triple P – Positive Parenting Program

Open Enrollment List Serve

Triple P America (TPA) offers various trainings across the U.S. (typically Columbia, SC; New Orleans, LA; and Los Angeles, CA). These trainings and associated travel costs are at the expense of the participant/agency. The following Course Summaries include the overview, learning outcomes, and necessary prerequisites to participate in each level of training. It also provides information regarding the cost of training, what is included, and the appropriate audience for each level of training. Please reference these summaries when determining if attending an Open Enrollment training opportunity is appropriate for you or a member of your agency/organization.

You can visit the Open Enrollment Calendar to see if there is a scheduled training in a region near you!

Also, to learn of these trainings, you can opt in to receive email notifications from Kristin Patterson of TPA by emailing Kristin Patterson at kristin.patterson@triplep.net.



Triple P - Positive Parenting Program®

Triple P Course Summaries

Level 2

Selected (Seminars) Triple P Provider Training Course

What does the cost of the training include?

- 1 training day (maximum of 20 practitioners).
- 1 accreditation day undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 10 practitioners per workshop and a total of 20 practitioners attending the day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Selected Triple P (includes a Facilitator's Manual and CD-Rom with Seminar Series PowerPoint presentations).
- Triple P Tip Sheet Series – Seminar Series (includes a Tip Sheet from each Seminar Series).

Do pre-requisites apply?

Practitioners must have completed one of the following courses: *Brief Primary Care, Primary Care, Group, or Standard Triple P.*

Who is best suited to this course?

This delivery modality is best suited to experienced and confident facilitators involved in education or health services e.g. school counselors, nurses.

Overview

The Selected (Seminars) Triple P Provider Training Course teaches Triple P Providers the skills to conduct parenting information seminars for parents with children up to 12 years. Selected Triple P is suitable as a universal prevention strategy where it is offered to parents entering an intervention or school age service.

Selected interventions are typically delivered through primary care services including maternal and child health services, general practitioners and family doctors, child care centers, kindergartens, and schools. These services are well positioned to provide brief information presentations to groups of parents.

The Triple P Selected Seminar Series consists of three 60-minute seminars (plus 30-minutes for questions) covering the following topics:

1. The power of positive parenting.
2. Raising confident, competent children.
3. Raising resilient children.

The seminar series may also assist parents with specific concerns about their child's behavior by building awareness of other Triple P services. This level of intervention is designed for the management of discrete child problem behaviors that are not complicated by other major behavior management difficulties or family dysfunction.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Organizing a successful seminar series.
- Presentation of the seminar series.
- Core principles of positive parenting and behavior change.
- Specific positive parenting strategies for promoting children's development.
- Responding to parents questions.

Estimating the number of program resources required for parents

Where Selected Seminars are considered part of core business for organizations it can be expected that each trained practitioner will run 2 rounds of the 3 seminars every year (6 seminars) with an average of 50 parents or carers attending each seminar. This equates to 300 seminar places.

Program Resource Formula
1 x Seminar Tip Sheet per seminar place

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Level 2

Brief Primary Care Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 1 accreditation day undertaken 6-8 weeks post-training. Each practitioner attends only one half-day workshop (maximum of 10 practitioners attending each workshop and a total of 20 practitioner attending the day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 practitioners.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Primary Care Triple P (includes Practitioner's Manual and Consultation Flip Chart).
- Triple P Tip Sheet Series (including a Positive Parenting Booklet and sample of the Triple P Tip Sheet Series).
- Every Parent's Survival Guide [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. Requires an organization to have established a successful referral process for families requiring further assistance. Please discuss with an Implementation Consultant if this course is appropriate for your organization.

Who is best suited to this course?

This course is best suited to practitioners working in a brief opportunistic consultation format with families experiencing mild behavioral/emotional difficulties with recent onset, including nurses, and family physicians.

Overview

The Brief Primary Care Triple P Training Course is relevant to practitioners who regularly offer advice and support to parents with children up to 12 years during brief opportunistic consultations. Using this model, practitioners have a brief consultation (15- to 30-minutes) with families plus a follow-up visit or phone call to review if required.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Early detection and effective management of child behavior problems.
- Core principles of positive parenting and behavior change.
- Factors influencing child behavior.
- Specific positive parenting strategies for promoting children's development.
- Effective parent consultation.
- Identification of indicators suggesting more intervention is required and appropraite referral procedures.

Estimating the number of program resources required for parents

Where Brief Primary Care Triple P consultations are conducted as part of core business, it can be expected each practitioner will see 125 parents or carers per year. Thus, each practitioner would require 125 *tip sheets* (any combination of topics) and 125 *Positive Parenting Booklets* per annum.

Program Resource Formula

1 x Tip Sheet per family

1 x Positive Parenting Booklet per family

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Level 3

Primary Care Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for detail).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following at training:

- Practitioner's Kit for Primary Care Triple P (includes Practitioner's Manual and Consultation Flip Chart).
- Triple P Tip Sheet Series – Sample Pack. (includes the Positive Parenting Booklet and a sample of the Triple P Tip Sheet Series).
- Every Parent's Survival Guide [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply.

Who is best suited to this course?

This course is best suited to practitioners working in a brief consultation format with families experiencing mild behavioral/ emotional difficulties with recent onset, including school counselors, nurses, home visitors, family physicians, pediatricians, and other allied health professionals.

Overview

The Primary Care Triple P Training Course is relevant to practitioners who regularly offer advice and support to parents with children up to 12 years during focused consultations carried out in the course of providing routine health surveillance and care. Using this model, practitioners have 3 to 4 consultations (15- to 30-minutes) with families over a 4 to 6 week period.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Early detection and effective management of child behavior problems.
- Core principles of positive parenting and behavior change.
- Specific positive parenting strategies for promoting children's development.
- Effective parent consultation.
- Identification of indicators suggesting more intervention is required and appropriate referral procedures.
- Risk and protective factors operating within families.

Estimating the number of program resources required for parents

Where Primary Care Triple P consultations are conducted as part of core business it can be expected each practitioner will see 50 parents or carers per year. Thus, each practitioner would require 150 *tip sheets* (any combination of topics) and 50 *Positive Parenting Booklets* per annum.

Note: Organizations may expect practitioners to use additional Tip Sheets as part of one-off opportunistic Triple P consultations with parents or carers.

Program Resource Formula
3 x Tip Sheets per Family
1 x Positive Parenting Booklet per family

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Level 3

Triple P Discussion Group Provider Training Course

What does the cost of the training include?

- 1 training days (maximum of 20 practitioners).
- 1 accreditation days undertaken 6-8 weeks post-training. Each practitioner attends only one half-day workshop (maximum of 10 practitioners attending each workshop and a total of 20 practitioners attending the day).
- Training materials include: participant notes and questionnaires /evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for detail).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following at training:

- Facilitator's Kit for Triple P Discussion Group (includes Presentation Guide, four Workbooks, and DVD/PowerPoint).
- Facilitator's Manual for Triple P Discussion Group.

Do pre-requisites apply?

Practitioners must have previously completed one of the following courses: *Brief Primary Care, Primary Care, Group, or Standard Triple P.*

Practitioners accredited in Selected (Seminars) or Group Triple P are exempt from Accreditation.

Who is best suited to this course?

This course is best suited to practitioners working in a brief consultation format with families experiencing mild behavioral/ emotional difficulties with recent onset, including school counselors, nurses, home visitors, family physicians, pediatrician and other allied health professionals.

Overview

The Triple P Discussion Group Provider Training Course is relevant to practitioners who regularly offer advice and support to parents with children up to 12 years. Using this model, practitioners will facilitate a 1-session 2-hour group discussion with an average of 10 families.

The discussion groups are designed to provide an overview and introduction to the principles of positive parenting for any interested parent. The discussion group topics are:

- Hassle free shopping with children.
- Managing fighting and aggression.
- Developing good bedtime routines.
- Dealing with disobedience.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Early detection and effective management of child behavior problems.
- Core principles of positive parenting and behavior change.
- Specific positive parenting strategies for promoting children's development.
- Effective parent consultation.
- Use of active skills training strategies in a group format.
- Group dynamics and common process issues.
- Identification of indicators suggesting more intervention is required and appropriate referral procedures.

Estimating the number of program resources required for parents

Where Triple P Discussion Group are conducted as part of core business, it can be expected each practitioner will facilitate 10 group sessions each with an average of 10 parents or carers. Thus, each practitioner would require 100 *Triple P Discussion Group Workbooks* (any combination of the four topics) per annum.

Program Resource Formula for group discussions
1 x Triple P Discussion Group Workbook per family

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Level 4

Group Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Group Triple P (includes Facilitator's Manual, CD-Rom with Group Triple P PowerPoint presentations, and the Every Parent's Group Workbook).
- Every Parent's Survival Guide [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of child development and psychopathology to undertake this training.

Who is best suited to this course?

Those who are able to provide long term regular group interventions, including school counselors, nurses, psychologists, social workers.

Overview

The Group Triple P Provider Training Course skills practitioners to deliver a broad focused parenting support program to groups of parents with children up to 12 years. Group Triple P is suitable for parents with concerns about their child's behavior or who wish to learn a variety of parenting skills that will promote their child's development and potential. Group Triple P is suitable as a universal prevention strategy where it is offered to parents entering an early intervention or school age service.

Group Triple P is delivered to parents over the course of 8 weeks. The program involves 5 (2-hour) group sessions that educate and actively train skills, and three (15- to 30-minute) individual telephone consultations that follow a self-regulatory format to facilitate independent problem solving.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Application of key parenting strategies to a broad range of target behaviors.
- Strategies for promoting generalization and maintenance of behavior change.
- Use of active skills training strategies in a group format.
- Group dynamics and common process issues.
- Telephone support consultations with parents.
- Identification of indicators suggesting more intervention is required.
- Appropriate referral procedures.
- Risk and protective factors operating within families.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it is expected that each practitioner would conduct, on average, 3 group programs per year with approximately 10 parents or carers in each program. Thus, each practitioner would require 30 copies of *Every Parent's Group Workbook* per annum.

Program Resource Formula
1 x Every Parent's Group Workbook per family

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Level 4

Standard Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Standard Triple P (includes Practitioner's Manual and Every Parent's Family Workbook).
- Every Parent's Survival Guide [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of child development and psychopathology to undertake this training.

Who is best suited to this course?

Recommended for psychologists, psychiatrists, social workers, family counselors, school guidance officers, behavior management teachers and other allied health professionals who regularly consult with parents about children's behavior.

Overview

The Standard Triple P Provider Training Course skills practitioners to deliver an intensive broad focused parenting support intervention individually to parents with children up to 12 years. Standard Triple P is suitable for parents with concerns about their child's behavior or who wish to learn a variety of parenting skills that will promote their child's development and potential.

Standard Triple P is designed as a 10 session intervention with each session being approximately 1 hour in duration. The intervention involves a thorough assessment of parent-child interaction, the application of parenting skills to a broad range of target behaviors and the use of generalization enhancement strategies to promote parental autonomy. The course provides practitioners the opportunity to develop advanced assessment and intervention skills.

Learning Outcomes

On completion of this program, practitioners will have enhanced knowledge and skills in the following areas:

- Early detection and effective management of child behavior problems.
- Risk and protective factors operating within families
- Core principles of positive parenting and behavior change.
- Advanced assessment of child and family functioning
- Application of key parenting strategies to a broad range of target behaviors.
- Strategies for promoting generalization and maintenance of behavior change.
- Identification of indicators suggesting more intervention is required.
- Appropriate referral procedures.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it is expected that each practitioner could conduct, on average 250 consultations per year equating to 25 parents or carers per year (given 10 sessions per Standard Triple P delivery per family). Thus, each practitioner would require 25 *Every Parent's Family Workbook* per annum.

Program Resource Formula
1 x Every Parent's Family Workbook per family

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Level 2

Selected (Seminars) Teen Triple P Provider Training Course

What does the cost of the training include?

- 1 training day (maximum of 20 practitioners).
- 1 accreditation workshop undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (a maximum of 10 practitioners per workshop and a total of 20 practitioners attending the day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Selected Teen Triple P (includes a Facilitator's Manual and CD-Rom with Seminar Series PowerPoint presentations).
- Triple P Tip Sheet Series – Seminar Series (Includes a Tip Sheet from each of the 3 teen seminars).

Do pre-requisites apply?

Practitioners must have completed one of the following courses: *Brief Primary Care Teen, Primary Care Teen, Group Teen, or Standard Teen Triple P.*

Who is best suited to this course?

This delivery modality is best suited to experienced and confident facilitators involved in education or health services e.g. school counselors, nurses.

Overview

The Selected (Seminars) Teen Triple P Provider Training Course teaches Triple P Providers the skills to conduct parenting information seminars for parents with teenagers up to 16 years. Selected Teen Triple P is suitable as a universal prevention strategy where it is offered to parents of teens transitioning to high school.

Selected interventions are typically delivered through primary care services including youth health services, colleges and high schools. These services are well positioned to provide brief information presentations to groups of parents.

The Triple P Selected Teen Seminar series consists of three 60-minute seminars (plus 30-minutes for questions) on the following topics:

1. Raising responsible teenagers.
2. Raising competent teenagers.
3. Getting teenagers connected.

The seminar series may also assist parents with specific concerns about their teenager's behavior by building awareness of other Triple P services. This level of intervention is designed for the management of discrete teen problem behaviors that are not complicated by other major behavior management difficulties or family dysfunction.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Organizng a successful seminar series.
- Presentation of the seminar series.
- Core principles of positive parenting and behavior change.
- Specific positive parenting strategies for promoting teenagers' development.
- Responding to parents' questions.

Estimating the number of program resources required for parents

Where Selected Teen Seminars are considered part of core business for organizations it can be expected that each trained practitioner will run 2 rounds of the 3 seminars every year (6 seminars) with an average of 50 parents or carers attending each seminar. This equates to 300 seminar places.

Program Resource Formula
1 x Teen Seminar Tip Sheet per seminar place

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Level 2

Brief Primary Care Teen Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 1 accreditation day undertaken 6-8 weeks post-training. Each practitioner attends only one half-day workshop (maximum of 10 practitioners attending each workshop and a total of 20 practitioners attending the day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Primary Care Teen Triple P (includes Practitioner's Manual and Consultation Flip Chart).
- Triple P Teen Tip Sheet Series–Sample Pack (includes Positive Parenting for for Parents with Teenagers and a sample of the Teen Tip Sheets).
- Every Parent's Survival Guide to Teenagers [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. Requires an organization to have established a successful referral process for families requiring further assistance.

Who is best suited to this course?

This course is best suited to practitioners working in a brief opportunistic consultation format with families experiencing recent onset of mild behavioral/emotional difficulties with a teenager. Those practitioners include nurses and family physicians.

Overview

The Brief Primary Care Teen Triple P Training Course is relevant to practitioners who regularly offer advice and support to parents with teenagers up to 16 years during brief opportunistic consultations. Using this model, practitioners have a brief consultation (15- to 30-minutes) with families plus a follow-up visit or phone call to review if required.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Early detection and effective management of teen behavior problems.
- Core principles of positive parenting and behavior change.
- Specific positive parenting strategies for promoting teenager's development.
- Effective parent consultation.
- Identification of indicators suggesting more intervention is required and appropriate referral procedures.

Estimating the number of program resources required for parents

Where Brief Primary Care Teen Triple P consultations are conducted as part of core business, it can be expected each practitioner will see 125 parents or carers per year. Each of these is likely to receive, on average 1 Teen Tip Sheet (any combination of topics) plus the Positive Parenting Booklet for Parents with Teenagers. Thus, each practitioner would require 125 *Tip Sheets* and 125 *Positive Parenting for Parents with Teenagers Booklets* per annum.

Program Resource Formula
1 x Teen Tip Sheets per family
1 x Positive Parenting Booklet for Parents with Teenagers per family

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Level 3

Primary Care Teen Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending the day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for detail).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Primary Care Teen Triple P (includes Practitioner's Manual and Consultation Flip Chart).
- Triple P Teen Tip Sheet Series–Sample Pack (includes Positive Parenting Booklet for Parents with Teenagers Booklet and a sample of the Teen Tip sheets).
- Every Parent's Guide to Teenagers [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply.

Who is best suited to this course?

This course is best suited to practitioners working in a brief consultation format with families experiencing recent onset of mild behavioral/emotional difficulties with a teenager. Those practitioners include school counselors, nurses, family physicians, pediatricians, and other allied health professionals.

Overview

The Primary Care Teen Triple P Training Course is relevant to practitioners who regularly offer advice and support to parents with teenagers up to 16 years during focussed consultations carried out in the course of providing routine health surveillance and care. Using this model, practitioners have 3 to 4 consultations (15- to 30-minutes) with families over a 4 to 6 week period.

Learning Outcomes

On completion of this course, practitioners should have skills and knowledge in the following areas:

- Early detection and effective management of teenager behavior problems.
- Core principles of positive parenting and effective behavior change.
- Factors influencing adolescent behavior.
- Specific positive parenting strategies for promoting teenagers' development.
- Identification of indicators suggesting more intensive intervention is required.
- Appropriate referral procedures.
- Risk and protective factors operating within families.

Estimating the number of program resources required for parents

Where Primary Care Teen Triple P consultations are conducted as part of core business it can be expected each practitioner will see 50 parents or carers per year. Each of these is likely to receive, on average, 3 Tip Sheets (any combination of teen topics) plus the Positive Parenting for Parents with Teenagers Booklet. Thus, each practitioner would require 150 *Tip Sheets* and 50 *Positive Parening for Parents with Teenagers Booklets* per annum.

Note: Organizations may expect practitioners to use additional Tip Sheets as part of one-off opportunistic Triple P consultations with parents or carers.

Program Resource Formula
3 x Tip Sheets per family
1 x Positive Parenting for Parents with Teenagers Booklet per family

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Level 3

Teen Triple P Discussion Group Provider Training Course

What does the cost of the training include?

- 1 training days (maximum of 20 practitioners).
- 1 accreditation days undertaken 6-8 weeks post-training. Each practitioner attends only one half-day workshop (maximum of 10 practitioners attending each workshop and a total of 20 practitioners attending the day).
- Training materials include: participant notes and questionnaires /evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for detail).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following at training:

- Facilitator's Kit for Teen Triple P Discussion Group (includes Presentation Guide, four Workbooks, and DVD/ PowerPoint).
- Facilitator's Manual for Teen Triple P Discussion Group.

Do pre-requisites apply?

Practitioners must have previously completed one of the following courses: *Brief Primary Care Teen, Primary Care Teen, Group Teen, or Standard Teen Triple P.*

Practitioners accredited in Selected (Seminars) Teen or Group Teen Triple P are exempt from Accreditation.

Who is best suited to this course?

This course is best suited to practitioners working in a brief consultation format with families experiencing mild behavioral/ emotional difficulties with recent onset, including school counselors, nurses, family physicians, and other allied health professionals.

Overview

The Teen Triple P Discussion Group Provider Training Course is relevant to practitioners who regularly offer advice and support to parents with teenagers up to 16 years. Using this model, practitioners will facilitate a 1-session 2-hour group discussion with an average of 10 families.

The discussion groups are designed to provide an overview and introduction to the principles of positive parenting for any interested parent. The discussion group topics are:

- Getting teenagers to coorperate.
- Coping with teenagers emotions.
- Building teenagers survival skills.
- Reducing family conflict.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Early detection and effective management of teen behavior problems.
- Core principles of positive parenting and behavior change.
- Factors influencing adolescent behavior.
- Specific positive parenting strategies for promoting teenager's development.
- Effective parent consultation.
- Use of active skills training strategies in a group format.
- Group dynamics and common process issues.
- Identification of indicators suggesting more intervention is required and appropriate referral procedures..

Estimating the number of program resources required for parents

Where Teen Triple P Discussion Groups are conducted as part of core business, it can be expected each practitioner will facilitate 10 group sessions each with an average of 10 parents or carers. Thus, each practitioner would require 100 *Teen Triple P Discussion Group Workbooks* (any combination of the four topics) per annum.

Program Resource Formula for group discussions

1 x Teen Triple P Discussion Group Workbook per family

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Level 4

Group Teen Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Group Teen Triple P (includes Facilitator's Manual, CD-Rom with Group Teen Triple P PowerPoint presentations, and the Teen Triple P Group Workbook).
- Every Parent's Guide to Teenagers [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of adolescent development and psychopathology to undertake this training.

Who is best suited to this course?

Those who are able to provide long term regular group interventions, including school counselors, nurses, psychologists, social workers.

Overview

The Group Teen Triple P Provider Training Course skills practitioners to deliver a broad focused parenting support program to groups of parents with teenagers up to 16 years. Group Teen Triple P is suitable for parents with concerns about their teenager's behavior or who wish to learn a variety of parenting skills that will promote their teenager's development and potential. Group Teen Triple P is suitable as a universal prevention strategy where it is offered to parents of teens transitioning to high school.

Group Teen Triple P is delivered to parents over the course of 8 weeks. The program involves 5 (2-hour) group sessions that educate and actively train skills, and three (15- to 30-minute) individual telephone consultations that follow a self-regulatory format to facilitate independent problem solving.

Group Teen Triple P Provider Training Course comprises attendance at a 3-day training program, followed some weeks later by demonstration of knowledge and competence in program delivery through a skills-based accreditation process.

Learning Outcomes

On completion of this course, practitioners should have knowledge and skills in the following areas:

- Application of key parenting strategies to a broad range of teenagers' target behaviors.
- Strategies for promoting generalization and maintenance of behavior change.
- Use of active skills training strategies in a group format.
- Group dynamics and common process issues.
- Telephone support consultations with parents.
- Identification of indicators suggesting a more intensive intervention is required.
- Appropriate referral procedures.
- Risk and protective factors operating within families.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it is expected that each practitioner would conduct, on average, 3 group programs per year with approximately 10 parents or carers in each program. Thus, each practitioner would require 30 copies of *Teen Triple P Group Workbook* per annum.

Program Resource Formula
1 x Teen Triple P Group Workbook per family

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Level 4

Standard Teen Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for a description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Standard Teen Triple P (includes Practitioner's Manual and the Teen Triple P Family Workbook).
- Every Parent's Guide to Teenagers [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of child and adolescent development and psychopathology to undertake this training.

Who is best suited to this course?

Recommended for psychologists, psychiatrists, social workers, family counselors, school guidance officers, behavior management teachers and other allied health professionals who regularly consult with parents about adolescent behavior.

Overview

The Standard Teen Triple P Provider Training Course skills practitioners to deliver an intensive broad focused parenting support intervention individually to parents with teenagers up to 16 years. Standard Teen Triple P is suitable for parents with concerns about their teenager's behavior or who wish to learn a variety of parenting skills that will promote their teenager's development and potential.

Standard Triple P is designed as a 10 session intervention with each session being approximately 1 hour duration. The intervention involves a thorough assessment of parent-teen interaction, the application of parenting skills to a broad range of target behaviors and the use of generalization enhancement strategies to promote parental autonomy. The course provides practitioners the opportunity to develop advanced assessment and intervention skills.

Learning Outcomes

On completion of this program, practitioners will have enhanced knowledge and skills in the following areas:

- Early detection and effective management of teenager behavior problems.
- Risk and protective factors operating within families.
- Core principles of positive parenting and behavior change.
- Advanced assessment of teenager and family functioning.
- Application of key parenting strategies to a broad range of target behaviors.
- Strategies for promoting generalization and maintenance of behavior change.
- Identification of indicators suggesting more intervention is required.
- Appropriate referral procedures.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it is expected that each practitioner could conduct, on average 250 consultations per year equating to 25 parents or carers per year (given 10 sessions per Standard Teen Triple P delivery per family). Thus, each practitioner would require 25 *Teen Triple P Family Workbooks* per annum.

Program Resource Formula
1 x Teen Triple P Family Workbook per family

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Level 2

Selected (Seminars) Stepping Stones Triple P Provider Training Course

What does the cost of the training include?

- 1 training day (maximum of 20 practitioners).
- 1 accreditation day undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 10 practitioners per workshop and a total of 20 practitioners attending the day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Selected Stepping Stones Triple P (includes a Facilitator's Manual and CD-Rom with Seminar Series PowerPoint presentations).
- Triple P Tip Sheet Series – Seminar Series (includes a Tip Sheet from each Seminar Series).

Do pre-requisites apply?

Practitioners must have completed one of the following courses: *Primary Care Stepping Stones, Group Stepping Stones, or Standard Stepping Stones Triple P.*

Who is best suited to this course?

This delivery modality is best suited to experienced and confident facilitators involved in providing services to parents of children with disabilities.

Overview

The Selected (Seminars) Stepping Stones Triple P Provider Training Course teaches Triple P Providers the skills to conduct parenting information seminars for parents of children with a disability up to 12 years. Selected Stepping Stones Triple P is suitable as a universal strategy where it is offered to parents entering an intervention or school age service.

Selected interventions are typically delivered through primary care services including maternal and child health services, general practitioners and family doctors, child care centers, kindergartens, and schools. These services are well positioned to provide brief information presentations to groups of parents.

The Stepping Stones Triple P Selected Seminar Series consists of three 60-minute seminars (plus 30-minutes for questions) covering the following topics:

1. Positive parenting for children with a disability.
2. Helping your child reach their potential.
3. Changing problem behavior into positive behavior.

The seminar series may also assist parents with specific concerns about their child's behavior by building awareness of other Triple P services. This level of intervention is designed for the management of discrete child problem behaviors that are not complicated by other major behavior management difficulties or family dysfunction.

Learning Outcomes

On completion of this program, practitioners will have knowledge and skills in the following areas:

- Organizing a successful seminar series.
- Presentation of the seminar series.
- Core principles of positive parenting and behavior change.
- Specific positive parenting strategies for promoting children's development.
- Responding to parents questions.

Estimating the number of program resources required for parents

Where Stepping Stones Triple P Seminars are considered part of core business for organizations it can be expected that each trained practitioner will run 2 rounds of the 3 seminars every year (6 seminars) with an average of 50 parents or carers attending each seminar. This equates to 300 seminar places.

Program Resource Formula

1 x Stepping Stones Seminar Tip Sheet per seminar place

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Level 3

Primary Care Stepping Stones Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for detail).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Primary Care Stepping Stones Triple P (includes Practitioner's Manual and Consultation PowerPoint CD).
- Stepping Stones Triple P Primary Care Booklet Series.
- Stepping Stones Triple P: A Survival Guide for Families with a Child with a Disability [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply.

Who is best suited to this course?

Those who work in a brief consultation format with families experiencing mild behavioral/emotional difficulties with recent onset with a child (e.g. family support workers, school counselors, special education teachers, nurses, family physicians, pediatricians and allied health professionals).

Overview

The Primary Care Stepping Stones Triple P Training Course is relevant to practitioners who regularly offer advice and support to parents who have a child with a disability up to 12 years during focused consultations carried out in the course of providing routine health surveillance and care.

Primary Care Stepping Stones Triple P involves teaching parents to apply parenting skills to specific target behaviors using active skills training. Using this model, practitioners have 3 to 4 brief consultations (15- to 30-minutes) with families over a 4 to 6 week period.

Learning Outcomes

On completion of this course, practitioners should have skills and knowledge in the following areas:

- Early detection and effective management of child behavior problems.
- Core principles of positive parenting and effective behavior change.
- Specific positive parenting strategies for promoting childrens' development.
- Identification of indicators suggesting more intensive intervention is required.
- Appropriate referral procedures.

Estimating the number of program resources required for parents

Where Primary Care Stepping Stones Triple P consultations are conducted as part of core business it can be expected each practitioner may see, on average, 50 parents or carers per year. Each of these families is likely to receive, on average 2 booklets (any combination of topics) plus the Positive Parenting Booklet. Thus, each practitioner would require 100 *Stepping Stones Triple P Primary Care Booklets* and 50 *Positive Parenting Booklet*s per annum.

Note: In addition, organizations may expect practitioners to use additional booklets as part of one-off opportunistic Triple P consultations with parents or carers. Organizations may like to factor in additional booklets per family per practitioner to account for this.

Program Resource Formula
2 x Stepping Stones Triple P Primary Care Booklets per family
1 x Positive Parenting Booklet per family

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Level 4

Group Stepping Stones Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Group Stepping Stones Triple P (includes Facilitator's Manual, CD-Rom with Group Stepping Stones Triple P PowerPoint presentations, and the Stepping Stones Triple P Group Workbook).
- Stepping Stones: A Survival Guide for Parents of Children with a Disability [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of child development, psychopathology and disability to undertake this training.

Who is best suited to this course?

Those who are able to provide long term regular group interventions, including disability specialists, school counselors, nurses, psychologists, social workers.

Overview

The Group Stepping Stones Triple P Provider Training Course skills practitioners to deliver a broad focused parenting support program to groups of parents who have children with a developmental disability up to 12 years. Group Stepping Stones Triple P is suitable for parents with concerns about their child's behavior or who wish to learn a variety of parenting skills that will promote their child's development and potential. Group Stepping Stones Triple P is suitable as a universal strategy to prevent behavioral and emotional problems in children with a developmental disability.

Group Stepping Stones Triple P is delivered to parents over the course of 9 weeks. The program involves 6 (2½-hour) group sessions that educate and actively train skills, and 3 (15- to 30-minute) individual telephone consultations that follow a self-regulatory format to facilitate independent problem solving.

Learning Outcomes

Practitioners successfully completing this program will have advanced knowledge and skills in the following areas:

- Application of key parenting strategies to a broad range of target behaviors.
- Strategies for promoting generalization and maintenance of behavior change.
- Use of active skills training strategies in a group format.
- Group dynamics and common process issues.
- Telephone support consultations with parents.
- Identification of indicators suggesting more intervention is required.
- Appropriate referral procedures.
- Risk and protective factors operating within families.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it is expected that each practitioner would conduct (on average) 5 group programs per year with approximately 7 parents or carers in each program. Thus, each practitioner would require 35 copies of the *Stepping Stones Triple P Group Workbook* per annum

Program Resource Formula
1 x Stepping Stones Triple P Group Workbook per family

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Level 4

Standard Stepping Stones Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Standard Stepping Stones Triple P (includes Practitioner's Manual, and the Stepping Stones Triple P Family Workbook).
- Stepping Stones: A Survival Guide for Parents of Children with a Disability [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of child development, psychopathology and disability to undertake this training.

Who is best suited to this course?

Recommended for psychologists, psychiatrists, social workers, family counselors, school guidance officers, behavior management teachers and other allied health professionals who regularly consult with parents about child behavior.

Overview

The Standard Stepping Stones Triple P Provider Training Course skills practitioners to deliver an intensive broad focused parenting support intervention individually to parents with children who have a developmental disability up to 12 years. Standard Stepping Stones Triple P is suitable for parents with concerns about their child's behavior or who wish to learn a variety of parenting skills that will promote their child's development and potential.

Standard Stepping Stones Triple P is designed as a 10 session intervention with each session being approximately 1 hour in duration. The intervention involves a thorough assessment of parent-child interaction, the application of parenting skills to a broad range of target behaviors and the use of generalization enhancement strategies to promote parental autonomy. The course provides practitioners the opportunity to develop advanced assessment and intervention skills.

Learning Outcomes

On completion of this program, practitioners will have enhanced knowledge and skills in the following areas:

- Early detection and effective management of child behavior problems.
- Risk and protective factors operating within families.
- Core principles of positive parenting and behavior change.
- Advanced assessment of child and family functioning.
- Application of key parenting strategies to a broad range of target behaviors.
- Strategies for promoting generalization and maintenance of behavior change.
- Identification of indicators suggesting the presence of additional family risk factors.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it can be expected that each practitioner could conduct, on average 8 or 9 Standard Stepping Stones Triple P consultations per week (350 consultations per year). This would equate to 35 different client families per year per practitioner (given 10 sessions per Standard Stepping Stones Triple P delivery per family). Thus, each practitioner would require 35 S*tepping Stones Triple P Family Workbooks* per annum.

Program Resource Formula
1 x Stepping Stones Triple P Family Workbook per family

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Level 5

Enhanced Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Enhanced Triple P (includes Practitioner's Manual and the Every Parent's Supplementary Workbook Modules).
- Supporting your Partner [DVD].
- Coping with Stress [DVD].

Do pre-requisites apply?

Practitioners must have previously completed one of the following courses: *Standard, Standard Teen, Standard Stepping Stones, Group, Group Teen, or Group Stepping Stones Triple P.*

This course includes training in Cognitive Behavior Therapy (CBT) strategies and experience in this area is an advantage when completing the course.

Who is best suited to this course?

Recommended for psychologists, psychiatrists, social workers, family counselors, school guidance officers, behavior management teachers and other allied health professionals.

Overview

The Enhanced Triple P Provider Training skills practitioners to provide family interventions which address family factors that may impact upon, and complicate, the task of parenting. These include problems with parental mood and adjustment and partner conflict. Typically families access Level 5 Enhanced interventions after completion of a Level 4 intervention.

Enhanced Triple P consists of a review interview which involves a brief assessment of progress to date, 3 stand alone modules, and a closure session. The 3 modules consist of a maximum of three 60- to 90-minute sessions.

- The *Practice Sessions* Module assists parents with implementation in the home environment and generalisation.
- The *Coping Skills* Module teaches a range of cognitive and behavioral strategies to manage mood and cope with everyday stress. It is designed for parents who are experiencing problems with personal adjustment which interfere with their parenting ability.
- The *Partner Support* Module is designed for two parent families with relationship adjustment or communication difficulties. It introduces parents to a variety of skills to enhance their teamwork as parenting partners including communication and problem solving skills.
- The *Maintenance and Closure* Module provides final opportunity to practise and plan for the future with a practitioner.

Learning Outcomes

On completion of this program, practitioners will have enhanced knowledge and skills in the following areas:

- Assessment of personal and relationship adjustment of parents.
- Specific strategies for improving personal coping skills and reducing parental stress, anxiety, and depression.
- Reducing parenting conflict, improving parents' communication skills and promoting partner support.
- Helping parents develop independent problem solving skills.
- Strategies for promoting generalization and maintenance of behavior change.

Estimating the number of program resources required for parents

Where Triple P is adopted by organizations as part of core business it can be estimated that a proportion of families accessing other Triple P interventions will require additional support in Enhanced Triple P (approximately 25 families per practitioner per annum). It is estimated that an average of 3 out of the available 4 supplementary workbooks are used by each family at this level of support.

Program Resource Formula
3 x Every Parent's Supplementary Workbook Modules per family

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Level 5

Pathways Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Practitioner's Kit for Pathways Triple P (includes Practitioner's Manual, CD-Rom with Group Pathways PowerPoint presentations, Pathways to Positive Parenting Modules).
- Coping with Stress [DVD].

Do pre-requisites apply?

Practitioners must have completed one of the following: *Standard, Standard Teen, Standard Stepping Stones, Group, Group Teen, or Group Stepping Stones Triple P.*

This course includes training in Cognitive Behavior Therapy (CBT) strategies and experience in this area is an advantage when completing the course.

Who is best suited to this course?

Recommended for psychologists, psychiatrists, social workers, family counselors, school guidance officers, behavior management teachers and other allied health professionals.

Overview

Pathways Triple P is a comprehensive parenting intervention for parents at risk of maltreating their children. Training to deliver this intervention is recommended for professionals who in the course of their duties regularly consult with parents at risk of maltreating their children, and have the capacity to deliver an extended group or individual program.

This course extends understanding of parent training with parents at risk for child maltreatment and the factors associated with abuse of children. It includes components addressing risk factors commonly encountered with maltreating parents, such as anger control problems and attributional biases. Modules include:

- Avoiding Parent Traps
- Coping with Anger
- Maintenance and Closure.

Learning Outcomes

On completion of this course, practitioners should have knowledge and skills in the following areas:

- Advanced assessment of child and family functioning.
- Identification of indicators suggesting the presence of additional risk factors within families.
- The delivery of interventions targeting additional risk factors, including anger management training and cognitive restructuring skills.
- Strategies for promoting generalization and maintenance of behavior change.

Estimating the number of program resources required for parents

Where Triple P is adopted by organizations as part of core business is can be estimated that a proportion of families accessing other Triple P interventions will require additional support in Pathways Triple P. It is predicated that three supplementary workbooks are used by each family who access this level of support.

Note: Organizations will need to determine what proportion of their clientele will require this Level 5 intervention. It is estimated each practitioner would see 25 families per annum.

Program Resource Formula
3 x Pathways to Positive Parenting Modules per family

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Level 5

Group Lifestyle Triple P Provider Training Course

What does the cost of the training include?

- 3 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).
- Access to the Triple P Provider Network for up to 20 Providers.

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Group Lifestyle Triple P (includes Facilitator's Manual, CD-Rom with Group Lifestyles Triple P PowerPoint presentations, Lifestyle Triple P Group Workbook, Active Games Booklet and Recipe Booklet).
- Every Parent's Survival Guide [DVD].

Do pre-requisites apply?

No Triple P pre-requisites apply. However, it is desirable that practitioners have knowledge of child development, psychopathology, physical science and food nutrition to undertake this training.

Who is best suited to this course?

Those who are able to provide long term regular group interventions, including school counselors, nurses, psychologists, social workers.

Overview

Group Lifestyle Triple P is a family intervention strategy designed for delivery to groups of parents who require information and practical strategies to help manage their children's weight-related behavior.

Specifically, Group Lifestyle Triple P is delivered to parents of overweight or obese children aged 5 to 10 years, over the course of 4 to 5 months (minimum 14 weeks). The program involves 10 (1½-hour) group sessions that educate and actively train skills related to nutrition, physical activity and positive parenting, and 4 (15- to 30-minute) individual telephone consultations that follow a self-regulatory format to facilitate individual family goal-setting and progress monitoring.

Learning Outcomes

Practitioners successfully completing this program will have advanced knowledge and skills in the following areas:

- Monitoring child growth using height, weight and BMI (Body Mass Index).
- Assessing child and family functioning.
- Strategies for promoting generalization and maintenance of behavior change.
- Use of active skills training strategies in a group format.
- Group dynamics and common process issues.
- Telephone support consultations with parents.
- Identification of indicators suggesting more intervention is required.
- Appropriate referral procedures.

Estimating the number of program resources required for parents

Where Triple P is adopted within organizations as part of core business it is expected that each practitioner would conduct, on average 2 group programs per year with approximately 10 families in each program. Thus, each practitioner would require 20 copies of *Every Parent's Group Lifestyle Workbook* per annum.

Lifestyle Triple P Extension Day

A two-day Lifestyle Triple P Extension course is available for practitioners who have already completed training in Group Triple P, and wish to extend their services to include assisting families with child weight-management concerns.

Program Resource Formula

1 x Every Parent's Group Lifestyle workbook per family
1 x Lifestyle Triple P recipe booklet per family
1 x Lifestyle Triple P active games booklet per family

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Level 5

Family Transitions Triple P Provider Training Course

What does the cost of the training include?

- 2 training days (maximum of 20 practitioners).
- 2 accreditation days undertaken 6-8 weeks post training. Each practitioner attends only one half-day workshop (a maximum of 5 practitioners attending each workshop and a total of 10 practitioners attending per day).
- Training materials include: participant notes and questionnaires/evaluation forms for each practitioner.
- Triple P practitioner resources (refer below for description).

What Triple P practitioner resources are included with training?

Each practitioner will receive a copy of the following:

- Facilitator's Kit for Family Transitions Triple P (includes Facilitator's Manual, CD-Rom with Family Transitions Triple P PowerPoint presentations, Family Transitions Triple P Workbook and Relaxation CD).
- Family Transitions Triple P- positive parenting after separation and divorce [DVD].

Do pre-requisites apply?

Practitioners must have completed one of the following: *Standard, Standard Teen, Standard Stepping Stones, Group, Group Teen, or Group Stepping Stones Triple P.*

This course includes training in Cognitive Behavior Therapy (CBT) strategies and experience in this area is an advantage when completing the course.

Who is best suited to this course?

Recommended for psychologists, psychiatrists, social workers, family counselors, school guidance officers, behavior
management teachers and other allied health professionals.

Overview

Family Transitions Triple P is a cognitive-behavioral family intervention designed to be delivered to parents who are experiencing personal distress from separation or divorce, which is impacting on, or complicating, the task of parenting.

A qualified provider typically delivers Family Transitions Triple P to parents over five group sessions before they complete a Level 4 Triple P program. Family Transitions Triple P assists in managing conflict with former partners, coping with distressing emotions and managing the transition from being a two-parent family to a single-parent family.

Learning Outcomes

Practitioners successfully completing this program will have enhanced knowledge and skills in the following areas:

- Assessment of personal adjustment in parents following divorce.
- Specific strategies for improving personal coping skills and reducing parenting stress anxiety, anger and depression.
- Specific strategies for reducing conflict between parents and improving communication.
- Strategies for promoting work, family, and play balance and gaining appropriate social support.
- Helping parents develop independent problem solving skills.
- Use of consultation resources (audio visual materials and parent workbooks).

Estimating the number of program resources required for parents

Where Triple P is adopted by organizations as part of core business it can be estimated that a proportion of families accessing Level 4 interventions will require additional support to help them to deal with separation and divorce. Organizations will need to determine what proportion of their clientele will require this Level 5 intervention. One Family Transitions Workbook and Relaxation CD is required for each parent.

Program Resource Formula
1 x Family Transitions Workbook per family
1 x Family Transitions Relaxation CD per family

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A Triple P Provider's Guide to Parent Resources

After you have completed your Triple P training, you might be wondering which resources are best suited for your delivery with parents. This document is designed to assist you in choosing the most appropriate resources and should be used in conjunction with the Practitioner Resource Order form. Simply find the course for which you have completed training in the list below and then select the resources you wish to purchase on the Practitioner Resource Order form.

Please note: Each of the below resources have been designed specifically to be used with a particular course; therefore you will only be able to purchase the resources designed for the course you have trained in. Conversely, Triple P DVDs can be purchased independent of the course you have trained in.

For Families with Children aged 0 – 12 years

I am trained in Selected Seminar Triple P

Any Seminar Series, Positive Parenting, Infant, Toddlers, Preschoolers and Primary Schoolers (0-12) TIPSHEETS

I am trained in Brief Primary Care/Primary Care Triple P

Any Positive Parenting, Infant, Toddlers, Preschoolers and Primary Schoolers TIPSHEETS

Positive Parenting Booklet - companion booklet to tip sheet series

I am trained in Triple P Discussion Group

Any Discussion Group Workbook Series 1 BOOKLETS

I am trained in Group Triple P or Group Indigenous Triple P

Any Positive Parenting, Infant, Toddlers, Preschoolers and Primary Schoolers TIPSHEETS

Every Parent's Group Workbook

Positive Parenting Booklet - companion booklet to tipsheet series

Indigenous Group Workbook

I am trained in Standard Triple P

Any Positive Parenting, Infant, Toddlers, Preschoolers and Primary Schoolers TIPSHEETS

Every Parent's Family Workbook

Positive Parenting Booklet - companion booklet to tipsheet series

Indigenous Group Workbook

I am trained in Enhanced Triple P

Any Enhanced WORKBOOKS (Supplementary Modules)

I am trained in Pathways Triple P

Any Pathways WORKBOOKS (Modules)

I am trained in Family Transitions Triple P

Family Transitions Workbook

Family Transitions Relaxation CD

I am trained in Group Lifestyle Triple P

Lifestyle Active Games Booklet

Lifestyle Recipe Booklet

Lifestyle Group Triple P Workbook

For Families with Teenagers aged 12-16 years

I am trained in Selected Seminar Teen Triple P

Any TEEN Seminar Series, Primary Schoolers and Teen TIPSHEETS

I am trained in Brief Primary Care Teen/Primary Care Teen Triple P

Any Primary Schoolers and Teen TIPSHEETS

Positive Parenting Booklet for Parents with Teenagers - companion booklet to teen tipsheet series

Primary Care Teen Wallchart

I am trained in Teen Discussion Group Triple P

Any Teen Discussion Group Workbooks

I am trained in Group Teen Triple P

Any Primary Schoolers and Teen TIPSHEETS

Teen Triple P Group Workbook

Positive Parenting Booklet for Parents with Teenagers - companion booklet to teen tipsheet series

I am trained in Standard Teen Triple P

Any Primary Schoolers and Teen TIPSHEETS

Teen Triple P Family Workbook

Positive Parenting Booklet for Parents with Teenagers - companion booklet to teen tipsheet series

For Families with a Child who has a Disability

I am trained in Selected Seminar Stepping Stones Triple P

Any Selected Stepping Stones TIPSHEETS

Any Stepping Stones BOOKLET SERIES

I am trained in Primary Care Stepping Stones Triple P

Any Stepping Stones BOOKLET SERIES

I am trained in Group Stepping Stones Triple P

Any Stepping Stones BOOKLET SERIES

Group Stepping Stones Workbook

I am trained in - Standard Stepping Stones Triple P

Any Stepping Stones BOOKLET SERIES

Standard Stepping Stones Family Workbook

See attachments for the following order forms:

- Facilitator Kit Resources Order Form FY 15-16
- Parent's Resources Order Form FY 15-16
- Program Resources Order Form FY 15-16

Important Triple P Websites

Stay Positive – Parent Website - http://www.triplep-parenting.net/nc-en/home/

Provider Network – Practitioner Website - http://www.triplep-parenting.net/provider/provider_login/

CHA – Triple P Provider Website - http://www.cabarrushealth.org/268/Triple-P-Provider

Triple P – Global Website - http://www.triplep.net/glo-en/home/

Triple P Online - http://www2.tripleponline.net/login.aspx?returnURL=/modules.aspx

LOCAL FUNDING OPPORTUNITITES

Section Contents:

Local Funding Opportunities

Attachments: Applications

Carolina Panthers Charities – Grant Application

Triple P – Positive Parenting Program

Local Funding Opportunities

Below are some possible funding sources to sustain Triple P efforts in Cabarrus County. Be advised that most funding sources require a 501c(3) status (non-profit organization). Please note this list is not conclusive.

Agnecy	Website	Application Deadline	Award Amount
Carolina Panthers Charities	See the grant application in the attachments or visit Panthers Charities	May 1 each year	Max $5,000
Walmart Foundation – Community Giving	Grant cycle begins February 1, 2016. Visit Community Grant Program more additional information	December 31, 2016	$250 - $2,500
United Way of Central Carolinas	Contact Community Investment Coordinator, Renee Warner or visit United Way to learn more about the Agency Funding Process		
Foundation for the Carolinas	Visit Competitive Grant Programs website for more information	Multiple	Multiple
City of Kannapolis	Contact Community Development Program Administrator, Sherry Gordon at sgordon@kannapolisnc.gov or 704-920-4332. Of visit Kannapolis NC for more	March 31 each year	$5,000 - $15,000 multiple
The Jonathan Foundation	Contact Sonja BohannonThacker at 980-621-1051 or Sonja.BohannonThacker@CabarrusHealth.org. You can visits The Jonathan Foundation website for additional information	RFA release mid-January; Apps due mid-February	Max $3,500

Business like Family Dollar, Dollar Tree, Walgreens, Harris Teeter, and even restaurants like Subway, Chick fil a, etc. are known for providing gift cards or small amounts of funding.

TRIPLE P RESEARCH

Section Contents:

University of Queensland

Facilitating Practitioner Flexibility Within an Empirically Support Intervention (Mazzucchelli & Sanders, 2010)

Facilitators and Barriers to implementation of an Evidence-Based Parenting Intervention to Prevent Child Maltreatment (Sanders, et al, 2012)

Population-Based Prevention of Child Maltreatment (Sanders, et al, 2009)

Some Key Research Findings

Professor Matt Sanders

What the Experts Say

Triple P Impact on Top Diagnoses for Medicaid Billing

Triple P Cabarrus APHA Dashboard

Triple P Cabarrus NACCHO Report – LHDs & Child Maltreatment – Oct 201

Triple P Cabarrus Evaluation Results – October-December 2015

Triple P Implementation Evaluation – Final Report – Jan 2016

The University of Queensland

Triple P Evidence-Base Research – The University of Queensland Australia website has more than 500 research articles related to the evidence-based research behind the Triple P program. You can browse articles by category (i.e. level of Triple P) or by topic (i.e. parenting skills, evidence-based practice, behavior outcomes, etc.).

According to the University of Queensland's Parenting and Family Support Centre, this database includes scientific papers that have contributed to the theory and development of essential procedures involved in forming part of the Triple P system of parenting interventions.

This includes research related to the efficacy, effectiveness and dissemination of intervention programs, epidemiological studies, correlational studies, service-based research, evaluations of professional training, large-scale population trials, and meta-analyses. It also includes observational studies of family interaction and independent program evaluations.

This is a great resource for providers who have a specific issue/barrier they want to learn how to overcome based on research.

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Facilitating Practitioner Flexibility Within an Empirically Supported Intervention: Lessons from a System of Parenting Support

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Abstract

Reluctance by practitioners to follow manuals is often cited as a reason for the lack of adoption of empirically supported treatments (ESTs). We contend that rigid adherence to the therapeutic techniques described in a manual is neither necessary nor desirable. Rather, practitioners should flexibly deliver interventions to meet the diverse needs of consumers, but in such a way that the intervention is not moved beyond its evidence base. This tension between adherence and flexibility is reframed as an issue of practitioner generalization. The present article draws on the authors' experiences from disseminating the Triple P-Positive Parenting Program to describe a number of strategies that can both safeguard the fidelity with which ESTs are delivered and encourage their flexible delivery.

Keywords: Dissemination; Empirically supported treatment; Evidence-based practice; Fidelity; Flexibility; Generalization

Introduction

While research has produced beneficial treatments for the main mental health problems that bring most children into clinics (e.g., conduct problems, oppositional behavior, ADHD, depression, fears, and anxiety), the majority of children treated in service settings each year receive treatments that have never been tested in any outcome study (Barrett & Ollendick, 2004; Kazdin & Weisz, 2003; Weisz, Jensen, & McLeod, 2005). Instead, most practitioners deliver interventions comprised of an eclectic mixture of goals and methods that therapists have fashioned from their own previous training, supervision, and clinical experience (Barlow, 1981). Unfortunately, the findings on such ''clinically derived'' treatments show little evidence of benefit (Weisz, 2004). This has led to increasing concern about the observed gap between the outcomes of child treatments as implemented in research versus practice settings (Schoenwald, Kelleher, & Weisz, 2008; Weisz, Donenberg, Han, & Kauneckis, 1995; Weisz, Donenberg, Han, & Weiss, 1995).

A number of reasons have been suggested as to why widespread dissemination, training, and deployment to practice settings of empirically supported treatments (ESTs; Chambless et al., 1996, 1998) have not occurred. These include the natural time course of interventions limiting the reach of programs, evidence not being a requirement for interventions in service settings, the lack of consensus criteria or lists of ESTs, differing disciplinary traditions of practitioners, limited practitioner and public awareness of ESTs, the lack of a dissemination engine for ESTs, the expense of training and supervision requirements, and lack of incentives for practitioners to change their practices (Weisz et al., 2005).

Recently, there has been increased awareness of these issues and attempts to address them in order to bridge the practice-research gap in mental health services. Recommendations and policy initiatives have

emerged that encourage the adoption of interventions that have been tested and shown to work (e.g., American Psychological Association, 2009; Council of Europe, 2007; National Academy of Parenting Practitioners, 2007; National Research Council and Institute of Medicine, 2009; President's New Freedom Commission on Mental Health, 2003; United Nations Office on Drugs and Crime, 2009; U.S. Public Health Service, Office of the Surgeon General, 2004). However, these do not address another major reason often cited for the lack of adoption of ESTs, concerns held by practitioners.

Practitioners often express concern about the relevance of ESTs, arguing that manualized treatments are neither relevant to their work nor appropriate for their clients. When trained in an EST, practitioners can sometimes either fail to adopt the treatment or adapt the treatment in ways that move it beyond the treatment's evidence base. The specific concerns of practitioners are diverse, but among those frequently mentioned are that (a) manualized treatments limit the practitioner's creativity and innovation, (b) manual use interferes with the development of a good therapeutic relationship and makes it hard to individualize treatment, and (c) the treatments are not suitable for real, severe, and complex client presentations (Addis & Krasnow, 2000; Addis, Wade, & Hatgis, 1999; Garfield, 1996; Havik & VandenBos, 1996; Strupp & Anderson, 1997; Weisz et al., 2005).

While concerns that the relatively structured approach required by manualized treatments will reduce the effectiveness of interventions have not been supported by research with adults (e.g., Jacobson et al., 1989; Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992), there is some evidence that if practitioners overemphasize the technical procedures of an intervention the therapeutic relationship can suffer and this can interfere with therapeutic change (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Najavits & Strupp, 1994). We contend that rigid adherence to the therapeutic techniques described in a manualized treatment may not actually be necessary nor lead to optimal delivery. Rather, to deliver an intervention effectively, it is essential that practitioners adapt and tailor treatments to meet the diverse needs and circumstances of consumers and to foster the therapeutic relationship. While this assumption may not be new (for similar views, see Abramowitz, 2006; Kendall & Beidas, 2007; Kendall, Chu, Gifford, Hayes, & Nauta, 1998), the challenge remains as to how to train practitioners to do this in an appropriate fashion so that an EST is not changed in such a way that it moves beyond its evidence base. In a sense, this tension between adherence to manuals and treatment flexibility might be reframed as an issue of practitioner generalization. The task for disseminators is to equip practitioners with the knowledge and skills necessary for them to flexibly deliver and appropriately adapt manualized treatments in ways so that the needs of consumers are best met.

The present article draws on our experiences from developing and disseminating the Triple P-Positive Parenting Program over the past 30 years. In the process of training over 21,000 practitioners in 19 countries from disciplines including psychology, medicine, nursing, occupational therapy, physiotherapy, policing, social work, and teaching, we have learned many lessons about the challenges of disseminating ESTs and adopted a number of strategies to both safeguard the fidelity with which the program is delivered and to encourage its flexible delivery. Although we draw examples from our experiences with the Triple P-Positive Parenting Program, the principles described are applicable to most ESTs.

What is the Triple P-Positive Parenting Program?

Triple P is a multilevel system of parenting intervention designed to improve the quality of parenting advice available to parents (Sanders, 2008). The system aims to prevent severe behavioral, emotional, and developmental problems in children and adolescents by enhancing the knowledge, skills, and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children from birth to age 16. The suite of multilevel programs includes intensive individually delivered face-to-face or telephone-assisted interventions, group interventions, more cost-effective brief interventions, and media-based interventions (see Table 1 and Sanders, 1999, for an overview of Triple P). This flexibility enables parents to participate in ways that suit their individual circumstances and allows participation from families in rural and remote areas who typically have less access to professional services. The system targets five different developmental periods from infancy to adolescence. Figure 1,

visually depicts the Triple P model, illustrating that the different levels of Triple P intervention can be delivered in a variety of formats and that within each developmental period, the reach of the intervention varies from very broad (targeting an entire population) to quite narrow (targeting only high-risk children). This multilevel strategy is designed to maximize efficiency, contain costs, avoid waste and overservicing, and ensure the program has a wide reach in the community.

Table 1. The Triple P model of parenting and family support

Level of intervention	Target population	Intervention methods	Practitioners
Level 1: Media-based parent information campaign Universal Triple P	All parents interested in information about parenting and promoting their child's development	Coordinated media and health promotion campaign raising awareness of parent issues and encouraging participation in parenting programs. May involve electronic and print media (e.g., community service announcements, talk-back radio, newspaper and magazine editorials)	Typically coordinated by area media liaison officers or mental health or welfare staff
Level 2: Health promotion strategy/brief selective intervention Selected Triple P Selected Teen Triple P	Parents interested in parenting education or with specific concerns about their child's development or behavior	Health promotion information or specific advice for a discrete developmental issue or minor child behavior problem. May involve a group seminar process or brief (up to 20 min) telephone or face-to-face clinician contact	Parent support during routine well-child health care (e.g., child and community health, education, allied health, and child care staff)
Level 3: Narrow-focus parent training Primary Care Triple P Primary Care Teen Triple P	Parents with specific concerns (as above) who require consultations or active skills training	Brief program (about 80 min over four sessions) combining advice, rehearsal, and self-evaluation to teach parents to manage a discrete child problem behavior. May involve telephone or face-to-face clinician contact or group sessions	Same as for Level 2
Primary Care Stepping Stones Triple P	Parents of children with disabilities who have specific concerns about their child's behavior and who require consultations or active skills training	Same as above with a focus on disabilities	Same as for Level 2
Level 4: Broad-focus parent training Standard Triple P Group Triple P Self-Directed Triple P Self-Directed Teen Triple P Standard Teen Triple P Group Teen Triple P	Parents who want intensive training in positive parenting skills. Typically parents of children with behavior problems, such as aggressive or oppositional behavior	Broad-focus program (about 10 hr over 8–10 sessions) focusing on parent–child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face dinician contact or group sessions)	Intensive parenting interventions (e.g., mental health and welfare staff, and other allied health and education professionals who regularly consult with parents about child behavior)
Standard Stepping Stones Triple P Group Stepping Stones Triple P Self-Directed Stepping Stones Triple P	Parents of children with disabilities who want intensive training in positive parenting skills. Typically parents of children who want to promote their children's development, or whose children have or are at risk of developing behavioral or emotional disorders	Parallel programs to those described above with a focus on disabilities	Same as above
Level 5: Intensive family intervention modules Enhanced Triple P	Parents of children with behavior problems and concurrent family dysfunction (e.g., parental depression or stress) or conflict between partners	Intensive individually tailored program with modules (sessions last 60–90 min) including practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills	Intensive family intervention work (e.g., mental health and welfare staff)
Pathways Triple P	Parents at risk of maltreating their children. Program targets anger management problems and other factors associated with abuse	Modules include attribution retraining and anger management	Same as above

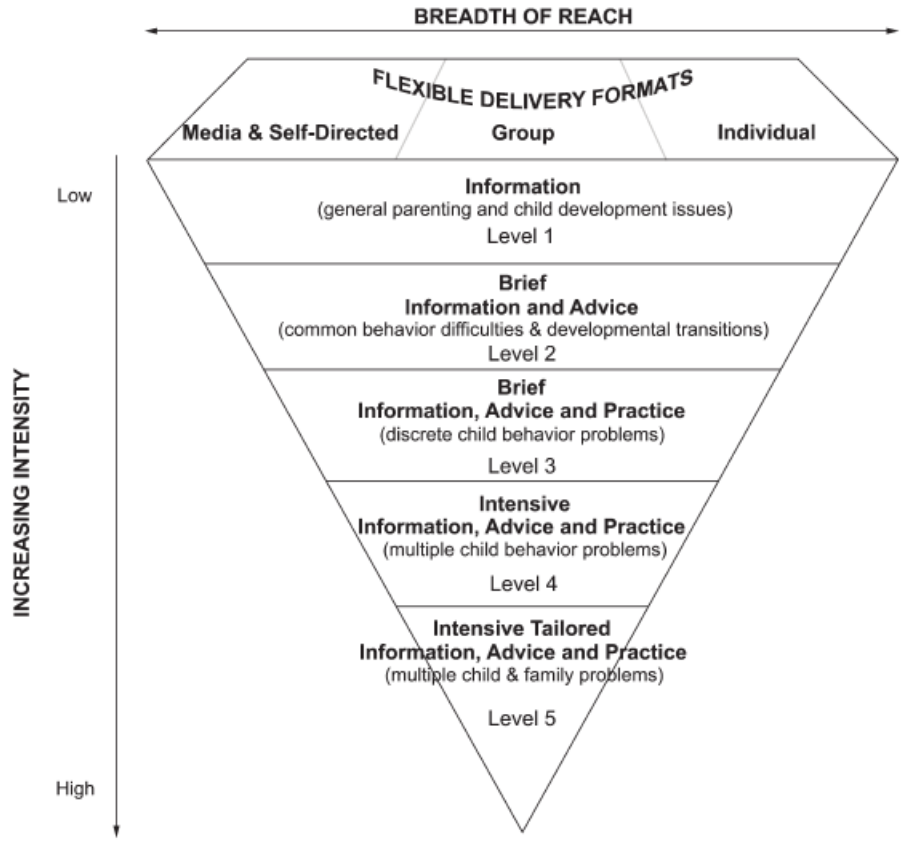


Figure 1. Triple P model of graded reach and intensity of parenting and family support services.

Content: Principles of Positive Parenting

Five core positive parenting principles form the basis of the program: (a) safe and engaging environment, (b) positive learning environment, (c) assertive discipline, (d) realistic expectations, and (e) parental self-care. These were selected to address specific risk and protective factors known to predict positive developmental and mental health outcomes in children. Table 2 shows how these principles are operationalized into a range of specific parenting skills (see Sanders, 1999, for a more complete overview).

Process: Self-Regulation of Parenting Skills

A central goal of Triple P is the development of an individual's capacity for self-regulation. Self-regulation is a process whereby individuals are taught skills to change their own behavior and become independent problem solvers (Karoly, 1993). The self-regulation model draws heavily on Bandura's (1977, 1986) cognitive social learning theory. This self-regulation framework influences the manner in which all consultation tasks are undertaken in Triple P. Consultation processes are employed such that parenting competence is enhanced while simultaneously building parents' capacity for self-regulation (e.g., Sanders, Mazzucchelli, & Ralph, in press).

Table 2. Core parenting skills introduced in Triple P

Basic skills					**Enhanced skills**		
Parent-child relationship enhancement skills	*Encouraging desirable behavior*	*Teaching new skills and behaviors*	*Managing misbehavior*	*Anticipating and planning*	*Self-regulation skills*	*Mood and coping skills*	*Partner support skills*
Spending brief quality time	Giving descriptive praise	Setting a good example	Establishing ground rules	Planning and advanced preparation	Monitoring children's behavior	Catching unhelpful thoughts	Improving personal communication habits
Talking with children	Giving nonverbal attention	Using incidental teaching	Using directed discussion	Discussing ground rules for specific situations	Setting developmentally appropriate goals	Relaxing and managing stress	Giving and receiving constructive feedback
Showing affection	Providing engaging activities	Using ask-say-do	Using planned ignoring	Selecting engaging activities	Setting practice tasks	Developing personal coping statements	Having casual conversations
		Using behavior charts	Giving clear, calm instructions	Providing incentives	Self-evaluating strengths and weaknesses	Challenging unhelpful thoughts	Supporting each other when problem behavior occurs
			Using logical consequences	Providing consequences	Setting personal goals for change	Developing coping plans for high-risk situations	Solving problems
			Using quiet time	Holding follow-up discussions			Improving relationship happiness
			Using time-out				

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Addressing the Fidelity-Flexibility Issue

In the dissemination of Triple P, we have adopted a systems-contextual perspective, incorporating a number of strategies to both safeguard the fidelity with which the program is delivered and to encourage its flexible delivery. A systems-contextual or ecological perspective recognizes that training and potential implementation of an EST occurs within a system and that if dissemination efforts are to be successful, a variety of contextual factors such as therapist variables, organizational support, quality of the training program, and client variables must be taken into account (Beidas & Kendall, 2010; Sanders & Turner, 2005; Turner & Sanders, 2006). Specific strategies used in the dissemination of Triple P are discussed below and summarized in Table 3. Not all of the strategies discussed will be unfamiliar to the field; however, we have attempted to clearly articulate a comprehensive list of strategies we have found to be useful and indicate the role that each plays in terms of either safeguarding fidelity or promoting flexibility.

Safeguarding Fidelity

Provide High-Quality Training and Accreditation

Parents seek support from a variety of professionals in the community. However, many service providers who support families have had little training in providing parenting and behavior management advice. Consequently, practitioners need instruction in both the theory and practice of ESTs that cover both the content and processes involved in working with parents. Research has demonstrated that participation in experiential and didactic training workshops is more effective in the acquisition of important practitioner skills than exposure to treatment manuals alone (Herschell et al., 2009; Sholomskas et al., 2005). There is also evidence that if workshops incorporate active learning strategies and are supplemented with continued consultation and feedback, learning outcomes are enhanced (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Sholomskas et al., 2005). Also, if participants return to training content in the weeks following training, they are dramatically more likely to incorporate the content of training into their practice (Bennett-Levy & Padesky, 2006).

Triple P practitioner training has two attendance components. The initial component provides practitioners with an overview of common developmental and behavioral problems and introduces strategies for promoting competencies and positive approaches to behavior management. In addition, practitioners receive active skills training in the consultation skills required to deliver the intervention. Although active skills training methods are used in most cognitive-behavioral training programs, Triple P extends these methods by incorporating them from a self-regulation framework (Karoly, 1993). Within certain boundaries, practitioners are encouraged to select their own learning goals, self-monitor and self-evaluate their own performance, and self-select personal goals for change. This self-regulatory framework is very useful for adult learning in a professional training context, as it is both respectful of and accommodates differences in practitioners' clinical knowledge and skill, and differences in practitioners' clients and service contexts (Sanders et al., in press). The self-regulatory process is discussed further later in this article. At the conclusion of the initial training component practitioners are encouraged to practice delivering the program with peers or clients.

Table 3. Strategies to overcome practitioner obstacles to the adoption of empirically supported treatments

Strategy	Description	Obstacles addressed
Safeguarding fidelity		
Provide high-quality training	Competency-based practitioner training in a supportive environment with mechanisms to ensure that participants return to training content in the weeks following training	Useful to address and challenge all obstacles cited by practitioners, including manualized interventions limiting therapists' creativity and innovation or ability to develop a good therapeutic relationship with clients, and ability individualize intervention
Educate regarding the evidence base	Compiling and presenting evidence regarding the effectiveness of interventions with diverse populations and making this evidence accessible to practitioners	Assuming evidence exists, this can challenge the notion that the intervention will not work in real-world settings with severe or comorbid cases, particular cultural groups, or other populations. Such evidence suggests that the intervention does not require any substantial adaptation
Provide population-specific variants	The development of variants of interventions to meet the needs of different populations or presenting problems (e.g., for children with a disability). Update these variants in the light of emerging evidence so that each reflects the best available evidence	Removes the need or temptation from practitioners to make major adaptations based on the assumption that because the population is different adaptations to the core program will be required
Program for process issues	Teaching the principles of effective parent consultation and practices for developing a collaborative practitioner-parent relationship. Also, providing protocols as to how to respond to a variety of common process issues such as the noncompletion of homework, emotional behavior, avoidance and nonengagement, and direct confrontations	Addresses practitioner's concerns that the complexity and volatility of clinically referred families make it impossible to follow a manualized treatment, or that manual use will interfere with the development of a good therapeutic relationship
Provide comprehensive program materials	The provision of complete and user-friendly materials so that interventions can be replicated in the manner in which they were originally tested	Decreases practitioner drift due to insufficient or difficult-to-follow intervention protocols
Encourage the collection of clinical outcome data	Provide reliable and valid free-to-use outcome measures to service providers. Ideally these should be the same measures used in outcome research	Decreases practitioner drift by connecting practitioners to a set of reinforcers that may maintain and control practitioner behaviors associated with the delivery of the EST. Provides a valuable indicator as to whether interventions are being delivered in a manner consistent with effectiveness trials and the point where flexible delivery becomes nonadherence. Also provides a means by which practitioners can collect their own evidence for the efficacy of interventions with different populations
Promote self- and peer evaluation and support	Provision of instruction and practice in self-reflective practice and how to conduct regular peer support/supervision sessions	Promotes learning and professional development, and safeguards against program drift
Provide post-training support	Provision of post-training information and assistance in various aspects of program implementation, as required	As above. Also ensures practitioners have access to best-available evidence
Promote organizational support	Provision of information and consultative advice to managers, administrators, and staff of organizations to support the adoption of the intervention	Facilitates the establishment of organizational processes that will support staff in delivering the intervention with fidelity. Counters myths about the intervention
Promoting flexibility		
Separate interventions into components	Providing intervention materials in modules that can be either implemented or omitted	Provides a means for practitioners to tailor interventions to identified needs of clients while maintaining treatment integrity
Train in intervention principles and instruct practitioners to be flexible	Instruction in the core content and processes of the intervention and the rationale and theories that underpin them. Instruct practitioners to adhere to the framework and principles that underpin the program but to be flexible as to how this content is delivered. Encourage practitioners for appropriate examples of the flexible delivery of the intervention	Promotes practitioner flexibility and appropriate adaptations
Train sufficient exemplars	Training practitioners in a wide range of all of the possible clinical presentations and response examples	Promotes practitioner flexibility in the application of the intervention to a range of populations, presenting problems and family circumstances
Use both positive and negative teaching examples	Practitioner training that includes "negative" examples, depicting how not to perform certain practitioner behaviors, intermixed with "positive" examples	Aids practitioners' understanding of the desired topography and appropriate or acceptable variations of program contact
Train practitioners to self-regulate behavior	Train practitioners in behaviors that will prompt and reinforce evidence-supported consultation behaviors in relevant settings, at appropriate times, and in all of its relevant forms	Encourages and maintains appropriate flexibility in practitioner behaviors
Train loosely	Varying noncritical aspects of the training setting	Reduces the chance that a single or small group of noncritical stimuli will acquire exclusive control over the targeted knowledge and skills and consequently inhibit or suppress the transfer of practitioner knowledge to the clinical setting
Facilitate dialogue between science and practice	Provision of means by which practitioners and researchers can exchange ideas and information and plan formal intervention research and development	Practitioners are less likely to engage in their own unnecessary ad hoc "experimentation."

Note: EST = empirically supported treatment.

The final attendance component of Triple P training courses consists of a competency-based accreditation workshop scheduled approximately eight weeks after the initial training. At these half-day workshops, small groups of practitioners are required to submit their answers to an objective test based on information provided in Triple P training and program material, and demonstrate their skills and knowledge in Triple P through role-play demonstration of core competencies (such as sharing assessment findings, using behavioral rehearsal to teach a parenting routine, giving constructive feedback to a parent after practicing parenting skills). Practitioners receive coaching and expert feedback at an individual level from a

trainer to assist them in attaining a reasonable level of provider mastery in these competencies. Performance at an 80% level in both quiz and assessed competencies is required for practitioners to receive official recognition of proficiency in program delivery. The intention of this component of training is to consolidate learning; address problems or concerns that service providers might have encountered with the program in their initial attempts at implementation; allow trainers to provide additional guidance to participants; and enhance provider confidence in delivering the newly acquired skills, which in turn might make program adoption more likely (Seng, Prinz, & Sanders, 2006). This training also makes it more likely practitioners are trained to a level necessary to come into contact with natural contingencies of reinforcement that will maintain newly acquired skills (Baer, 1999; also, see the section in this article on encouraging the collection of clinical outcome data).

Parents seek support from a variety of service providers in the community. These service providers have a legitimate mandate, and Triple P aims to resource them with high-quality information and skills. Prior to enrolling in Triple P provider training courses, practitioners are provided with information regarding the theoretical underpinnings of Triple P, recommended prerequisites, and the expectations of practitioners after training so practitioners can self-select into training programs most appropriate for their occupation and agency. Most Triple P training courses nevertheless involve an interdisciplinary mix and bring together professionals with different backgrounds, theoretical orientations, and clinical experience. Triple P accounts for differing professional experience by ensuring that training provides instruction in both the theory and practice of Triple P. Group discussion is used by trainers to explore, in a collaborative fashion, the advantages and disadvantages of alternate theoretical viewpoints or practitioner behaviors (as they are raised by practitioners) and to clearly present (and allow participants to practice) the Triple P approach. Providers from diverse backgrounds with varying levels of previous training, experience, self-efficacy, and confidence have been found to be equally likely to complete Triple P training and to be highly satisfied with the training provided. The majority of practitioners who complete training go on to deliver the program with families in the community (Seng et al., 2006).

Training programs themselves must be carefully managed to minimize program drift and ensure that practitioners receive the same training experience no matter where they are trained. Triple P trainers undergo intensive training and accreditation, use identical materials, adhere to a quality assurance process, and join a trainer network. This network allows for regular training updates of processes and materials in response to data from the field and in line with program revisions (Turner & Sanders, 2006).

Practitioners consistently rate the quality of Triple P training they receive very highly and report an increase in self-efficacy in various consultation tasks, such as conducting behavioral rehearsals with parents (Sanders, 2008; Sanders, Murphy-Brennan, & McAuliffe, 2003; Sanders, Tully, Turner, Maher, & McAuliffe, 2003). Triple P training has also been demonstrated to result in improved parent consultation skills as assessed by independent behavioral observation (Sanders, Tully, et al., 2003).

Educate Regarding the Evidence Base

Practitioner judgments about the potential applicability of an intervention to their own work and to their client needs will influence the extent that practitioners will perceive the need to modify an intervention (Turner & Sanders, 2006). Educating practitioners about an intervention's evidence base can modify such perceptions (Persons & Silberschatz, 1998). It is important that dissemination of an intervention does not commence until it has undergone rigorous scientific evaluation with significant positive outcomes (Society for Prevention Research, 2004). Treatment outcome studies can be broadly considered to be either efficacy or effectiveness research. Whereas efficacy research tests the impact of interventions under optimal conditions, effectiveness research tests the impact of treatments in real-world clinical settings. Both forms of research are important, but evidence from effectiveness research can be particularly convincing for practitioners (Persons & Silberschatz, 1998).

As of January 2010, 92 studies (including 27 effectiveness trials) have accrued that demonstrate the efficacy of the various Triple P variants in changing risk and protective factors and producing better mental health and developmental outcomes in children than comparison conditions. Triple P has been found to be

effective for children aged in their preschool years through to children in their teenage years, for a diverse range of clinical and high-risk populations, within a range of cultural contexts (see www.pfsc.uq.edu.au for a current list of all evaluation studies). The availability of such evidence is advantageous in that practitioners can be encouraged to make the assumption that the intervention will be effective with a broad range of presenting families and does not require any substantial adaptation.

Provide Population-Specific Variants

The onus should be on program developers to, when necessary, develop variants of interventions to meet the needs of different populations or presenting problems. This removes the need or temptation from practitioners to make major adaptations. Examples of the core Triple P intervention that have been developed and tested include Family Transitions Triple P for families who are transitioning through divorce; Indigenous Triple P for aboriginal Australians and Torres Strait Islanders, and Lifestyle Triple P for parents of overweight and obese children. Practitioners are encouraged to receive specialist training in and use the Triple P program that has the closest match to the populations and the intervention context in which the practitioner will be working. When working with diverse populations and contexts, practitioners are encouraged to receive extension training in all relevant variants/levels of the Triple P system. Training, practitioner, and parent materials for the different Triple P variants are updated in the light of emerging evidence so that each reflects the best available evidence.

Program for Process Issues

Practitioners sometimes express concern that the complexity and volatility of clinically referred families make it impossible to follow a manualized treatment, or that manual use will interfere with the development of a good therapeutic relationship. It is therefore important that therapists recognize that they can employ empirically supported ''relationship-building'' strategies (Norcross, 2002). Triple P explicitly teaches principles of effective parent consultation and practices for developing a collaborative practitioner-parent relationship (e.g., Sanders & Lawton, 1993). Further, a model for understanding parental resistance is provided (Patterson & Chamberlain, 1988, 1994), as are protocols as to how to respond to a variety of process issues such as the noncompletion of homework, emotional behavior, avoidance and nonengagement, and direct confrontations. Additionally, Triple P intervention modules that provide additional protocols to address personal adjustment difficulties (coping skills), relationship conflict (partner support), and anger and misattributions (pathways) are available to address these commonly encountered obstacles.

Provide Comprehensive Program Materials

Interventions are more likely to be delivered with fidelity if they have good supporting resource materials, such as clinician manuals and client workbooks, that are complete and user-friendly, relatively low-cost, and professionally produced (Turner & Sanders, 2006). Examples of the resources provided by Triple P include practitioner manuals, training manuals, parent workbooks, DVDs, and tip sheets. Practitioner manuals include detailed descriptions and example verbatim scripts of how to undertake various intervention tasks, including assessment, delivery of Triple P content, and the management of process issues. Training manuals include information beyond what is included in practitioner manuals about how to prepare for and implement the intervention. Parent materials provide enough detail so that the parent can decide whether each depicted strategy is acceptable, can follow suggested solutions, and can generalize the strategies to other situations.

Encourage the Collection of Clinical Outcome Data

Service providers are encouraged to routinely collect clinical outcome data. There are many benefits to the collection of such data ranging from their utility in planning individual interventions to answering field- generated research questions (e.g., Leung, Sanders, Ip, & Lau, 2006). From a flexibility/adherence perspective there are at least two additional reasons. First, by providing a reliable and valid means of obtaining information on the effectiveness of interventions, an important set of potential reinforcers is introduced that may maintain and control practitioner behaviors (effectively connecting practitioners to natural maintaining contingencies; see Stokes & Baer, 1977). Second, such measures allow comparisons to be drawn to outcomes achieved in effectiveness trials. This can provide a valuable indicator as to whether interventions are being delivered in a manner consistent with effectiveness trials or the point where flexible delivery becomes nonadherence. Sometimes practitioners express doubts as to whether interventions will be effective with particular populations. An effective way to challenge these notions is to encourage practitioners to collect their own evidence in order to test their hypotheses. Triple P facilitates the collection of data by providing reliable and valid free-to-use measures to service providers. Typically these are the same measures used in outcome research.

Promote Self- and Peer-Evaluation and Support

Reflection and supervision are considered to be essential for learning and professional development (Bennett-Levy, 2006; Fleming & Steen, 2004). These practices also have an important role in promoting the use of ESTs after initial training (Holloway & Neufeldt, 1995; Luoma et al., 2007) and in safeguarding against program drift (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). As part of Triple P practitioner training, practitioners receive instruction and practice in self-reflective practice and how to conduct regular peer support/supervision sessions. Adoption of a self-regulatory perspective encourages ''ownership'' and professional accountability and represents a cost-effective method of maintaining professional standards and program fidelity (Sanders & Prinz, 2008).

Provide Post-Training Support

Practitioners need summaries of research findings and updates based on new research to ensure that their practice is based on the best-available evidence (Glanville, Haines, & Auston, 1998). Post-training support offered by Triple P via the Internet includes an electronic newsletter, online question and answer forums via webinar, and access to a web-based ''Triple P Provider Network.'' This network provides links to a variety of web-based resources, tailored to the level of training each individual practitioner has been trained and accredited. Resources include access to a frequently asked questions page, updates on Triple P research, an online client scoring application, and downloadable monitoring sheets, forms, questionnaires, and promotional materials. In addition to Internet support, telephone supervision has been provided to isolated practitioners. Post-training workshops have also been developed to consolidate provider skills in various aspects of program implementation, such as interpreting clinical outcome data, conducting peer supervision sessions, and meeting the needs of different clinical populations. These workshops incorporate active skills training methods and provide practitioners with individualized feedback, coaching, and support.

Promote Organizational Support

Adherence to an evidence-based treatment by staff within an organization is more likely when managers, administrators, and colleagues support the adoption of the treatment (Backer, Liberman, & Kuehnel, 1986; Sanders, Prinz, & Shapiro, 2009; Zazzali et al., 2008), and when adequate supervision and support are available (Henggeler et al., 1997). Consequently, an effective dissemination process must not only adequately train practitioners in the content and processes of an intervention, but it must also engage

participating organizations to ensure that the accurate delivery of the intervention is supported. Triple P attempts to maximize agency support by providing support specific to the needs of each agency adopting the program (see Sanders, Turner, & Markie-Dadds, 2002). This support may include the provision of orientation sessions for administrators, supervisors, or managers about the program, including information about the distinguishing features of the intervention, the potential benefits, the logistics involved, costs of adoption and ongoing delivery, training and accreditation procedures, potential barriers to training completion and program adoption and how these might be overcome, and the expectations of the agency and staff members to be involved in implementing the program. After training, ongoing consultation to key advocates can be provided via email, face-to-face contact, teleconferencing, or video link-ups.

Zazzali et al. (2008) found that the organizations that adopted an EST (functional family therapy) did so largely due to rational or technical explanations, and the perception of a good fit of the program with sites' philosophy, mission, and resources. In organizations where there appeared to be a closer fit between the requirements of the EST and the organization's capabilities, there seemed to be a more successful or smoother implementation process. One of the advantages of the tiered multilevel system adopted by Triple P is that services and practitioners have flexibility to determine the scope of the intervention they wish to adopt given their own service priorities and funding.

Promoting Flexibility

Separate Interventions into Components

By separating interventions into components that can be either implemented or omitted, it is possible to promote flexible delivery of interventions while maintaining treatment integrity (Backer et al., 1986). This concept has been applied by Triple P through the development of a core parenting intervention which may then be ''enhanced'' with a variety of additional intervention modules. For instance, Home Visits provides additional in situ active skills training, Partner Support provides instruction in teamwork skills, and Coping Skills introduces parents to mood management skills, while Pathways is a reattributional training module useful for parents at risk of harming their children (Sanders, 1999).

Train in Intervention Principles and Instruct Practitioners to Be Flexible

Practitioners who are trained in the principles and processes that underpin ESTs but are then given permission or encouraged to be flexible are more likely to make appropriate adaptations (Stokes & Baer, 1977). Knowing the difference between an appropriate modification and one that eliminates, or even contradicts, a key feature of the program requires a thorough understanding of the underlying principles of the intervention (Abramowitz, 2006). Triple P training courses provide practitioners with a thorough grounding in the core content and processes of Triple P (e.g., session structuring skills, introducing influences on children's behavior) and the rationale and theory that underpin them (such as social learning theory and self-regulation). Practitioners are then instructed to adhere to the framework and principles that underpin the program but to be flexible as to how this content is delivered. For instance, in Standard Triple P all parents are introduced to a variety of parenting strategies, but the particular strategies that are practiced, for which behaviors, and in which settings are collaboratively determined with the parent(s), guided by the individual formulation derived from the assessment phase. During training, practitioners are encouraged to provide appropriate examples of the flexible delivery. Miller et al. (2004), in their work on disseminating motivational interviewing, have similarly noted the advantages of a training approach that places more of an emphasis on principles and the ''underlying spirit'' of a treatment rather than a focus on techniques.

Train Sufficient Exemplars

To be most useful, evidence-supported practitioner behaviors must be performed in various ways across a wide range of clinical presentations. Since it is impossible to train every desired form of a target behavior in every setting/situation in which the practitioner may need that behavior in the future, a sufficient exemplar or diverse training approach should be used (Stokes & Baer, 1977; Stokes & Osnes, 1989). This involves training participants in a subset of all of the possible clinical presentations and response examples and then assessing practitioners' performance on untrained problems and presentations. Throughout practitioner training for a single Triple P intervention, diverse examples are used to illustrate appropriate practitioner responses and behaviors to different clinical presentations. This may include case examples, video scenarios, modeling by the trainer, and examples from the participants themselves. The aim is to demonstrate how a single process or strategy might be applied in different ways to a range of presenting problems and family circumstances. Subsequently, practitioners' understanding and application are tested through untrained exercises. In addition to this, practitioners can receive training in additional levels of intensity, modes of delivery, or population focus of the core Triple P program. Each represents another empirically supported example of how the intervention might be delivered. It is hypothesized that such training in successive exemplars facilitates the generalization of practitioner behaviors so that practitioners can apply the principles of Triple P appropriately and flexibly to a range of populations, presenting problems, and family circumstances.

Use Both Positive and Negative Teaching Examples

Practitioner training that includes ''negative'' examples, depicting how not to perform certain practitioner behaviors, as well as ''positive'' examples can aid practitioners' understanding of the desired topography and appropriate or acceptable variations of program content. Both ''positive'' and ''negative'' examples of variations to Triple P are provided during Triple P practitioner training. Discussions regarding the advantages and disadvantages of changes to the manualized program, including consideration of their potential short- and long-term consequences, are facilitated at these times. Variations in which advantages seem to outweigh disadvantages are considered low-risk variations; variations in which disadvantages seem to outweigh advantages are considered high risk. For example, it might be advantageous to provide more practice sessions to parents to ensure that they use the parenting strategies competently. However, a potential risk of this adaptation is that parents could become more dependent on the practitioner for support, particularly if the practitioner is not careful to reduce prompting and assistance over successive sessions. Similarly, it might be more efficient in the short term to advise parents precisely what to do to resolve their present difficulties, but if this is at the cost of preventing parents from solving their own problems or increasing their understanding of the principles of behavioral intervention, the result might be greater parent dependence on the practitioner in the longer term. Further examples of low- and high-risk adaptations are provided in Table 4.

Table 4. Examples of low- and high-risk variations to parenting interventions

	Low risk	High risk
Process variations	Provide more sessions when additional support is required Increase or shorten the length of sessions Conduct sessions at the parents' home or workplace, in the community, or over the telephone, taking into account the goals of the intervention or issues concerning access Contacting a child's school to obtain assessment information or seek a teacher's cooperation in establishing a consistent response to problematic behaviors Switch from a more intensive manualized intervention to a briefer manualized intervention if it is the parents' preference, or initial assessment indicates it is warranted Conduct initial assessment session and practice sessions individually for a family who is participating in a group intervention, but whose parenting is complicated by a child with a disability or with complex support needs Use a subset of recommended questionnaires Emphasizing the video resources and/or behavioral rehearsal (instead of written materials) for a parent who cannot read Slow down the pace of the intervention and provide more sessions for a depressed parent Deliver a brief intervention consisting of information and advice that is normally provided to an individual parent to several parents as a mini-seminar	Advise a parent that he or she must (or must not) use certain parenting strategies (instead of discussing the principles of a strategy and the circumstances in which they might be useful) Not structuring sessions with an agenda Not routinely reviewing homework Repeatedly abandoning the scheduled agenda to spend the entire session discussing events from the past week Adopting an adversarial style when homework is not completed Immediately providing answers/solutions instead of eliciting them from parents Giving feedback instead of assisting the parents to develop their own self-management skills
Content variations	Modify examples to illustrate how particular parenting strategies might apply to the family's circumstances, such as how parenting skills might be applied over the telephone, by writing a letter, or in a prison visiting room for incarcerated parents In collaboration with parent, adjust a standard parenting plan from how it is described in a tip sheet Change the focus of sessions to promote supportive partner behaviors, by implementing an additional manualized intervention that focuses on this topic, before returning to a focus on parenting skills	Withhold information by not providing accompanying intervention resources or refusing to provide instruction in some of the intervention content Suggest parents stray from the principles underpinning strategies (e.g., suggesting parents assist child to calm down when they are in time-out)

Train Practitioners to Self-Regulate Behavior

If practitioners can be taught behaviors that prompt and reinforce evidence-supported consultation behaviors in relevant settings, at appropriate times, and in all of its relevant forms, then maintenance and appropriate flexibility in practitioner behaviors are much more likely to occur. Just as Triple P aims to develop parents' capacity for self-regulation, Triple P also aims to promote self-regulation skills in practitioners. Practitioners are encouraged to self-regulate in several contexts, such as when choosing intervention methods for specific problems, and when self-evaluating to strengthen professional skills. Active skills training methods are incorporated within practitioner training as a means of promoting practitioners' capacity for such self-management skills as self-selection of appropriate goals, self-monitoring, self-evaluation, and self-reinforcement (Sanders et al., in press). Protocol adherence checklists detailing session content are provided to facilitate practitioners' self-evaluation of their performance in delivering Triple P interventions.

Train Loosely

By varying noncritical aspects of the training setting, the chance that a single or small group of noncritical stimuli will acquire exclusive control over the targeted knowledge and skills and consequently inhibit or suppress the transfer of this knowledge to the clinical setting is reduced (Stokes & Baer, 1977). Triple P training includes didactic instruction, modeling by the trainer, videotaped examples of discrete skills, small-group exercises for active skills practice, and small- and large-group discussions of key issues. The multicomponent training where practitioners are encouraged to practice delivering the program with peers or clients after the initial training before returning for further coaching and feedback at the competency-based accreditation workshop (which itself is often held at a different location than the original training and facilitated by a different trainer) further supports the transfer of skills and knowledge to other situations and other forms of behavior.

Facilitate Dialogue Between Science and Practice

As stated previously, in order to satisfy practitioners that the intervention is appropriate for the population they service, it is essential that programs have an adequate evidence base that demonstrates efficacy and effectiveness. Practitioners may also be less likely to engage in their own unnecessary ad hoc ''experimentation'' if they are aware that there are mechanisms to promote more formal program research and development and that the disseminated programs evolve in the light of new evidence. Triple P has formed an international network of researchers to promote scientific inquiry into all aspects of the program. The annual Helping Families Change Conference, a web-based practitioner network, and an electronic newsletter provide a means to disseminate scientific findings and promote interaction between researchers and practitioners around the world. Field-generated issues have directly led to collaborative efficacy research trials with families of children with disabilities (Harrison, 2006), autistic spectrum disorders (Whittingam, Sofronoff, Sheffield, & Sanders, 2009), and attachment disorders (Sofronoff, 2009).

The routine collection of clinical outcome data also provides the means for practitioners to assess the effectiveness of variations in the standard delivery of interventions in the scientist practitioner tradition (Barlow, Hayes, & Nelson, 1984). An example of this was the testing of a hybrid group delivery of the normally individually delivered Triple P intervention for families of children with a disability, the results of which were communicated to practitioners and researchers at a Helping Families Change Conference (Allen, Brown, & Gasper, 2009).

Conclusion

While there are obstacles to the adoption of ESTs, there is reason to be optimistic that the adoption and effective use of ESTs will increase. Increasingly, identified obstacles are being addressed. The strategies derived from Triple P-Positive Parenting Program for enhancing practitioner adherence to EST while simultaneously promoting appropriate practitioner flexibility may provide useful lessons for the dissemination of other ESTs. Research on the usefulness of these dissemination techniques is needed to support and further refine them.

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Facilitators and Barriers to Implementation of an Evidence-Based Parenting Intervention to Prevent Child Maltreatment : The Triple P-Positive Parenting Program

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Facilitators and Barriers to Implementation of an Evidence-Based Parenting Intervention to Prevent Child Maltreatment: The Triple P-Positive Parenting Program

Cheri J. Shapiro,[1] Ronald J. Prinz,[1] and Matthew R. Sanders[2]

Abstract

The prevention of child maltreatment via parenting interventions requires implementation on a broad scale, which is facilitated by drawing on a multidisciplinary array of service workers located in multiple settings. This underscores the importance of understanding factors that impact worker implementation of evidenced-based parenting and family support interventions. This study involved structured interviews with 174 service providers from several disciplines who had been trained previously in the delivery of the Triple P-Positive Parenting Program. These follow-up interviews, conducted an average of about 2 years after professional in-service training, provided the basis for examining predictors of sustained program use. Predictors examined included facilitators and barriers to program use, as well as organizational and provider-level characteristics such as attitudes toward evidence-based interventions. Highlighting the importance of a systems–contextual perspective on implementation, several provider and organization-level characteristics significantly predicted program use including provider self-confidence after training, fit of program with ongoing duties, availability of posttraining support, and perceived benefit of intervention for children and families. Implications for prevention and implementation science are discussed in view of the challenges inherent in the field of child maltreatment.

Keywords

public health, parenting, prevention, evidence-based treatment, implementation, dissemination

Improved parenting is a cornerstone of child maltreatment prevention (Barth, 2009). Thus, strengthening parenting and family interactions and improving child behavior across entire populations is a preventive approach that should ultimately reduce the prevalence rates of child maltreatment. One primary barrier to this approach is reaching large numbers of parents with effective, evidence-based programs for improving parent–child interactions. Such evidence-based parenting approaches are available; however, the reach of these services is quite poor and only a minority of parents avail themselves of parenting support services (Prinz & Sanders, 2007). Improving the accessibility of parenting support requires a public health approach involving media and communication strategies to support positive parenting, along with a range of services of increasing intensity for families that need and want more support (Sanders, 2008). Provision of broadly accessible parenting support requires training a wide range of service providers in multiple settings in evidence-based parenting approaches (Sanders, Cann, & Markie-Dadds, 2003). Training a large, multidisciplinary workforce of existing service providers supports program delivery at a population level, increasing the likelihood that parents will have the opportunity to benefit from evidence-based parenting approaches. Importantly, prior research has demonstrated population-level impact on child mental health and parenting outcomes from systematic, coordinated implementation of parenting support across agencies and service sectors (Sanders et al., 2008). To provide the broadest reach, training providers who work in settings that have access to the largest number of families, such as child care, education, or primary care, would be necessary. However, these providers are not routinely trained or supported in implementation of evidence-based parenting programs. The reach of such programs would be greatly expanded by training such a large, existing workforce (Shapiro, Prinz, & Sanders, 2010).

While training a workforce of existing service providers to implement evidence-based parenting approaches is a necessary step, it is not sufficient to produce population-level changes in parenting or child outcomes. Service providers must then

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actually implement the intervention for desired impact. A wide range of variables impacting implementation have been identified (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). These include aspects of the intervention, as well as provider, organizational, and contextual factors, acting alone and in combination, that serve as facilitators or barriers to implementation.

Implementation of evidence-based practices (EBPs), or the process of technology transfer, has been conceptualized as occurring in stages, involving exploration, adoption, program installation, implementation, full operation, and maintenance or sustainability (Fixsen et al., 2005; Simpson, 2002). Research examining the influences on these stages has highlighted the importance of organizational variables such as motivation, resources, climate, and openness to change; provider characteristics such as skills and attitudes toward EBPs; features of the program itself such as relative advantage over other programs, as well as aspects of the posttraining environment including implementation support and dedicated time or resources (Greenhalgh et al., 2004; Sanders & Murphy-Brennan, 2010). Given the wide variety of variables that can impact implementation, a conceptual framework that captures this complexity is required. The systems–contextual approach represents such a framework that captures the variety of provider, client, and organizational variables that must be considered when examining the process of implementation and dissemination (Beidas & Kendall, 2010). This approach takes into account contextual variables that can influence the relationship between provider training and subsequent provider behavior (e.g., program use). Contextual variables including those operating at the level of systems, organizations, and providers create a complex set of facilitators and barriers that interact to impact program use by providers. This is especially true within child welfare settings, in which significant barriers to the use of EBPs have been identified (Horwitz, Chamberlain, Landsverk, & Mullican, 2010). Potential barriers include lack of fit within the child welfare system and concerns about acceptability by client populations. However, research is beginning to emerge about implementation of evidence-based interventions within child welfare systems. For example, Chagnon, Pouliot, Malo, Gervais, and Pigeon (2010) examined research knowledge utilization among a large sample of administrators and practitioners within child welfare. Among these groups, relatively few (less than 20%) reported use of research-based knowledge in practice. Organization culture, relationships with researchers, and methods of knowledge dissemination were identified as particularly important. In a more direct assessment of use of an evidence-based parenting intervention within a child welfare context, Petra and Kohl (2010) conducted a pilot study of an evidence-based parenting intervention, Pathways Triple P, in collaboration with child welfare partners in one Midwestern city. Administrators, case managers, and parents found the intervention to be both useful and acceptable (Petra & Kohl, 2010).

Examination of factors that impact implementation must be accompanied by efforts to define and measure program use. Program use can be measured directly (through observation of providers delivering the program) or indirectly (through provider or client reports or case records). Direct measurement provides the most accurate data but is labor-intensive and time-consuming; indirect measurement methods are feasible and practical but may yield less accurate information. These issues become particularly salient in primary prevention of maltreatment, which requires broad reach of evidence-based parenting interventions across multiple service settings and a large number of providers (Sanders, Cann, & Markie-Dadds, 2003). Thus, reliance on provider self-reports of program use remains the most practical option in examining large-scale dissemination efforts that cross service systems and organizations.

At present, little is known about implementation of evidence-based parenting interventions among service providers from multiple disciplines. One evidence-based parenting intervention that is designed specifically as a public health approach to supporting parenting that is designed for use by a wide variety of providers from multiple disciplines is the Triple P-Positive Parenting Program (Triple P). Triple P is a multilevel intervention designed to improve parenting confidence and competence by introducing a range of parenting strategies using a self-regulatory framework (Sanders, 1999). Triple P interventions have been evaluated in a wide a range of service delivery settings (e.g., home, primary care, and school settings; Markie-Dadds & Sanders, 2006a, 2006b; Turner & Sanders, 2006) with a wide variety of populations (e.g., preschoolers, adolescents, and children with conduct problems, attention deficit hyperactivity disorder, or developmental disabilities; Bor, Sanders, & Markie-Dadds, 2002; Hoath & Sanders, 2002; Morawska & Sanders, 2006; Roberts, Mazzucchelli, Studman, & Sanders, 2006; Sanders, Markie-Dadds, Tully, & Bor, 2000). These evaluations have encompassed both brief and more extensive forms of program delivery. Primary Care Triple P, typically delivered in 2–4 sessions, has resulted in positive outcomes including improvements in child behavior problems, dysfunctional parenting styles, parent stress, and partner support (Crisante, 2003; Turner & Sanders, 2006). Common outcomes from more intensive Triple P interventions (e.g., 8–10 sessions) include reductions in parent-reported child behavior problems, reductions in aversive parenting practices, and improvements in parental self-efficacy (Bor et al., 2002; Hoath & Sanders, 2002; Sanders et al., 2000; Sanders, Cann, & Markie-Dadds, 2003). Meta-analyses have documented the positive effects of Triple P (e.g., deGraaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008). Triple P has also been used to effectively train a broad range of providers to deliver parenting interventions (Sanders, Markie-Dadds, & Turner, 2003; Shapiro et al., 2008).

In order to examine factors related to implementation of EBPs, the current descriptive study examines use of an evidence-based parenting intervention in real-world settings by a large, diverse group of providers. Our goal is to examine the relationship of specific provider attributes including training history, perceived barriers and facilitators of program use, and attitudes toward use of EBPs, with self-reported implementation of an evidence-based parenting intervention (Triple

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Table 1. Provider Characteristics

Characteristic	*N* (%)
Gender	
Female	163 (93.7)
Male	11 (6.3)
Provider profession	
Counseling professionals	60 (34.5)
Parent educators	39 (22.4)
Education	37 (21.3)
Child care	17 (9.8)
Administrators	13 (7.5)
Other professionals	8 (4.6)
Provider education	
High school	8 (4.6)
Some college	18 (10.3)
College	54 (31.0)
Graduate/professional degree	89 (51.2)
Did not respond	5 (2.9)
Work setting	
Education	109 (62.6)
Not-for profit/independent	23 (13.2)
Mental health/substance abuse	13 (7.5)
Child care	12 (6.9)
Social services	7 (4.0)
Other	6 (3.5)
Health	4 (2.3)
Type of Triple P training	
Primary care Triple P (Level 2/3)	134 (77.0)
Level 4 standard Triple P	23 (13.2)
Level 4 GROUP Triple P	17 (9.8)

P).This study also represents a partial replication of an earlier study designed to examine posttraining program use and perceived facilitators and barriers to that use with a different group of providers (Sanders, Prinz, & Shapiro, 2009).

Method

Participants

Service providers in this study were trained in Triple P as part of the U.S. Triple P System Population Trial, a study focusing on use of the Triple P system of interventions as a child maltreatment prevention strategy in one state in the Southeast region of the United States (South Carolina). The current study drew from a pool of 343 service providers from a variety of disciplines, who underwent Triple P training over a 3-year period in the latter part of the larger population trial. Service providers were working with parents in a variety of settings (primarily public) including education (schools), mental health (community mental health centers), child care, social services (county social services departments), and not-for-profit organizations (organizations providing home visitation or parent education services), were invited to participate in a telephone survey. See Table 1 for a summary of background characteristics of these providers. Of the 343 participants, 51 (14.8%) were not eligible to participate in the survey because they were no longer working in a setting in which they were able to use parenting or family interventions, or supervise others in these activities. Of the 292 remaining possibly eligible participants, 174 (59.5%) completed the survey; 31 (10.6%) indicated initial interest but could not be reached to complete the survey, and 21 (7.2%) declined to be interviewed. A total of 66 (22%) of the potential participants could not be located or were not interviewed due to retirement, job elimination (service position or work unit closed), relocation, or death (1 person).

Most of the 174 providers who completed the survey (94%) were female. Disciplinary backgrounds included counseling professionals (e.g., counselors, social workers, psychologists; 34.5%), parent educators (22.4%), education professionals (21.3%), child care professionals (9.8%), administrators (7.5%), and other professionals (e.g., nurses, interns, law enforcement; 4.6%).

Procedures

As part of the U.S. Triple P System Population Trial, Triple P training was implemented in nine counties that were randomly assigned to receive the Triple P System of Interventions; nine other counties served as comparisons. The rationale, goals, and outcomes of this randomized controlled population trial have been previously described (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Briefly, the initial outcome data from the population trial indicated evidence of positive impact on three population-level indicators related to child maltreatment (substantiated child maltreatment cases, out-of-home placements, and child-maltreatment related injuries requiring hospital treatment; Prinz et al., 2009).

Training of service providers occurred in the context of implementing the full Triple P system, which includes five levels of intervention that together form a public health approach to parenting and family support (Sanders, 2008). The core Triple P system includes five levels of intervention of increasing intensity. Level 1 is a coordinated set of universal media and communication strategies designed to provide broad access to parenting information and support and to destigmatize the process of seeking parenting support. Level 2 involves parenting seminars or brief, one-session consultation for individual families on specific parenting challenges. Level 3 interventions are designed as brief, 3–4 session family-based interventions targeting a range of common parenting situations. More intensive parenting/family interventions delivered in a group or individual family format are available for families that have children evidencing more significant behavioral challenges (Level 4). Level 5 involves additional programming to boost the intensiveness of Level 4 with families that require it. Only Levels 2 through 5 of Triple P are germane to this report because Level 1 did not involve training of service providers.

Service providers working in the intervention counties who learned of and were interested in receiving Triple P training registered for training courses in the county in which they worked. Service providers chose the level of intervention and type of training to attend in consultation with a training consultant (Shapiro et al., 2010). The vast majority of service providers

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were trained at the lower level of intervention (i.e., Primary Care Triple P), as this level is the most flexible and can thus be accessed by the widest range of providers.

All service providers who completed Triple P training during a 3-year span and who at the time were employed in a setting providing services to parents or families or who were supervising staff working with parents or families were eligible to participate in the 20-min structured telephone interview. Service providers were told that the survey was for individuals who had participated in Triple P professional training courses in the last 3–4 years, and the survey focused on their work with children and families. Providers were informed that they would be asked about their opinions regarding issues related to services for children. Service providers were interviewed an average of 1.89 years after completion of training (range 0.3–3.7 years). Four female project staff (three with master's degrees, one with a doctorate) were trained to administer the interviews by the first author and conducted the interviews.

Measures

Descriptive background information. Information on provider characteristics was collected, including gender, profession, work setting, level of education, and level and type of Triple P training completed. Eleven professional job categories were classified into six profession types; 19 work settings were classified into 7 types of settings. Background information also included a provider rating of self-efficacy in conducting parent consultations about child behavior completed at the end of Triple P training. Providers responded on a 7-point scale ranging from 1 (*no, definitely not*) to 7 (*yes, definitely*) to the question: ''How confident are you in conducting parent consultations about child behavior?''

Structured Telephone Interview

Attitudes toward EBPs. Provider attitudes toward EBP were assessed using the Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004; Aarons, McDonald, Sheehan, & Walrath-Greene, 2007). The EBPAS is a 15-item measure developed to assess mental health provider attitudes toward EBPs. The items are organized into four subscales reflecting attitudes toward adoption of EBPs: Appeal (appeal of EBPs), Openness (open to new practices), Requirements (likelihood of use given requirements to do so), and Divergence (degree to which a provider's current practice diverges from research-based interventions; Aarons et al., 2007). Aarons and colleagues report adequate internal consistency for the measure as a whole and for each of the four subscales (Cronbach's α ranges from .66 to .93 for the subscales; $\alpha = .794$ for the EBPAS total score; Aarons et al., 2007, p. 469).

Self-efficacy in parent consultation. Self-efficacy in conducting parent consultations about child behavior was assessed by a single item on the provider survey: ''How confident are you in conducting parent consultations about child behavior?'' Providers responded on a 7-point scale ranging from 1 (*no, definitely not*) to 7 (*yes, definitely*).

Program use. Program use was measured by a series of questions during the structured telephone interview. Questions were asked about whether or not providers were using Triple P with families through their work (yes/no) or outside of their work (yes/no). Providers were also asked about how many families in the last 12 months they had used Triple P with (amount of use). Fidelity of use was not captured by these questions and was not assessed as part of the larger Triple P System Trial in which this study was embedded.

Facilitators and barriers to program use. A total of 15 facilitators and 18 barriers to program use were assessed during the structured telephone interview. Facilitators included items such as ''Your organization welcomes change and innovation;'' ''Staff in your workplace provide support for Triple P.'' Barriers included items such as ''An obstacle to using Triple P is Triple P not being integrated with caseload or other responsiblities at work;'' ''An obstacle to using Triple P is difficulty applying Triple P to the needs of the child or family.'' Providers were read a series of statements about potential facilitators and barriers or obstacles to their use of Triple P. Providers indicated their level of agreement or disagreement with each statement by responding on a 4-point scale (*strongly agree, agree, disagree, or strongly disagree*).

Results

Provider Characteristics

The characteristics of the providers who completed the survey are summarized in Table 1. Service providers were primarily female (93.7%) and relatively well educated, with the majority having received a college or graduate/professional degree (82.18%). Just over one third (34.5%) were counseling professionals, 22.4% were parent educators, and 21.3% classified themselves as educators. More than half were located in schools or other educational settings (62.6%); the remainder were located in private practice, not-for-profit organizations supporting school readiness, mental health or substance abuse treatment settings, or child care settings. A smaller number were located in social service or health settings (4.0% and 2.3%, respectively). The majority of providers had undergone Triple P Training at the Level 2/3 or Primary Care level ($n = 134$; 77.0%). A smaller number had undertaken Level 4 Standard or Group Triple P. Of the 174 providers completing the survey, 148 (85.1%) reported use of Triple P with families while 26 (14.9%) reported no use of Triple P.

Chi-square analyses were conducted to determine if the subsample of providers who completed the survey differed from the larger sample of providers eligible for the survey. These analyses revealed no significant differences between survey completers and noncompleters in provider gender ($\chi^2 = .247$, $df = 1$, $p = .619$), education level ($\chi^2 = 3.872$, $df = 3$, $p = .276$), work

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setting ($\chi^2 = 5.961$, $df = 6$, $p = .428$), or in the type of Triple P training that they had undertaken ($\chi^2 = .1.739$, $df = 1$, $p = .187$). Survey completers did differ significantly from noncompleters in type of profession ($\chi^2 = 13.897$, $df = 5$, $p = .016$); however, this significant finding is accounted for by a small group of providers within the "other" category who were volunteers at the time of training and who were less likely to have completed the survey. No significant differences were apparent for the remaining groups of professionals.

Provider Characteristics and Program Use

Logistic regression analyses were undertaken to ascertain the extent to which provider background characteristics were associated with their use of Triple P. Logistic regression analyses results indicated no relationship between background characteristics and use of Triple P. Use of Triple P was not significantly related to provider education (Wald statistic = 3.743, $p = .809$), profession (Wald statistic = 3.495, $p = .982$), or work setting (Wald statistic = 2.291, $p = 1.00$). Use of Triple P was not significantly related to level of Triple P provider training (Primary Care $B = -.716$, odds ratio [OR] = .489, Wald statistic = 961, $p = .327$; Level 4 Group $B = -1.010$, OR = .364, Wald statistic = 2.471, $p = .116$; Level 4 Standard $B = -.078$, OR = .925, Wald statistic = .012, $p = .914$).

Linear regression analyses examined the extent to which provider characteristics predicted the amount of Triple P used. Amount of use was defined as the number of families that providers reported having used Triple P within the past 12 months. Because the distribution for amount of use was significantly skewed, a square root transformation was applied to this variable, which significantly reduced the skew. Linear regression analyses using the transformed dependent variable and independent variables of gender, education, profession, work setting, and level of Triple P training revealed that amount of Triple P use with families was not significantly associated with gender, education, profession, work setting, and level of Triple P training, $F(7, 125) = .861$, $p = .539$.

Provider Attitudes Toward EBP and Program Use

Provider attitudes were assessed using the EBPAS. In order to assess the reliability of the EBPAS in the current sample, Cronbach's αs of the EBPAS subscales and EBPAS total scales were calculated. Cronbach's $\alpha = .920$ for the requirements subscale, .815 for the appeal subscale, .725 for the openness subscale, .386 for the divergence subscale, and .751 for the total EBPAS. These internal consistency reliability estimates are quite similar to those found by Aarons (2004). The Divergence subscale, in particular, appears to have weaker internal consistency than the other subscales. Factor analyses were also conducted with the EBPAS in the current sample; the factor structure for the requirements, appeal, and openness subscales were identical to that found by Aarons. However, the divergence subscale did not emerge as a unitary subscale in this sample. Given the low internal consistency for this subscale, caution is recommended regarding use of the Divergence subscale.

Logistic regression analyses were conducted to explore the association of provider attitudes toward evidence-based interventions and use of Triple P. The EBPAS subscale of requirements (the likelihood of adopting and EBP given requirements to do so) significantly predicted program use ($B = .850$, OR = 2.341, Wald statistic = 4.081, $p = .043$), while the remaining subscales of openness ($B = -.602$, OR = .548, Wald statistic = 2.683, $p = .101$), divergence, ($B = -.174$, OR = .841, Wald statistic = .189, $p = .664$), and appeal ($B = -.238$, OR = .788, Wald statistic = .214, $p = .644$), did not. The total EPBAS score was not significantly predictive of use of Triple P ($B = -.108$, OR = .897, Wald statistic = .038, $p = .846$).

Linear regression analyses were conducted to examine the impact of provider attitudes toward EBP, as assessed using the EPBAS, and amount of program use. Provider attitudes as assessed by the EBPAS did not significantly predict the amount of use of Triple P with families in the last year, $F(5, 141) = .599$, $p = .701$.

Self-Efficacy in Conducting Parent Consultations About Child Behavior

Provider self-efficacy or confidence in conducting parent consultations about child behavior as rated at the completion of training ($M = 5.95$, $SD = .943$) was significantly predictive of program use ($B = -.534$, OR = .586, Wald statistic = 6.034, $p = .014$). However, confidence rated at the time of the survey ($M = 5.71$, $SD = .994$) was not significantly predictive of program use ($B = -.309$, OR = .734, Wald statistic = 2.112, $p = .146$). Further examination of the relationship between these two measures revealed a moderate and significant correlation (Spearman's ρ = .308; Pearson chi-square = 42.370, $p = .002$). Mean confidence scores did decrease significantly over time, $t = 2.634$, $df = 169$, $p = .009$.

Linear regression analyses were conducted to examine the impact of provider self-efficacy and amount of program use. Provider self-efficacy did not significantly predict the amount of use of Triple P in the last year, $F(2, 140) = 2.76$, $p = .067$.

Provider Perceptions of Facilitators and Barriers to Program Use

Logistic regression analyses were undertaken to examine the association of facilitators on use of Triple P. Three of 15 facilitators to use of Triple P significantly predicted program use. These include supervision and case consultation ($B = 1.202$, OR = 3.338, Wald statistic = 3.692, $p = .05$); Triple P producing change in children and families ($B = 1.949$, OR = 7.022, Wald statistic = 4.558, $p = .03$) and provider knowledge and skills in behavioral family intervention ($B = 2.467$, OR = 11.791, Wald statistic = 6.394, $p = .01$). See Table 2 for data on provider perceptions of facilitators to program use.

One of 18 perceived barriers, lack of integration of Triple P with a provider's caseload or other responsibilities, was

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Table 2. Provider Perception of Facilitators to Program Use

Facilitator	Wald	*p*	OR
Organization-level facilitators			
Organization welcomes change and innovation	1.025	.311	.610
Providing family services are a central focus of agency	.003	.959	1.032
Agency encourages delivery of parenting programs	.072	.789	1.195
Staff in your workplace provide support for Triple P	2.426	.119	.377
Provider-level facilitators			
Supervision, consultation, or case discussions have been helpful for the use of Triple P	3.692	.055*	3.338
Knowledge of ways to track and measure behavior	.048	.826	.831
Knowledge and skills in BFI	6.394	.011*	11.791
Setting specific goals or agendas for sessions makes it easier to use Triple P	2.745	.098	3.847
Family-Level Facilitators			
Triple P is producing change in children and families	4.558	.033*	7.022
Feedback from parents regarding Triple P is positive	1.237	.266	.457
Triple P can be tailored to the needs of families	.838	.360	2.168
Program-level facilitators			
Contact with Triple P training consultants	1.069	.301	.488
Triple P parent and practitioner materials are helpful	.889	.346	.493
Self-regulation framework of Triple P is useful	.199	.655	1.612
Studies of Triple P's effectiveness justify its use	3.411	.065	.163

$p < .05$.

Table 3. Provider Perception of Barriers to Program Use

Barrier: "An obstacle to using Triple P is . . ."	Wald	*p*	OR
Organization-level barriers			
Insufficient access to consultation or supervision	.468	.494	1.333
Lack of recognition by staff in the workplace for Triple P	.002	.967	.983
No overtime or comp time for after-hours appointments	.2.671	.102	1.832
After-hours appointments clash with other commitments	.506	.477	.728
Triple P not integrated with caseload or responsibilities	5.970	.015*	.333
Not having enough clients	1.503	.220	.586
Triple P resource materials not being available	.568	.451	.671
Provider-level barriers			
Clash with theoretical perspective	2.481	.115	.428
Difficulty tailoring the program to individual families	.137	.712	.778
Use of baseline monitoring measures	.473	.492	1.585
Setting specific goals or agendas for sessions	.092	.762	1.280
Keeping parents on track during consultations	.002	.966	1.021
Covering session material in the scheduled time	.008	.927	1.050
Not enough knowledge and skills in BFI	.232	.630	.800
Family-level barriers			
Lack of progress by children or families	.196	.658	1.278
Difficulty engaging families	.081	.776	.882
Coordinating with other practitioners involved with family	.079	.779	.881

*$p < .05$.

significantly related to program use ($B = -.1099$, OR = .333, Wald statistic = 5.970, $p = .015$). Table 3 provides information on provider's perceived barriers to use.

A linear regression analysis was conducted to examine the potential contribution of facilitators and barriers on the number of families providers reported having used Triple P within the last 12 months. Facilitators and barriers did not significantly predict the amount of use of Triple P, $F(33, 102) = 1.39$, $p = .111$.

To test the stability of the variables that were significant in the exploratory logistic regression analyses, an additional set of regression analyses was conducted. The significant variables included the EBPAS subscale of requirements, three facilitators (supervision/consultation on cases, Triple P producing change in children and families, and provider knowledge and skills in behavioral family intervention [BFI]), one barrier (Triple P not being integrated with caseload or other responsibilities), and provider self-efficacy in parent consultations about

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child behavior at the conclusion of Triple P training. These variables collectively predicted use of Triple P ($\chi^2 = 19.724$, $df = 6$, $p = .003$).

A linear regression analysis was conducted to examine the impact of these variables on the amount of Triple P used in the last 12 months. The results of the linear regression were significant, $F(6, 132) = 2.664$, $p = .018$; $R^2 = .108$. Taken together, provider self-efficacy and BFI skills, likelihood of program use given requirements to do so, supervision, seeing change in families, and (negatively) lack of integration of Triple P with caseload or other responsibilities significantly predicted the amount of Triple P use with families.

Discussion

The ability to engage and train a large, multidisciplinary workforce in the use of EBPs is a necessary but not sufficient condition to produce population-wide reduction of child-maltreatment prevalence rates. It is further necessary for the workforce, once trained, to sustain use of the EBP with families. One of the most practical and feasible methods for assessing program use with a large, multidisciplinary sample of providers working in multiple service sectors is through provider self-report. Provider self-reports are an important source of information in implementation research, as factors operating at the provider level, as well as at the organization and systems level, have an impact on program use. The results of this study highlight the importance of both individual-provider and organizational–contextual factors in implementation of EBPs. This study also extends the literature by documenting factors related to ongoing use of an EBP nearly 2 years after training in a large, multidisciplinary work force. Importantly, 85% of the surveyed providers reported that they were using Triple P with families 2 years after training on average. This finding attests to the robustness of Triple P interventions and the potential for providers in real-world settings to incorporate EBPs into their work with families.

The robustness of Triple P interventions is further underscored by the result that the use of Triple P was not significantly related to gender, education, profession, or work setting of providers. This highlights the accessibility of Triple P for a diverse workforce employed across a range of work settings, including social services agencies. Accessibility of an evidence-based parenting program by a wide range of providers in a variety of real-world work settings is a necessary step in population-level implementation of EBPs. Use of Triple P was not significantly related to the level of Triple P training that providers had undergone; this finding is not surprising given that providers actively selected the level of Triple P training that was most feasible given their methods of service delivery (Shapiro et al., 2010).

Underscoring the value of adopting a systems–contextual approach (Beidas & Kendall, 2010) to training of service providers and consistent with implementation research highlighting the impact of a range of variables operating at multiple levels on program use, in this study the variables that significantly impacted provider reports of program use occurred at both the provider and the organizational levels.

Organizational Characteristics

Implementation of Triple P occurs in a context of organizational supports and structures (Sanders & Murphy-Brennan, 2010). The balance of facilitators and barriers in the posttraining environment may, in fact, be one of the most important aspects that determine the success of implementation efforts. In this study, the ability to discuss cases and receive consultation or supervision significantly predicted program use. Such support is necessary early in implementation to integrate new skills and programs into existing services (Fixsen et al., 2005). The one organizational barrier identified as a significant (negative) predictor of program use involved Triple P not being integrated with caseload or other responsibilities at work. These findings underscore the importance of a priori examination of elements necessary to support program delivery as well as fit of the program within the organization and with provider work duties before a decision is made to adopt a program. For example, if delivery of an evidence-based intervention requires time to prepare for sessions, time for supervision, or additional measures to monitor client progress, organizations will need to consider whether or not providers have the ability to accommodate these activities into their current schedule.

Provider Characteristics

Provider characteristics such as needs, motivation, attitudes, and skills can impact program implementation (Greenhalgh et al., 2004). In this study, confidence in conducting parent consultations about child behavior assessed at training completion was significantly related to program use. This finding is consistent with prior research in identifying self-efficacy in program delivery as an important predictor of training completion and program use (Turner, Nicholson, & Sanders, 2011). However, self-efficacy in program delivery as measured at the time of the survey was not related to program use. While the lack of a significant relationship between program use and self-efficacy at the time of the survey may initially be puzzling, further inspection of the data revealed that provider self-efficacy remained relatively high but had decreased slightly by the time of the survey. It is possible that self-confidence in program delivery may fade over time if the rate of program use is relatively low, or as the length of time since training increases. This hypothesis is a plausible explanation, given that the survey was conducted an average of 2 years posttraining and that a large number of providers used Triple P with a relatively small number of families (which may impact self-efficacy in program delivery).

In addition to provider confidence in conducting parent consultations about child behavior, provider's perception of their knowledge of behavioral family intervention skills was significantly related to program use. Skill acquisition in BFIs presumably occurred as a function of Triple P training as few service providers receive preservice or inservice training on

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evidence-based parent consultation or in behavioral approaches more generally. Knowledge of BFI skills may also influence provider confidence; in this study both constructs emerged as significantly related to implementation of Triple P with families.

Provider perceptions of the reasons for change in family functioning appeared in this study as an important indicator of program use. Triple P was seen as producing change in families, which served to facilitate program implementation. Feedback from client progress thus represents a potential positive reinforcement mechanism for providers who implement EBPs in real-world settings. As noted by Greenhalgh, Robert, Macfarlane, Bate, and Kyriakidou (2004), providers are not passive recipients of innovations (p. 598). Use of EBPs is associated with activities to evaluate and make meaning of these experiences; if providers perceive themselves and the interventions they use as successful, they are more likely to continue to use the intervention in the future.

Service provider attitudes toward adoption of EBPs may also impact implementation. This study adds to the growing literature on the impact of provider attitudes on use of EBPs as assessed using the EBPAS.

In this sample, the EBPAS total score and three of the four subscales (requirements, appeal, and openness) demonstrated good reliability. The divergence subscale internal consistency was low (as was noted by Aarons, 2004). The requirements subscale did significantly predict program use; providers were more likely to use Triple P with families if they believed that use of EBPs was required by their supervisor, agency, or state. This finding supports the importance of management, organization, and systems-level buy-in prior to implementation of EBPs and highlights the need for clear communication about expectations for use. How such expectations are conveyed, and the activities that are engaged in at a systems–contextual level to support use of EBPs, become important considerations to support implementation. Other provider attitudes as assessed by the EBPAS related to use of EBPs were not significant predictors of program use or amount of use.

The lack of impact on the variables examined on the amount of program use may be explained by the finding that most providers used the intervention with a limited number of families (58% of providers used the program with 10 or fewer families in the prior 12 months). However, what is not captured are the approximately 40% of providers who reported program use with much larger groups of families (from 20 to 80 families in the last year). A minority of providers ($n = 4$) reported extremely high use (i.e., more than 100 families in the prior 12 months). However, given the small number of these extraordinarily high users ($n = 4$), further analyses were not possible; however, such a high degree of use by a few providers has the potential to positively impact program reach at a population level. While the most desirable outcome would be moderate-to-high use by all trained providers, understanding the factors that influence unusually high rates of use are important. Follow-up qualitative surveys with these providers are planned.

While examination of variables related to program implementation by a real-world sample of providers from multiple settings is a strength of this study, several study limitations are worthy of mention. One primary limitation of this study is reliance on provider self-report of program implementation. In the context of a population trial, collection of data from individual client records across multiple agencies or observational methods in multiple settings was simply not feasible. A second limitation is the high rate of use among those providers completing the survey; this may have constrained the potential predictions achievable with logistic regression. A third limitation is the exploratory and descriptive nature of this study; the number of analyses conducted and the lack of a comparison group limits the strength of inferences that can be made. The current findings should be considered preliminary and caution is recommended in interpretation of the variables that emerged as significant predictors, given the number of variables examined. A fourth limitation is the survey was reliance on provider self-report, which captured variables primarily at the level of the provider. Measuring program use through provider self-report is feasible and practical in large-scale studies but does not provide objective data about the quality of implementation or fidelity to the intervention model. Current theoretical models focus on the multiple steps in the process of technology transfer that are impacted by provider, organizational, and systems/contextual-level variables (Simpson, 2002). Future research efforts should include additional measures of organizational and contextual-level variables, as well as measures of fidelity of implementation.

Implications for Prevention of Child Maltreatment

These findings underscore the importance of taking a systems–contextual approach to training, implementation, and dissemination of evidence-based parenting interventions on a broad scale. Significant attention to program fit with current methods of service delivery and provider caseloads is important to address prior to training. Once a decision is made to adopt an evidence-based parenting program, high-quality training that results in increase in provider skills and self-confidence in program delivery is necessary to increase the likelihood of program implementation. This study also underscores the critical importance of the posttraining environment, such as supervision and case consultation, which appear to influence program use. Further research is needed to examine more specifically which models of supervision are most likely to be useful (i.e., a peer-supported self-regulatory approach as compared to an expert supervision model). Changing parenting on a broad scale through use of evidence-based parenting programs is possible; however, we must move well beyond a ''train and hope'' model in order for the investment in training to pay off.

Authors' Note

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

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Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial

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Abstract The prevention of child maltreatment necessitates a public health approach. In the U.S. Triple P System Population Trial, 18 counties were randomly assigned to either dissemination of the Triple P—Positive Parenting Program system or to the services-as-usual control condition. Dissemination involved Triple P professional training for the existing workforce (over 600 service providers), as well as universal media and communication strategies. Large effect sizes were found for three independently derived population indicators: substantiated child maltreatment, child out-of-home placements, and child maltreatment injuries. This study is the first to randomize geographical areas and show preventive impact on child maltreatment at a population level using evidence-based parenting interventions.

Keywords Child maltreatment · Parenting · Population intervention · Dissemination

Child maltreatment (CM) is without question a significant public health problem in the U.S. and elsewhere. In 2005 there were 3.3 million referrals of alleged child abuse or neglect and approximately 899,000 child victims of substantiated child abuse or neglect in the U.S. (U.S. Department of Health & Human Services 2007). CM exacts an enormous toll on society. CM results in costs associated with utilization of administrative services and systems (e.g., child protective services, foster care, judicial system), child treatment services (e.g., healthcare, mental health, educational systems), long-term impact (e.g., psychological and health problems in adulthood), and next generation victimization. Although there is much uncertainty about the cost of CM and its consequences, Prevent Child Abuse America estimated costs associated with child abuse and neglect in the U.S. to be over $94 billion per year in 2001 dollars (Fromm 2001). This figure likely underestimates the cost because it is based only on official reports of child abuse and neglect and does not take into account the cost of unreported maltreatment.

The official rates of substantiated CM, and even the referral rates for alleged maltreatment, likely represent only the tip of the iceberg in terms of parenting problems and child adversity because: (a) many episodes of abusive or neglectful parenting might not get reported to or investigated by child protective services (Sedlak and Broadhurst 1996), and (b) much in the way of coercive or inadequate parenting practices may not technically rise to the level of official reports, but could very well have a detrimental impact on child development. For example, Theodore et al. (2005) found in an epidemiological study conducted in the Carolinas that maternal reports of physical abuse from anonymous telephone surveying were 40 times greater than the official child physical abuse reports. Theodore et al. also found that the rate of harsh physical discipline was not significantly different for low-versus high-income households, which flies in the face of the assumption that problematic parenting is only or predominantly associated with poverty.

Undoubtedly, CM and associated patterns of inadequate parenting constitute a serious public health problem that

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warrants strong prevention measures to reduce population prevalence of problematic parenting. The CM prevention field to date has not focused for the most part on prevalence reduction. The research has consisted mainly of intervention studies aimed at treatment of child-abusing parents (Skowron and Reinemann 2005; Timmer et al. 2005), prevention of recidivism among abusing parents (Chaffin et al. 2004; Gershater-Molko et al. 2002; Harder 2005; MacMillan et al. 2005), or high-intensity service delivery to specific subsets of families at pronounced risk for abuse (Cicchetti et al. 2006; Duggan et al. 2004; Fergusson et al. 2005; Rodrigo et al. 2006). Some intervention approaches have demonstrated positive effects with specific clinical or high-risk samples of parents (Olds et al. 2007; Prinz 2007). However, to date no studies on child maltreatment have randomized communities to condition and examined population-level preventive effects of parenting interventions.

Most parents never receive any parenting help in dealing with common everyday behavior problems, and few of those who do are exposed to evidence-based parenting programs (Sanders et al. 1999), despite the strength of the evidence for social-learning based parenting interventions (McMahon 1999; Prinz and Dumas 2004; Prinz and Jones 2003; Taylor and Biglan 1998). When few families derive the benefits of receiving an evidence-based parenting program, the potential of parenting programs to reduce the prevalence of problematic outcomes for parents and children in the entire population is diminished, and the value of proven programs becomes limited (Biglan and Metzler 1998). Hence, broader strategies for reaching parents regarding empirically supported parenting information are needed (Sanders and Turner 2002).

To address the difficulties of poor population reach via evidence-based parenting programs, a public health approach to improving parenting is required. Reducing the prevalence of coercive parenting in the community requires that a large proportion of the population be reached with effective parenting strategies (Biglan 1995). Thus, a key assumption of a population-based approach is that parenting intervention strategies should be more widely accessible in the community. To achieve this aspiration, a variety of formats, delivery modalities, provider disciplines, and access points need to be invoked.

One of the few examples of a public health approach to parenting is the Triple P system developed by Sanders and colleagues (Sanders 1999; Sanders et al. 2002). The Triple P—Positive Parenting Program was designed as a comprehensive population-level system of parenting and family support. This multilevel system includes five intervention levels of increasing intensity and narrowing population reach. The system was designed to enhance parental competence, and prevent or alter dysfunctional parenting practices, thereby reducing an important set of family risk factors both for child maltreatment and for children's behavioral and emotional problems. The Triple P system meets the standards-of-evidence criteria for dissemination promulgated by the Society for Prevention Research (2004): substantial evidence of efficacy and effectiveness; the ability to go to scale including professionally developed resource materials and a standardized training and accreditation process for service providers; clear and readily available cost information relating to program cost effectiveness (e.g., Mihalopoulos et al. 2007); availability of evaluation tools for providers; and, identification of the conditions necessary to promote program sustainability and quality assurance (e.g., Turner and Sanders 2006).

The evidence base for Triple P is extensive. Various components of the Triple P system have been subjected to a series of controlled evaluations, and have consistently shown positive effects on observed and parent-reported child behavior problems, parenting practices, and parents' adjustment across sites, investigators, family characteristics, cultures, and countries. The substantial evidence base supporting Triple P to date includes 43 controlled trials addressing efficacy, effectiveness, and dissemination, as well as 22 service-based field evaluations (e.g., Morawska and Sanders 2006; Plant and Sanders 2007; Sanders 1999; Sanders et al. 2002, 2004, 2007a, b; Turner and Sanders 2006). An integrated series of controlled outcome studies has provided considerable evidence demonstrating the benefits of the various levels of intervention and modes of delivery in a variety of populations (see Sanders 2008). This program of research has shown successful outcomes with a number of populations and problem areas, with consistent improvement in quality of parenting across studies (e.g., Bor et al. 2002; Sanders et al. 2000; Sanders and McFarland 2000). Triple P has been evaluated as a universal, whole of population strategy and shown to strengthen parenting and reduce the prevalence of conduct problems in preschool-aged children from high-risk neighborhoods (Zubrick et al. 2005), and to reduce coercive parenting practices through the implementation of multiple levels of Triple P (Sanders et al. 2008). Several effectiveness and dissemination studies have been conducted on Triple P demonstrating portability and broad utility in multiple settings (Sanders et al. 2003a, b; Turner and Sanders 2006; Zubrick et al. 2005). Additionally, several independent replications of Triple P implementation and findings in diverse cultural contexts have been conducted (Bodenmann et al. 2008; Cann et al. 2003; Crisante and Ng 2003; Dean et al. 2003; Gallart and Matthey 2005; Heinrichs et al. 2005, 2006a, b, c; Leung et al. 2003; Rogers et al. 2003; Turner et al. 2007).

The Triple P system was designed in specific ways for broad and efficient dissemination. The tiered levels of intervention matched to families' differing needs work well

with the public health principle of minimal sufficiency (i.e., the least amount of intervention to solve the problem at hand and prevent future difficulties). Use of the media as a universal tool is another public-health compatible feature. In the Triple P system, a media and communication strategy is utilized extensively in a sophisticated and strategic manner to normalize and acknowledge the difficulties of parenting experiences, to break down parental sense of social isolation regarding parenting, to de-stigmatize getting help, to impart parenting information directly to parents, and to alter the community context for parenting (Sanders 1999; Sanders and Turner 2002).

Building on the public health strategies and evidence base of Triple P, Prinz and Sanders (2007a, b) launched the U.S. Triple P System Population Trial (TPSPT) to test the extent to which implementation of the Triple P system can reduce the prevalence of CM at a population level. This trial is based on the following conceptual frame:

1. Official CM grossly underestimates the magnitude of the problem. There are many parents in the population who might be engaging in abuse-prone parenting practices, which means a broad strategy is needed for preventive interventions.
2. A preventive approach is needed that reduces the population pool of families who might contribute to substantiated and potential cases of CM.
3. Triple P offers a population-based approach to strengthening parenting. In addition to evidence supporting the effectiveness for various facets of Triple P in improving parenting and reducing children's problems, Sanders et al. (2008) recently showed how the concurrent implementation of multiple levels of Triple P in a population application can reduce coercive parenting.
4. Although the accruing evidence for Triple P provides justification, it is nonetheless new territory to determine whether a population approach to parenting intervention such as Triple P can have preventive impact on population-level indicators of child maltreatment.

This population trial randomizes geographical units (i.e., counties) to condition, matching on demographic and child-abuse variables, and evaluates the impact of implementing Triple P with the existing workforce on population indicators related to child maltreatment (i.e., rates of substantiated child maltreatment, child out-of-home placements, and child hospitalizations and emergency room visits for maltreatment injuries). In contrast to a clinical trial which examines preventive effects at the level of the individual, a population trial targets rates and aggregate dimensions for entire geographic areas. By necessity this population trial gains advantage in studying broad impact but gives up the measurement and methodological precision inherent in clinical evaluation of individual families. However, the impact of Triple P on individual families has already been thoroughly documented in terms of many controlled efficacy and effectiveness studies.

There are very few CM-related indicators that lend themselves to population-level measurement and are available across a time period extending for several years. The population indicators chosen for this population trial met several criteria: (1) standardized across counties and delivered to a central repository; (2) measure of CM (substantiated CM cases; CM injuries) or its immediate consequence (child out-of-home placement); (3) associated with significant human and financial costs; and (4) recorded by personnel not involved in the dissemination of the preventive intervention in the population trial. Substantiated CM was chosen over reports because the former is associated with real and potentially costly sequelae beyond the initiation of an evaluation or investigation. The three population indicators chosen for the study had the added benefit of being derived from three separate systems (i.e., Child Protective Services, Foster Care System, and hospitals), which allowed for relatively independent corroboration and documentation of possible preventive effects.

Method

Design

The design for the U.S. TPSPT consists of the stratified random assignment of 18 medium-sized counties in a southeastern state to dissemination and control conditions, controlling for county population size, county poverty rate, and county child abuse rate. The conditions were: (1) Triple P System, which involved implementation of the core Triple P system with the existing workforce; and (2) Control, which meant services as usual without implementation of Triple P. Prevention of CM in this design is defined by three population indicators (see Measures section) evaluated after a 2-year period of intervention dissemination controlling for the pre-intervention level. The pre-post randomized design builds in a 2-year period deemed to be necessary to train a sufficient number of service providers in the participating counties and to allow a sufficient amount of time for those providers to deliver the preventive interventions to many families. Using the three control variables for stratified random assignment of counties was intended to reduce initial between-condition differences with respect to population size, which could be correlated with services available to families; poverty rate, which might make it more difficult to achieve intervention success; and child abuse rate, which is related to the outcomes of interest.

Participants

Counties All of the 18 counties selected for the TPSPT had population sizes between 50,000 and 175,000, and none of the counties had any prior exposure to Triple P at the start of the population trial. Counties were not selected on the basis of community or organizational amenability to participation; and recruitment of providers and organizations did not take place until after randomization of counties. Population size was the main factor in selecting counties to arrive at units that were reasonably comparable by eliminating very small counties that would not have sufficient population to implement the preventive interventions and detect effects, and by eliminating very large counties that would individually account for too much of the overall variance. The counties ranged in demographics from rural to semi-urban. In terms of the broader context, the agencies and services in these counties had suffered significant funding cuts over several years. Although multiple disciplines and agencies served the target population (i.e., families), services often were disconnected, with inadequate referral pathways operating and providers sometimes relying on conflicting approaches. The counties appeared to have little or no prior exposure to evidence-based parenting programs of any kind.

Families For this trial, the referent population in the 18 counties was all families with at least one child under 8 years of age (though because this was a population-level trial, no families formally entered the trial). In the Triple P System counties, this is approximately 85,000 families in any given year. The birth to 8 years child group refers to the target age for assessing preventive effects on CM and was chosen because this is the period of greatest risk for CM selected by the funder (CDC) for the initiative. Separate from the target age for judging preventive effects, however, it should be noted that providers were trained in Triple P for a broader age range (birth to 12 years) consistent with the inherent breadth of Triple P so that providers who straddled the target age (e.g., 5–12 years) in terms of the families they served would find Triple P of greater utility in their work.

Service providers A key facet of the population-based dissemination of the Triple P system involves the engagement, training, and support of a broad array of service providers from several disciplines and settings including: family support services (social workers and therapists affiliated with county health centers, mental health centers, and schools), social services (family services, social workers), preschool and child-care settings (directors, teachers), elementary schools (parent educators, guidance counselors, kindergarten teachers), non-governmental organizations (e.g., early childhood NGOs, child-abuse prevention NGOs), private-sector practitioners, health centers (primary healthcare providers), and other community entities having direct contact with parents and families. For the 2-year intervention period pertinent to this report, 649 service providers participated in Triple P professional training courses. Demographically, 91.7% of the providers were female, 57.0% European American (not Hispanic), 38.3% African American, 1.3% Hispanic, and 3.4% other ethnic/racial groups, with a mean age of 44.5 (SD=14.1). Most (81%) of the providers had already been engaged in parent consultation work for at least 5 years prior to Triple P training, and 59% had over 10 years of such experience.

System of Parenting Interventions

The Triple P—Positive Parenting Program, developed by Sanders and colleagues at the University of Queensland, is a multi-level preventive intervention system designed for families having at least one child in the birth to 12-year-old range (the core programs). All programming levels of Triple P have intervention manuals that have been carefully developed, systematic training regimens for providers/practitioners, and coordinated resource materials for parents (videos, workbooks, and tip sheets). The five core principles of positive parenting that are invoked throughout the multi-level Triple P system to promote social competence and emotional self-regulation in children are: (1) ensuring a safe, engaging environment, (2) promoting a positive learning environment, (3) using assertive discipline, (4) maintaining reasonable expectations, and (5) taking care of oneself as a parent. The emphasis is on parents learning how to apply these skills to different behavioral, emotional and developmental issues in children, ranging from common child-rearing challenges (e.g., toileting, mealtime behavior, bedtime, behavior in public) to more intense challenges (e.g., child aggressive behavior, fears and anxiety, ADHD difficulties). The five positive-parenting principles translate into 35 specific strategies and parenting skills that cluster into several major categories: (a) parent–child relationship enhancement, (b) encouraging desirable behavior, (c) teaching new skills and behaviors, (d) managing misbehaviors, (e) preventing problems in high-risk situations, (f) self-regulation skills, (g) parental mood management and coping skills, and (h) partner support and communication skills. Triple P provides developmentally tailored menu options that facilitate parental goal setting and self-regulation. Parents learn how to apply those techniques and strategies that are relevant to their child, the parent's goals, and the family situation.

Universal Triple P (Level 1) The Universal (Level One) facet of the Triple P intervention involves the implementation of media and informational strategies pertaining to positive parenting. These strategies are intended to destigmatize parenting and family support, make effective parenting strategies readily accessible to all parents, and facilitate help-seeking and self-regulation by parents who need higher intensity intervention. Universal Triple P includes use of radio, local newspapers, newsletters at schools, mass mailings to family households, presence at community events, and website information. Use of local newspapers takes three forms: (1) Positive parenting articles written by Sanders on specific topics of interest to parents; (2) local press releases on human interest stories that link with Triple P activities; and (3) stories generated by reporters with whom the publicity team has developed working relationships. The TPSPT avoided any media outlets (e.g., television) or communication strategies that overlapped with the Control counties.

Selected Triple P (Level 2) The Selected Triple P program has utility for many parents and is intended to normalize parenting interventions. There are two delivery formats for Selected Triple P: (1) brief and flexible consultation with individual parents; and (2) parenting seminars with large groups of parents. The brief and flexible consultation format involves one to two consultation contacts (20 min each) and is designed for parents with relatively minor and fairly discrete problem behaviors that do not require more intensive levels of intervention. However, this is also a useful and non-threatening strategy to help parents begin to address their own parenting behaviors but in the context of their asking for information or assistance about their child's behavior. The intervention can be provided in the context of well childcare, daycare and preschool settings, and in other settings where parents may have routine contact with service providers and other professionals who regularly assist families. Selected Triple P can be viewed as a form of anticipatory development guidance. The parenting seminar format of Selected Triple P, called the Triple P Seminar Series, involves three 90-min sessions designed for delivery to large groups of parents. The seminar series includes specific seminars on the following topics: The Power of Positive Parenting; Raising Confident, Competent Children; Raising Resilient Children. The three seminars are independent of each other so that parents can attend any or all of them and still benefit. Seminars are used to promote awareness of Triple P and as brief and informative sessions for any parent. Each seminar includes a presentation, a question and answer period, distribution of a parenting tip sheet, and availability of practitioners at the end of the session to deal with individual inquiries and requests for further assistance.

Primary Care Triple P (Level 3) The Primary Care Triple P program, like Selected Triple P, is appropriate for the management of discrete child problem behaviors that are not complicated by other major behavior management difficulties or significant family dysfunction. The key difference is that provision of advice and information alone is supported by active skills training for those parents who require it to implement the recommended parenting strategies. This program level is especially appropriate for parents of infants, toddlers, and preschoolers with respect to common child behavior problems and parenting challenges. Level Three involves a series of four brief (20-min) consultations that incorporate active skills training and the selective use of parenting tip sheets covering common developmental and behavioral problems of preadolescent children. This brief and flexible consultation modality also builds in generalization enhancement strategies for teaching parents how to apply knowledge and skills gained to non-targeted behaviors and other children in the family.

Standard and Group Triple P (Level 4) The Level 4 program benefits indicated populations of children who have detectable problems but who may or may not yet meet diagnostic criteria for a behavioral disorder, and parents who are struggling with parenting challenges. Parents learn a variety of child management skills and how to apply these skills both at home and in the community. Level 4 combines the provision of information with active skills training and support, as well as teaching parents to apply skills to a broad range of target behaviors in both home and community settings with the target child and siblings. Two different delivery formats for Level 4 Triple P were deployed in the TPSPT: (1) Standard: a 10-session program (up to 90 min per session) with individual families that utilizes active skills training methods, as well as home visits or clinic observation sessions (40–60 min each); (2) Group: An 8-session group-administered program which employs an active skills training process; consists of five 2-h group sessions that provide opportunities for parents to learn through observation, discussion, practice and feedback; three 15–30 min follow-up telephone sessions provide additional support to parents as they put into practice what they have learned in the group sessions.

Enhanced Triple P (Level 5) Enhanced Triple P is an optional augmentation of Standard (Level 4) Triple P for families with additional risk factors that might need to be addressed through the intervention. Many families can receive sufficient benefit from Standard Triple P without extending programming with Enhanced Triple P. Enhanced Triple P includes optional intervention modules on partner communication, mood management and stress coping skills for parents, and additional practice sessions addressing parent–child issues.

Recruitment and Training of Service Providers

After randomization of counties to condition, recruitment of service providers and organizations took place in the nine Triple P System counties. Service providers were recruited through many settings that provided services to families to participate in Triple P professional training courses. The dissemination staff identified and contacted stakeholders at both the state and local (county) levels in support services for parents of young children, including representatives from a wide range of provider systems such as education, school readiness, childcare, mental health, social services, and health. The staff introduced the Triple P system of interventions to each stakeholder group and organization and then worked with each entity to consider training needs and the ability to deliver parent consultation services (described in more detail in Shapiro, Prinz and Sanders 2008). Communications with prospective service providers and organizations included discussion of how Triple P could be incorporated into existing workplace activities to serve significant numbers of families. Providers who served families in the Triple P System counties were invited to the training courses, and providers in other counties (including the Control counties) were not permitted to undertake the training.

The Triple P system has a standardized training and quality-promotion protocol that is used worldwide and was adopted in the TPSPT. Triple P professional training courses delivered by experienced trainers involved attendance at a multi-day training program (2 or 3 days, depending on course level), intensive self-review of intervention materials, competency practice and feedback at a day-long session, and completion of accreditation requirements. The training process included didactic instruction, modeling by the trainer, video examples of discrete skills, small-group exercises for active skills practice, and group discussions of key issues. More details about the Triple P professional training process can be found elsewhere (Sanders et al. 2003a, b; Shapiro et al. 2008).

Measures

Public awareness of Triple P A random telephone survey of households was conducted pre-intervention and again at post-intervention to determine relative growth in public awareness of Triple P in the two sets of counties. The surveys were based on random-dialing sampling of population databases of households where children resided. Response rates for the two administrations of the survey were 42.6% and 49.7% respectively. Respondents who identified themselves as primary caregivers for at least one child under 8 years of age were asked whether they had heard of each of a number of parenting programs including Triple P in the list (query order of programs was rotated across respondents). The number of respondents in the Triple P System counties was 1,794 at pre-intervention and 1,854 at post-intervention, and 1,836 and 1,826 respectively in the Control counties.

Estimated number of families participating in Triple P Follow-up telephone interviews with Triple P trained service providers were used to estimate the number of families to whom programming was delivered. Six months after participating in Triple P professional training, providers were contacted and asked about the number of families they served with Triple P (a) in the most recent 4-week period and (b) during the time since participation in Triple P training. The responses to these two interview questions were converted to annualized figures, which provided an upper and lower estimate of the number of families whom providers indicated had participated in Triple P programming. These estimates are considered to be rough projections, which on the one hand could be overestimates because there is an assumption of constant rate of programming by any given provider, but on the other hand are likely to be underestimates because the data are extrapolated to a 12-month period even though the intervention period was actually 24 months.

Population outcome indicators Three population indicators related to CM served as the outcome variables for this study and were derived from independent data-collection systems deposited with a state-run statistical division. The first indicator was substantiated CM recorded by child protective services staff. These data were unduplicated such that no CM case was counted more than once in a given year. The second was child out-of-home placements recorded through the foster care system. The third was child hospitalizations and emergency-room visits due to CM injuries, which were recorded by medical staff in compliance with mandatory state reporting requirements for hospitals, regardless of whether or when Child Protective Services was involved. All three population indicators were computed as annual rates per 1,000 children in the birth to 8-year-old age range.

Results

Pre-intervention Demographic Characteristics of the Counties

The two sets of counties were compared with respect to pre-intervention demographic characteristics. At pre-intervention, the Triple P System counties did not differ significantly (alpha=0.10) from the Control counties with respect to county population, percentage of the population in poverty,

and racial composition, and were quite comparable as reflected in Table 1. Pre-intervention levels for the three outcome indicators, calculated as an average over the 5-year period prior to the study (i.e., prior to randomization) for each indicator, also did not differentiate the two sets of counties (Table 1).

Implementation

Triple P training of existing workforce During the first 2 years of dissemination, a total of 649 service providers in the Triple P System counties received training across the system levels via 69 Triple P professional training courses. A breakdown by discipline and employment for Triple P trained providers is found in Table 2 and reflects wide diversity of individuals and disciplines. Table 2 also shows a breakdown of settings in which Triple P trained providers were working. With respect to level of Triple P, 63.9% were trained only in Levels 2/3 Triple P and 36.1% were trained in Level 4 Triple P or above. About a third of the latter group also received training in Levels 2/3 Triple P, which allowed them to be more flexible implementers. In terms of distribution of providers across the nine Triple P system counties, the mean per-county number of Triple P trained individuals was 38.8 providers per 50,000 population (SD=14.8), which ranged from a low of 20.9 providers per 50,000 to a high of 60.0 providers per 50,000 population. This broke down into 25.4 providers per 50,000 population (per county) for Levels 2/3 Triple P (SD=13.7) and 13.4 providers per 50,000 for Level 4+ Triple P (SD=7.9).

Media and communications dissemination Universal (Level 1) Triple P was disseminated widely in the Triple P System counties over the 2-year intervention period. The number of occurrences is summarized in Table 2 for each of the media and communications vehicles.

Public awareness of Triple P After 2 years of intervention, randomly surveyed households in the Triple P System counties showed significantly higher proportion of awareness regarding Triple P (Mean=17.1%, SD=3.5) than did those in the Control counties (Mean=5.5%, SD=2.7), t (16)=7.86, $p<.0001$. Consistent with this observation, the Triple P System counties showed significant growth in proportion of Triple P awareness from a mean of 4.8% (SD=1.6) to a mean of 17.1% (SD=3.5), t (8)=9.24, $p<.0001$, while Control counties did not show significant change from a mean of 4.5% (SD=1.5) to a mean of 5.5% (SD=2.7), t (8)=0.95, ns.

Estimation of family participation Based on follow-up telephone interviews with Triple P trained service providers, it was estimated that between 8,883 and 13,560 families participated in Triple P within the Triple P System counties (i.e., totaled across the nine counties and approximately mirroring the distribution of trained providers across the counties). Between 71% and 75% of these families were reported to have received Levels 2/3 Triple P, and the remainder Level 4 Triple P and above.

Population Outcomes

The unit of randomization, county, was the unit of analysis for the three population outcome indicators: Substantiated CM, child out-of-home placements, and hospitalizations or emergency-room visits for CM injuries.

Preliminary analyses Prior to conducting the primary pre-post analyses, preliminary analyses of the three population indicators for the 5 years prior to the TPSPT were undertaken retrospectively to determine if the two clusters of counties showed any pre-study trends or differences.

Table 1 Pre-intervention demographic characteristics of the Triple P System and Control counties

Characteristic	County cluster		*t*-test comparison	
	Triple P system mean (SD)	Control mean (SD)	t (df=16)	Significance
County population	96,054 (39,035)	99,216 (40,813)	0.17	NS (p=0.87)
Percentage of individuals in poverty	14.8 (2.8)	15.3 (3.0)	0.36	NS (p=0.73)
Percentage of children (birth to 17) in poverty	21.2 (4.5)	21.4 (4.1)	0.10	NS (p=0.92)
Racial composition (% African American)	31.4 (11.8)	30.8 (14.9)	0.11	NS (p=0.92)
Child maltreatment rate over 5-year pre-randomization period	10.82 (4.36)	11.40 (6.75)	0.22	NS (p=0.83)
Child out-of-home placement rate over 5-year pre-randomization period	4.02 (1.59)	3.76 (1.91)	0.30	NS (p=0.77)
Child maltreatment injuries rate over 5-year pre-randomization period	1.72 (0.66)	1.44 (0.53)	0.99	NS (p=0.34)

Notes: Rates for child maltreatment, out-of-home placement, and injuries are per 1,000 children under 8 years of age, annualized. Child maltreatment injuries are based on data reported for hospitalizations and emergency-room visits

Table 2 Implementation variables in the U.S. Triple P System Population Trial

	Percentage	Quantity
Service providers trained in Triple P		
Type of service provider		
Counselors, therapists, guidance counselors	29.7%	
Parent educators, family literacy workers	16.3%	
Social workers	15.5%	
Childcare staff	10.5%	
Nurses, nurse practitioners	7.4%	
Administrators, managers	5.1%	
School personnel (other than parent educators)	4.6%	
Other (e.g., law enforcement, clergy, other medical)	10.9%	
Settings with Triple P providers		
Type of setting		
Education	24.9%	
Non-governmental organizations (NGO) and independent practitioners	23.5%	
Mental health and substance abuse services	19.7%	
Childcare and preschools	16.2%	
Healthcare	10.5%	
Social services	3.8%	
Other	1.4%	
Universal (Level 1) Triple P: media and communication strategies		
Media/communication vehicle		
Positive parenting newspaper articles		21
Press releases related to Triple P dissemination		185
Local newspaper stories related to Triple P dissemination		63
Newsletters to parents		26,000
Radio public service announcements distributed		37
Community events where Triple P was represented		24

Each population indicator was subjected to a County Cluster (2 clusters) by Time (5 pre-randomization years) repeated measures analysis of variance, and the County Cluster by Time interactions were of particular interest. All three interactions were clearly non-significant: substantiated CM, $F(4, 13)=0.22$, $p=0.92$; out-of-home placements, $F(4, 13)=1.34$, $p=0.31$; child CM injuries, $F(4, 13)=1.38$, $p=0.30$.

Primary analyses For each of the indicators, post-intervention rates for the Triple P System and Control conditions were compared, controlling for pre-intervention rate from the year just prior to the initiation of intervention. As reflected in Table 3, differential and positive effects on the Triple P System counties were found for rates of substantiated CM, child out-of-home placements, and hospitalizations or emergency-room visits for CM injuries. The effect sizes calculated as Cohen's *d* ranged from 1.09 to 1.22, which are all considered to be in the large to very large range according to Cohen (1988).

Supplementary analysis Although not a primary population indicator in this study, CM investigation rate was examined in a supplementary analysis because some investigators have argued that substantiations and investigations should both be evaluated (Drake and Jonson-Reid 2000). A differential and positive effect for CM investigation rate was found, with a medium effect size of $d=0.51$ (significance level notwithstanding because of so few statistical sampling units), $t(16)=1.08$, $p=0.15$ (Triple P System: pre-intervention rate 18.08, post-intervention rate 18.49; Control: pre-intervention rate 18.74, post-intervention rate 21.91).

Discussion

The U.S. Triple P System Population Trial is the first study of its kind, of which we are aware, to randomize communities to condition, implement evidence-based parenting interventions as a prevention strategy, and then demonstrate positive impact

Table 3 Child maltreatment-related population outcomes for Triple P System versus Control conditions

	Rates per 1,000 children (birth to 8 years of age)							
	Triple P system counties		Control counties		*t*	*df*	Signif.	Effect size
	Pre-intervention	Post-intervention	Pre-intervention	Post-intervention				
Substantiated CM cases	10.86	11.74	11.12	15.06	2.09	16	$p<0.03$	1.09
Out-of-home placements	4.27	3.75	3.10	4.46	2.60	16	$p<0.01$	1.22
Child CM injuries (hosp & ER)	1.73	1.41	1.41	1.69	2.36	16	$p<0.02$	1.14

Notes: The *t*-tests compared the two conditions with respect to pre-post difference scores. The effect size is Cohen's *d* statistic

on population indicators of CM. Preventive effects for all three population indicators (substantiated cases of CM, child out-of-home placements, and CM injuries) differentiated Triple P System from Control conditions, taking into account baseline levels.

Several design and implementation facets of this study support the proposition that observed preventive effects were attributable to the intervention manipulation. Randomization of counties to condition while controlling for county characteristics (size, poverty level, child abuse level) guarded against threats to internal validity. The two randomized sets of counties were comparable on the dependent variables over the 5-year pre-randomization period, as reflected in non-significant and negligible county cluster by time interactions. Dissemination in the Triple P System counties via professional training, well distributed across all nine counties, and media/communications strategies was extensive and well-documented. Public awareness showed significant differential growth in the Triple P System counties. Finally, follow-up telephone interviews regarding implementation of Triple P indicated that providers reported delivering Triple P to a large number of families (i.e., estimated between 8,883 and 13,560 families).

The prevention effect was fairly robust in magnitude. All three population indicators showed large effects, which were also all statistically significant despite only 18 units of randomization. Each of the three indicators was derived from an independently recorded data source, which lends further support to the robustness of the findings. Substantiated CM was recorded by child protective services workers, child out-of-home placements were recorded within the foster care system, and CM injuries were recorded by medical personnel in hospitals. Interestingly, for substantiated CM the preventive effect took the form of holding the growth of CM down in comparison to the control counties which showed substantial growth in CM, whereas for the child out-of-home placements and CM injuries, the preventive effects reflected decreases in those indicators for the Triple P System counties. However, it should also be noted that the increase in substantiated CM in the control counties mirrored similar increases across the other 28 counties in the same state that were not part of the TPSPT, suggesting that the preventive intervention disrupted the trend occurring throughout the state.

The real-world magnitude of the observed effects can be derived from the data. In a community with 100,000 children under 8 years of age, these effects would translate into 688 fewer cases of CM, 240 fewer out-of-home placements, and 60 fewer children with injuries requiring hospitalization or emergency room treatment. These types of data lend themselves to a cost–benefit analysis, which is planned for the future and will build on an article recently published regarding the infrastructure cost associated with dissemination in this population trial (Foster et al. 2008).

The results of this study demonstrate the feasibility and benefits of implementing a large-scale parenting intervention, using a population-based approach, to prevent CM. The concurrent implementation of all levels of the Triple P system took the form of a workforce development strategy that involved training the existing service providers to use evidence-based parenting interventions, rather than hiring a large number of additional providers. The training was brief (typically 3 to 6 days depending on program level), the dissemination utilized a multidisciplinary workforce of providers who remained in their existing service settings, and many points of access for parents were created.

One question that might arise is whether there was a systematic reporting bias in one or more of the three population indicators. With respect to substantiated CM cases, which are reported in a standardized system for Child Protective Services workers, the TPSPT did not involve training of these workers who undertook CM investigations. Furthermore, less than 3% of the providers who were trained in Triple P were employed through social services, which meant that the preventive intervention did not constitute a major presence in that agency. The reporting of out-of-home placements by Foster Care System staff is a relatively concrete enterprise (i.e., either a placement was made or it was not). And finally, hospitalization and emergency room reporting of child injuries were made by medical staff who were not involved in Triple P training. It appears to be unlikely that the observed effects for all three population indicators could be accounted for by reporter bias.

The present findings need to be interpreted in light of the study's potential limitations. First, the indices used to gauge the prevalence of CM, although independent from each other, are relatively gross measures that tend to underestimate the true prevalence of harmful parenting practices. Second, it is important to determine whether effects observed following population exposure to parenting intervention are maintained over an extended time period. However, the Triple P intervention model assumes that effects will continue to the extent that parenting support continues to be available to parents in the community. The approach is not the equivalent of a parenting vaccine, where a single-shot exposure will afford continuing protection for the population. With a mobile population, parents of children at various ages are always entering a catchment area but have no prior exposure to Triple P. A third caveat is the possibility of spillover effects from intervention to control counties. Some Triple P trained providers might have moved to control counties, or families residing in a control county might have received services in an intervention county. Some of the media communications might have spilled over into control counties, although the media

vehicles were carefully selected to minimize this type of event. Most importantly, any spillover that might have occurred would have worked *against* finding an intervention effect of the Triple P system.

Additional limitations stem from the fact that this was a population trial rather than a more traditional clinical trial. A population trial in which place is randomized to condition, which is a relatively new or at least uncommon design for the field of CM prevention, is not a gigantic clinical trial. The focus was on training and dissemination on a broad scale and the impact on population-level indicators, rather than on data related to service delivery (e.g., engagement, intervention fidelity) and behavior change at the individual family level. There are practical, methodological, and conceptual reasons for not trying to collect these kinds of data. On the practical side, conducting a clinical and a population trial at the same time would have taken considerably higher resources. Methodologically, attempts to collect individual-level data might have been intrusive for organizations, providers, and families, which might have invoked reactance and possibly created obstacles to full dissemination. Finally, from a conceptual perspective, a large body of evidence on Triple P has already established effectiveness (including intervention fidelity and transportability), which provided a sound foundation on which to build the population trial. That said, there is still a big need to conduct studies on how to increase engagement of families in preventive intervention contexts.

Effect sizes are important for deriving policy implications from population trials such as the present one. It is important to note, however, that the effect sizes observed at a population level should not be confused with effect sizes for individual families or children found in more traditional trials conducted at the level of the individual. The population-level effect sizes reported here, which appropriately treated county (not individual) as the unit of analysis, should only be compared to other population-level effects reported in the literature, and not to individual-level effects. Similarly, the effects observed for individual-level trials cannot and should not be assumed to correspond to or predict population-level effects, and in fact the effect-size values from those trials might translate into smaller effect sizes when recalibrated to apply to a population rather than a selected sample. From a policy standpoint, population level effects are of primary importance (Nilsen 2005).

Population trials are new to both the parenting intervention and the CM fields. There is much to learn about how to conduct and interpret population trials, and to better understand what is needed to sustain or enhance effects on prevalence indicators. Some of the challenges discovered during this effort include: (1) the need for unobtrusive but systematic ways to track the occurrence of other programs and interventions in the communities; (2) how to determine what levels of program penetration of the population are required to attain particular levels of impact on population indicators; (3) unobtrusive strategies for tracking density of program delivery; and (4) the need for surveillance procedures for characterizing the size of the existing workforce in a community that is serving parents and families. The latter issue is more difficult than it might appear. In the TPSPT, the dissemination drew on many different types of providers across a wide variety of settings, but there was no master list of providers. There are registries of licensed professional in a county (e.g., all licensed social workers), but this information would be misleading because many of the social workers might be serving other populations besides families of young children, such as the elderly or the terminally ill. In addition, many of the providers who can deliver Triple P work in less traditional settings and come from a broad variety of disciplines.

This trial provides an excellent opportunity to enhance the field's understanding about population dissemination. As such the trial should be viewed as the beginning of a line of population research in the prevention of CM, from which we can expect to learn much over the next several years.

All things considered, this study provides an encouraging demonstration that evidence-based parenting interventions can achieve population-level preventive impact on major social problems such as CM. Furthermore, the study's findings support the utility of blending prevention of CM and promotion of child and family well-being in a public health strategy (Carmona 2006), with the Triple P system providing an integrated model for this approach.

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Triple P –
Some key research findings

Here is a selection of some of the key findings:

- **In the US, Triple P has been shown to cut rates of child abuse, reduce foster care placements and decrease hospitalizations from child abuse injuries.**
  Prinz, R.J., Sanders, M.R., Shapiro, C.J., Whitaker, D.J., & Lutzker, J.R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10(1), 1-12.

- **Triple P reduces problem behavior in children and improves parents' wellbeing and parenting skills.**
  Nowak, C. & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P–Positive Parenting Program using hierarchical linear modelling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review,* 11, 114-144.

- **In communities where Triple P is widely available, children have fewer behavioral and emotional problems.**
  Sanders, M.R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). Every Family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention*, 29, 197-222.

- **Parents using Triple P say they are less stressed, less depressed and don't use harsh discipline.**
  Sanders, M.R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). Every Family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention*, 29, 197-222.

- **Parents of children with Autism Spectrum Disorders using Stepping Stones Triple P report they are more satisfied as parents, their children's behavior has improved and their relationship with their partner is better.**
  Whittingham, K., Sofronoff, K., Sheffield, J. & Sanders, M.R. (2008). Stepping Stones Triple P: An RCT of a parenting program with parents of a child diagnosed with an Autism Spectrum Disorder. *Journal of Abnormal Child Psychology.* 37(4), 469-480

- **Parents with an intellectual disability using a modified version of Group Triple P report an improvement in their parenting practices and their child's behavior, and less distress. Parents also report high satisfaction with the information and support they received.**
  Glazemakers, I. & Deboutte, D. (2012). Modifying the 'Positive Parenting Program' for parents with intellectual disabilities. *Journal of Intellectual Disability Research.* Advance online publication. doi: 10.1111/j.1365-2788.2012.01566.x

- **UK parents who watched a reality television series (*Driving Mum and Dad Mad*) which showed other parents using Triple P, feel more confident in their parenting, less angry and less depressed than before watching the series. They also say their children's behavior improved as a result.**
  Calam, R., Sanders, M.R., Miller, C., Sadhnani, V., & Carmont, S. (2008). Can technology and the media help reduce dysfunctional parenting and increase engagement with preventative parenting interventions? *Child Maltreatment,* 13(4), 347-361.

- **Triple P reduces disruptive child behavior problems in Chinese families living in Hong Kong.**
  Leung, C., Sanders, M.R., Leung, S., Mak, R. & Lau, J (2003). An Outcome evaluation of the implementation of the Triple P – Positive Parenting Program in Hong Kong. *Family Process*, 42(4), 531-544.

- **The cost of offering Triple P throughout a community in the US would be recovered in a single year if it brought about a (modest) 10 percent reduction in cases of child abuse and neglect.**
  Foster, E.M., Prinz, R.J., Sanders, M.R., & Shapiro, C.J. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, 30, 493-501.

Additionally, Triple P has been tested and shown to be effective in many culturally and ethnically diverse populations around the world. Here are some of the results:

- **Iran**
  Tehrani-Doost, M., Shahrivar, Z., Gharaie, J.M. & Alaghband-Rad, J. (2009). Efficacy of Positive Parenting on Improving Children's Behaviour Problems and Parenting Styles. *Iranian Journal of Psychiatry and Clinical Psychology,* 14(4), 371-379.

- **Hong Kong**
  Leung, C., Sanders, MR., Leung S., Mak, R. & Lau, J. (2003). An Outcome evaluation of the implementation of the Triple P – Positive Parenting Program in Hong Kong. *Family Process*, 42(4), 531-544.

  Leung, C., Sanders, M.R., Ip, F. & Lau, J. (2006). Implementation of Triple P – Positive Parenting Program in Hong Kong Hong: Predictors of programme completion and clinical outcomes. *Journal of Children's Services,* 1(2), 4-17.

  Crisante, L. & Ng, S. (2003). Implementation and process issued in using Group Triple P with Chinese parents: preliminary findings. *Australian e-Journal for the Advancement of Mental Health,* 2(3), 226-235.

- **Japan**
  Matsumoto, Y., Sofronoff, K. & Sanders, M.R. (2007). The Efficacy and acceptability of the Triple P–Positive Parenting Program with Japanese parents. *Behaviour Change*, 24(4), 205–218.

- **Switzerland**
  Bodenmann, G., Cina, A., Ledermann, T. & Sanders, M.R. (2008). The efficacy of the Triple P–Positive Parenting Program in improving parenting and child behavior: A comparison with two other treatment conditions. *Behaviour Research and Therapy,* 46(4), 411-427.

- **Indigenous Australians**
  Turner, K.M.T, Richards, M., and Sanders, MR. (2007). Randomised clinical trial of a group parent education programme for Australian Indigenous families. *Journal of Paediatrics and Child Health*, 43(6), 429-437.

More research findings, publications and journal articles can be viewed at
http://www.pfsc.uq.edu.au/publications/evidence

Professor
Matt Sanders

Matt Sanders is a Professor of Clinical Psychology and the founder of the Triple P – Positive Parenting Program. His home base is in Brisbane, Australia, where he is Director of the Parenting and Family Support Centre, University of Queensland. Professor Sanders is also a visiting Professor at Manchester University, University of South Carolina, Glasgow Caledonian University and the University of Auckland.

Over four decades, Professor Sanders has built a highly-regarded international reputation for conducting outstanding research and translating it into practical programs which address childhood behavior problems and promote stronger families.

Professor Sanders' Triple P parenting system has now helped approximately six million children and their families. It is used in more than 20 countries and has been translated into 18 languages. More than 55,000 practitioners have been trained in its delivery.

Professor Sanders is the author of more than 200 publications, including more than 170 peer-reviewed articles, and has written or co-written 12 books, including the popular *Every Parent: A Positive Approach to Children's Behaviour.* His work has inspired three international TV series, including the UK's high-rating *Driving Mum and Dad Mad.*

Professor Sanders has consulted and advised governments at senior policy levels in Australia, Canada, the UK, Ireland, Switzerland, New Zealand, Hong Kong, Singapore, Japan, Iran, Germany, France, Sweden, Belgium and the Netherlands.

He has been a consultant to the World Health Organisation and is Expert Consultant on Positive Parenting to the Council of Europe. In 2006 he met and discussed policy with the then British Prime Minister, Tony Blair, shortly before the Home Office launched a national parenting initiative which includes Triple P.

Career awards have included:

- International Collaborative Prevention Research Award (from the Society for Prevention Research in the US)
- President's Award for Distinguished Contribution to Psychology (from the Australian Psychological Society)
- Trailblazers Award (from the Association for Behavioural and Cognitive Therapy)
- National Violence Prevention Award (from the Australian Heads of Government)
- Queenslander of the Year
- Distinguished Career Award (from the Australian Assoc. for Cognitive Behaviour Therapy)

Professor Sanders is also a compelling communicator who effectively shares his knowledge with the community. He writes regular newspaper columns and is a sought-after family commentator on radio and TV.

He is married with two adult children.

Triple P -
What the experts say

- **"Triple P is the only research-based parenting program that provides the flexibility to adapt to the needs of families and to a variety of service settings. It is highly appealing to me as a pediatrician because it provides a set of tools that allow me to address common concerns of parents efficiently and effectively."**
  John C. Duby, M.D.
  Director, Division of Developmental and Behavioral Pediatrics
  Akron Children's Hospital, Ohio

- **"My colleagues and I regard Triple P as the world standard of best practice in the family intervention area."**
  Professor Kurt Hahlweg
  Institut fur Psychologic, Technische Universitat
  Braunschweig, Germany

- **"The program is a revolution by which ordinary families will have access to the best that the past 30 years of research on families can offer. The materials are outstanding, the program design is excellent and the science is superb. The program is the best in the world."**
  Professor Patrick McGrath
  School of Psychology, Psychiatry and Biomedical Engineering
  Dalhousie University, Canada

- **"Triple P is a great program. To my mind, it is the best in the world at addressing the needs of the whole community. The different components are carefully tailored to the needs of a range of parents. The content is based on best scientific practice, and is accessible and fun. Above all, it has been proven in numerous controlled trials to be highly effective."**
  Dr Stephen Scott
  Consultant Child and Adolescent Psychiatrist
  National Specialist Team for Parenting and Antisocial Behaviour
  Maudsley Hospital, London

- **"Triple P offers straight forward, sensible techniques that have proven to be very effective."**
  Professor Fiona Stanley AC
  Telethon Institute for Child Health Research
  2003 Australian of the Year

- **"Triple P was an excellent choice of parenting program for our national demonstration project due to its strong evidence base, ability to be quickly implemented, first class resources and training, plus support and backup."**
  Dr Linda de Caestecker
  Director of Public Health, NHS Greater Glasgow and Clyde
  Scotland

- **"The Every Parent video series should be in the hands of every parent. They will find it user friendly and it will make a difference in how their kids develop and grow. Prof Sanders is an internationally known researcher and therapist who has now produced the best video series available for parents. I recommend it highly."**
  Professor Howard Markman
  Professor of Psychology, University of Denver
  Colorado, USA

- **"The Triple P videos are recommended with enthusiasm. They offer an excellent medium of guidance for parents of young children. They are clear and easy to follow, provide vivid examples of behavior management strategies and the material is thoughtful and reasonable for parents to follow through at home."**
  Professor Margot Prior
  Department of Psychology, The University of Melbourne
  Australia

- **"This video series is the best thing to happen to parent-child relationships. It is the first empirically-validated state-of-the-art contribution to solving everyday family concerns and problems. It is fun to watch, makes sense, and helps families by using the medium of our age from scientific researchers who know and care about children."**
  Professor John Lutzker
  Director of the Center for Healthy Development
  Georgia State University, USA

Triple P Impact on Top Diagnoses for Medicaid Billing

Oppositional Defiant Disorder and ***Attention Deficit with Hyperactivity*** – There is ample evidence to support Triple P's impact on ODD and ADHD and the accompanying symptoms in children. This research spans particular levels of Triple P and a community-level study.

Most of these articles can be found on the UQ Research site: www.pfsc.uq.edu.au/research/evidence/

***Research Trials and Meta-analyses*:**

De Graff, I., Speetjens, P., Smith, F., De Wolff, M., & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on behavioral problems in children. *Behavior Modification.* doi: 10.1177/0145445508317134

Thomas, R. & Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of parent-child interaction therapy and Triple P-Positive Parenting Program: A review and meta-analysis. *Journal of Abnormal Psychology.* doi: 10.1007/s10802-007-9104-9

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

Bor, W., Sanders, M.R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occuring disruptive behavior disorders and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology.* doi: 10.1023/a:1020807613155

Rogers, H., Cann, W., Cameron, D., Littlefield, L., & Lagioia, V. (2003). Evaluation of the Family Intervention Service for children presenting with characteristics associated with Attention Deficit Hyperactivity Disorder. *Australian e-Journal for the Advancement of Mental Health, 2.*

Hoath, F. E. & Sanders, M.R. (2002). A feasibility study of Enhanced Group Triple P – Positive Parenting Program for parents of children with Attention Deficit Hyperactivity Disorder. *Behavior Change.* doi: 10.1375/bech.19.4.191

Moharreri, F., Shahrivar, Z., Tehrani-doost, M., & Mahmoudi-Gharaei, J. (2008). Efficacy of the Positive Parenting Program (Triple P) for parents of children with Attention Deficit Hyperactivity Disorder. *Iranian Journal of Psychiatry, 3*, 59-63.

Additionally, a recent study has indicated that parent behavior training approaches such as Triple P have a greater level of evidence for preschoolers than methylphenidate (Charach, A., Carson, P., Fox, S., Ali, M. U., Beckett, J., & Lim, C. G. (2013). Interventions for Preschool Children at High Risk for ADHD: A Comparative Effectiveness Review. Pediatrics. doi:10.1542/peds.2012-0974)

***Cost Benefit Analyses of particular interest*:**

Mihalopoulos, C., Sanders, M.R., Turner, K.M.T., Murphy-Brennan, M., & Carter, R. (2007). Does the Triple P –Positive Parenting Program provide value for money? *Australian and New Zealand Journal of Psychiatry, 41,* 239-246.

- Triple P would only have to divert 1.5% of cases of conduct disorder in order to pay for the service delivery of Triple P in to families in the community.

Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). Return on Investment: Evidence-based options to improve statewide outcomes, April 2012 (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy.

- After accounting for costs, Lee and colleagues found that the Triple P system of interventions (all Levels 1-5) would save the community $1137 per participant with 100% chance of a positive net result (i.e., benefits that exceed the costs). Level 4 Standard Triple P alone would save the community $5447 per participant with a 79% chance of a positive net result. Finally, Level 4 Group Triple P alone would save the community $3374 per participant with an 89% chance of a positive net result.
- The technical appendix reports on the diagnostic categories that went into the cost benefit analyses they performed. The current model focuses on ADHD, Depression, Anxiety, and Disruptive Behavior. The latter category covers the DSM categories of Oppositional Defiant Disorder and Conduct Disorder. Obviously, there are other recognized mental health disorders. It is anticipated that future development of the Institute's model will include additional categories.

Other cost benefit information can be found on pages 13-14 of the Triple P Training Guide.

Hypertension NOS – Though there are no studies actually measuring parent's blood pressure, studies consistently show decrease in parent stress and depression as an outcome of Triple P. And, there are numerous studies which link depression and stress levels with hypertension (Player, M. S., & Peterson, L. E. (2011). Anxiety Disorders, Hypertension, and Cardiovascular Risk: A Review. The International Journal of Psychiatry in Medicine, 41(4), 365–377. doi:10.2190/PM.41.4.f). Additionally the Adverse Childhood Experiences Study documents the harmful effects of child abuse and neglect that can lead to chronic diseases. Triple P is meant to address prevent and mitigate the harmful effects of these ACEs. ACEs are

associated with the following disorders so any intervention or set of interventions that can prevent them will substantially reduce long term healthcare costs. Notable for Triple P are all of the mental health and substance abuse disorders, but also other chronic conditions such as type II diabetes when you consider the potential impact of Group Lifestyle TP – in ultimately preventing end stage renal disease, amputations, and so forth. ACEs are associated with the following disorders:

- Alcoholism and alcohol abuse**
- Chronic obstructive pulmonary disease (COPD) *
- Depression **
- Fetal death ** Maternal/neonatal disorders
- Health-related quality of life
- Illicit drug use **
- Ischemic heart disease (IHD) *
- Liver disease **
- Risk for intimate partner violence **
- Multiple sexual partners
- Sexually transmitted diseases (STDs) ** HIV, Other communicable diseases
- Smoking *Cancer
- Suicide attempts* **
- Unintended pregnancies

* Leading cause of death in US (CDC)

** Leading cause of disability in US (WHO)

***Example research trial on Triple P*:**

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

Routine Child Health Exam – This would be a great time for Brief Primary Care as to prevent many of the diagnoses that cost so much at a later point.

Intellectual Disabilities – Stepping Stones Triple P was developed specifically for parents of children with developmental and/or intellectual disabilities (inclusive of Autism Spectrum Disorders). This intervention significantly improves the behaviors of children and improves parenting skills and confidence. I would say that this intervention is better suited for parents of children with mild to moderate intellectual disabilities (as compared to severe or profound intellectual disabilities).

***Meta-analysis on Stepping Stones Triple P*:**

Tellegen, C. L. & Sanders, M.R. (2013). Stepping Stones Triple P- Positive Parenting Program for children with disability: A review and meta-analysis. *Research in Developmental Disabilities, 34,* 1556-1571.

Living in a residential institution – One would think that some adolescents who were living in a residential treatment facility for conduct disorder or drug abuse, might be preventable with widespread Triple P.

Single LB in Hospital (Teen birth rate) – The ACE study indicates that preventative approaches such as Triple P can reduce ACEs thereby reducing risk of teen pregnancy

PTSD – WSIPP study (cited in cost benefit studies above) will lump PTSD into the anxiety disorders category; many children receiving Triple P may qualify for a PTSD diagnosis and certainly have benefitted from Triple P. A recent LA County Triple P outcome report indicated that 3% of children whose parents were receiving Triple P had a PTSD diagnosis.

Heart and Lung Disease – The ACE study comes to mind here; Triple P can prevent ACEs! The ACE categories are as follows:

ACE Category*		Women (N = 9,367)	Men (N = 7,970)	Total (N = 17,337)
Abuse				
	Emotional Abuse	13.1	7.6	10.6
	Physical Abuse	27.0	29.9	28.3
	Sexual Abuse	24.7	16.0	20.7
Neglect				
	Emotional Neglect[1]	16.7	12.4	14.8
	Physical Neglect[1]	9.2	10.7	9.9
Household Dysfunction				
	Mother Treated Violently	13.7	11.5	12.7
	Household Substance Abuse	29.5	23.8	26.9
	Household Mental Illness	23.3	14.8	19.4
	Parental Separation or Divorce	24.5	21.8	23.3
	Incarcerated Household Member	5.2	4.1	4.7

So, Triple P can definitely impact the abuse and neglect ACEs – that's half of the ACE categories! It can also mitigate the potential harmful effects of parent divorce/separation through Family Transitions and we know that it is being applied with incarcerated individuals so that when they are released, they are in better shape to parent.

Rehab costs – Jurisdictions may include a lot of things as "rehab," including welfare to work treatments. If this is the case, then we know that Triple P is a potentially beneficial intervention for parents who are struggling to re-enter the workforce but are challenged with parenting difficulties and difficult to manage children. Triple P can assist with parenting so that the home situation improves to a point where a parent could engage in more work searches or work behavior.

Triple P - Positive Parenting Program

Cabarrus County, North Carolina

Parenting - Empowerment - Community

Triple P Cabarrus

Triple P is a multi-tiered system of evidence-based education and support for caregivers of children and adolescents. Cabarrus Health Alliance, in partnership with Triple P America, trains Cabarrus County's existing workforce in clinical and non-clinical settings to deliver evidence-based Triple P interventions to parents.

Triple P → Effective Parenting Practices → Improved Child Behavior → Decreased Parent Stress

Outcome Goals

- Reduce out-of-home placements
- Reduce substantiated child abuse cases
- Reduce hospitalization/ER visits for child maltreatment injuries

Existing Workforce Trained

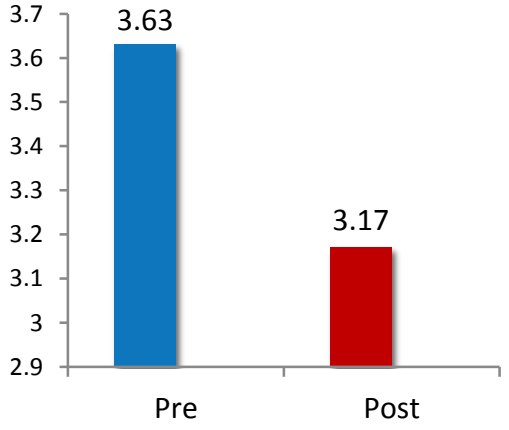


Community Agencies	8%
Early Childhood Development	11%
Education	25%
Faith Community	2%
Healthcare	20%
Mental Health	25%
Public Safety	1%
Social Services	8%



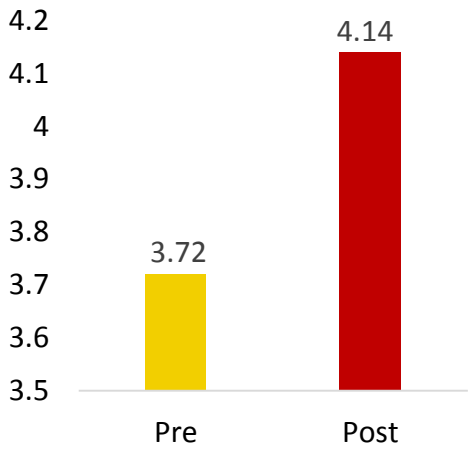
Caregivers report parenting is <u>less</u> stressful

Stress of parenting…1-not at all 5-extremely



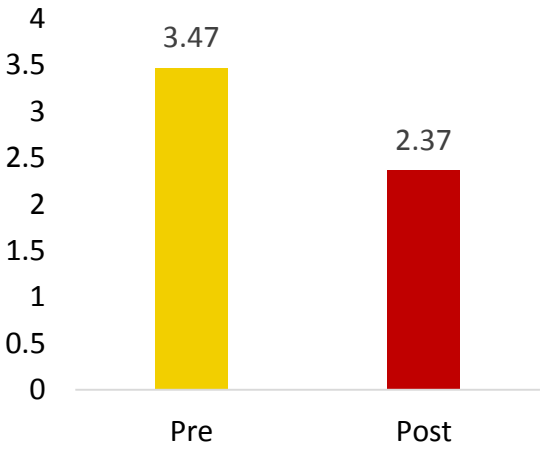
Caregivers report parenting is more fulfilling

Fulfillment of parenting… 1-not at all 5-extremely



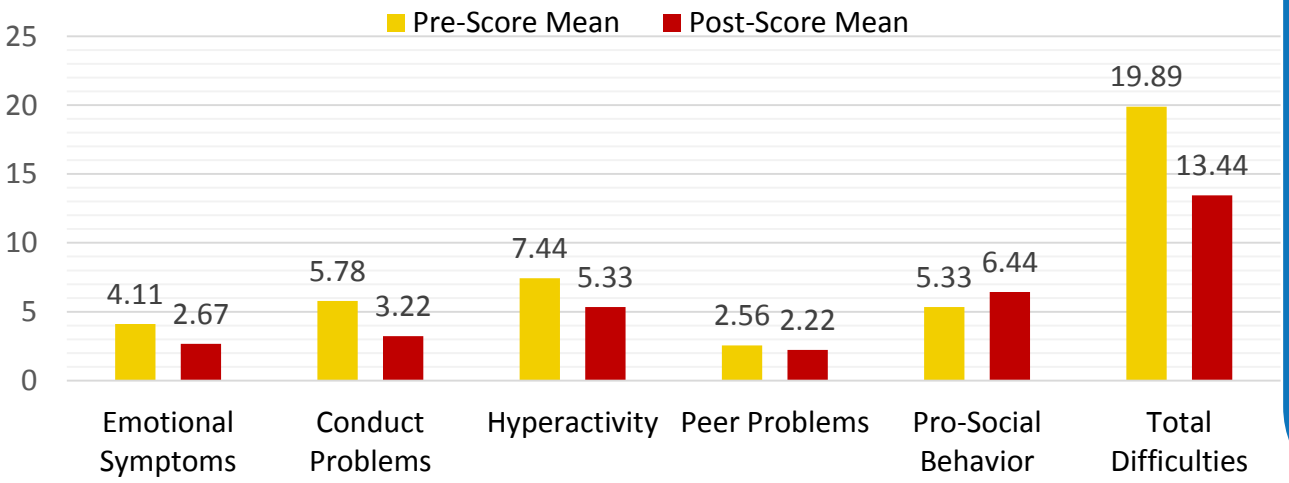
Decrease in dysfunctional parenting practices

Parenting Scale Tool Total Score



Decrease in child difficulties & Increase in child strengths

Strength and Difficulties Questionnaire



Key Outcome Findings from Caregiver Survey:

Triple P helps caregivers be more effective in dealing with child's problem behavior.

After completing Triple P…

- Overall scores show improved child behavior.
- Overall scores show effective parenting practices improved.

Statistical analyses indicate statistically significant improvements in:

- Difficulty of child's behavior, parenting is rewarding, parenting is demanding, parenting is stressful, parenting is fulfilling, parenting is depressing, parent's confidence in parenting, and parent's perceived support in parenting *(Parenting Experience Survey)*
- Total difficulties, Emotional symptoms, conduct problems, and prosocial behavior *(SDQ)*
- Total Score, Laxness, over-reactivity *(Parenting Scale)*

[REPORT]
October 2015

Local Health Department Efforts to Prevent Child Maltreatment



NACCHO
National Association of County & City Health Officials

Introduction

Child maltreatment is "any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child."[1] The federal Child Abuse Prevention and Treatment Act (CAPTA) provides guidance to states by identifying a minimum set of behaviors that define child abuse and neglect, specifically for sexual abuse and special cases of neglect.[2] In addition to the minimum standards set, each state that accepts CAPTA funding further defines child maltreatment. Many states recognize the four types of maltreatment in their definitions.[3,4]

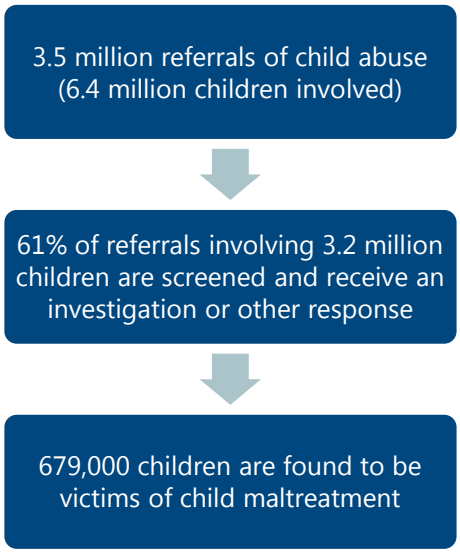
This report provides an overview of the current state of child maltreatment in the United States and highlights evidence-based public health programs and services in local health departments (LHDs) to reduce child maltreatment.

Background

Scope of the Problem

In the United States, there were 3.5 million referrals of child abuse involving 6.4 million children in 2013.[5] Sixty-one percent of referrals, involving 3.2 million children, received an investigation or alternative response from child protective services (CPS) (Figure 1).[5] Each year, an estimated 679,000 children are found to be victims of abuse and neglect, a rate of 9.1 per 1,000 children; of those children, 27.3% are younger than three years and 19.7% are between three and five years.[5,6]

Figure 1 | Child Maltreatment Referrals and Cases[5]



TYPES OF MALTREATMENT

Physical Abuse—intentional force against a child (e.g., hitting, shaking)

Sexual Abuse—engaging a child in sexual acts (e.g., fondling, rape)

Emotional Abuse—behaviors that harm a child's self-worth or emotional well-being (e.g., name-calling, withholding love) or needs (e.g., housing, food, clothing)

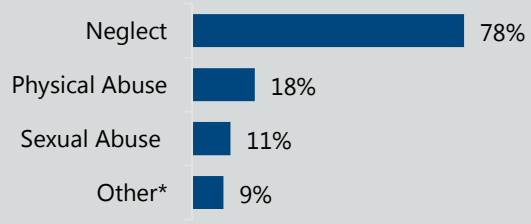
The most common form of child maltreatment is neglect; 78% of children who experienced child maltreatment were victims of neglect, 18% were victims of physical abuse, and 11% were victims of sexual abuse (Figure 2).[7] Most child maltreatment victims are White (44%), Hispanic (22.4%), or Black (21.2%) (Figure 3).[5]

In 2013, an estimated 1,520 children died from abuse and neglect. The number of children who die from abuse and neglect is likely considerably higher than the official government statistic, primarily because some child maltreatment deaths are not reported to CPS.[5,8] Seventy-one percent of child fatalities are caused by neglect and 46.8% are caused by physical abuse.[5] Racial disparities exist for child fatalities; the rate of Black child fatalities (4.52 per 100,000) is roughly three-times the rates of White children (1.53 per 100,000) and Hispanic children (1.44 per 100,000).[5]

Risk and Protective Factors

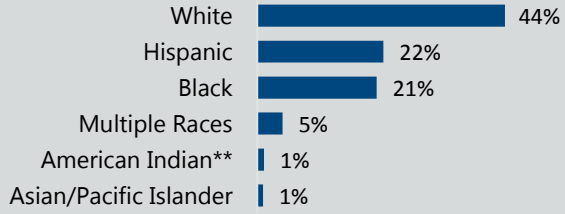
While children are never responsible for neglect or abuse inflicted upon them, certain characteristics increase risk for child maltreatment.[9] Risk factors for child maltreatment are characteristics that make it more likely for child maltreatment to occur.

Figure 2 | Victims of Child Maltreatment by Type of Maltreatment[7]



*Other includes emotional abuse, threatened abuse, parental drug/alcohol abuse, or lack of supervision.
**American Indian and Alaska Native

Figure 3 | Victims of Child Maltreatment by Race/Ethnicity[5]



Risk factors of child maltreatment can be grouped in the following categories: child factors; parent or caregiver factors; family factors; and community factors (Table 1).

Protective factors for child maltreatment are those that reduce its likelihood. Protective factors of child maltreatment have not been studied as rigorously as risk factors; however, varying degrees of evidence suggest some characteristics may buffer children from maltreatment. These include supportive family environment and social networks; nurturing parenting skills; household rules and child monitoring; stable family relationships; family support; caring adults outside the family who can serve as role models or mentors; parental employment; adequate housing; coordination of resources and services among community agencies; and access to mental health and substance abuse services.[11,13]

Consequences of Child Maltreatment

Child maltreatment has wide-ranging effects on physical, psychological, and behavioral health; it also has economic consequences. The effects vary based on the child's age; the type of maltreatment; the frequency, duration, and severity of the maltreatment; and the relationship between the child and the perpetrator.[11,14]

Child maltreatment has both immediate and long-term consequences on one's physical well-being.[11] Immediate consequences may include bruises, burns, cuts, broken bones, sexually transmitted infections, or death.[9] Child maltreatment causes stress that can disrupt or alter early brain development and impair the development of the nervous and immune systems, negatively impacting a child's physical, cognitive, emotional, and social growth.[10,15] Physical exposure to child maltreatment is related to risk factors for ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.[9] The Adverse Childhood Experience Study, conducted by Kaiser Permanente, investigated the relationship between child maltreatment and family dysfunction and current health status and behaviors.[16] The study found that the impact of adverse childhood experiences is cumulative; in other words, the more adverse childhood experiences one has, the greater likelihood of negative health outcomes.[9]

Table 1 | Child Maltreatment Risk Factors by Category

CATEGORY OF RISK	RISK FACTORS
Child Factors	Children younger than four years of age; those with special needs (e.g., physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment); and those who are unwanted or fail to fulfill the expectations of parents.[10,11]
Parent or Caregiver Factors	Young parental age; low education; low income; poverty; single parenthood; large number of dependent children; substance abuse or mental health disorders; lack of understanding of children's needs, child development, and parenting skills; and parents' history of child maltreatment.[11,12]
Family Factors	Social isolation; physical, developmental, or mental health problems of a family member; and violence between other family members.[11,12]
Community Factors	Community violence, neighborhood poverty, high unemployment rates, and high density of alcohol outlets; cultural norms that support aggression toward others; and social norms around masculinity and femininity.[11,12]

Child maltreatment also contributes to poor mental and emotional health. Experiencing child maltreatment is a risk factor for psychiatric disorders including borderline personality disorder, depression, and antisocial traits.[11,14] Chronic child maltreatment may cause stress and anxiety, making victims more vulnerable to post-traumatic stress disorder; conduct disorder; and learning, attention, and memory difficulties.

Behavioral consequences of child abuse may occur at different stages of a child's behavioral development, from infancy to adolescence. When children are abused as toddlers, they may display excessive anger and aggression.[9,14,17] By ages four and five, maltreated boys tend to respond through expression of anger, aggression, and verbal bullying, while maltreated girls tend to respond through depression and social withdrawal.[19] During pre-adolescence, difficulties in school, such as poor academic performance, poor concentration, and absenteeism arise.[9,11,14,17]Adolescents who experience maltreatment are at increased risk for smoking, alcoholism, illicit drug use, early sexual activity, high-risk sexual behaviors, homelessness, gang involvement, carrying guns, and other criminal behavior. [9,11,14,17]

In 2012, the Centers for Disease Control and Prevention (CDC) released a report that estimated the total lifetime economic burden of fatal and nonfatal child maltreatment to be $124 billion.[18] The estimated average lifetime cost per victim of fatal child maltreatment is $1,272,900.[18] The estimated cost per victim of non-fatal child maltreatment is $210,012, including $32,648 in childhood healthcare costs; $10,530 in adult medical costs; $141,100 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs.[18]

Maltreated children can grow up without suffering the consequences described above. Resilience, or the ability to cope, is a trait that results from both risk and protective factors and positively influences a child's reaction to adverse experiences.[14] Factors that contribute to resilience are positive attachment, self-esteem, intelligence, emotional regulation, humor, and independence. Additional research is needed to examine if additional factors may moderate the effects of child maltreatment or if certain types of maltreatment are worse than others in regard to long-term consequences.[19]

Role of Public Health in Child Maltreatment Prevention

Child maltreatment is preventable and requires a comprehensive approach at the primary, secondary, and tertiary prevention levels.

Strategies to prevent child maltreatment and its consequences include (1) changing individual behaviors, relationships, families, and

communities through social norms change; (2) providing effective parenting education and skills-building programs; and (3) increasing factors that protect children from child maltreatment.[20,21] LHDs convene and coordinate community resources and services to help ensure every child grows up safe and healthy.[22] Public awareness of child maltreatment, universal education for all families, and targeted programs and services are ways in which the public health system can work to prevent child maltreatment.[20] LHDs and their partners may engage the news media to promote programs or activities, healthy parenting practices, and child safety skills. LHDs may also develop regional messages, public service announcements, and resources that inform community members of how to access services.[23]

Evidence shows that safe, stable, and nurturing relationships and environments (SSNREs) between children and their caregivers are crucial for healthy brain development in children.[24]

Public health practice emphasizes SSNREs because they have positive effects on child maltreatment prevention and contribute to the development of skills that enhance the adoption of healthy habits. Parent education and skills-building programs are widely used as a strategy to promote SSNREs and prevent child maltreatment. Research indicates that parent education programs result in better parenting, positive child development and well-being, stronger families and communities, and ultimately the prevention of child maltreatment.[25,26] Parent education and skills-building programs also help parents and caregivers learn how to develop more appropriate expectations of their children, treat their children with empathy and nurturance, and use positive discipline instead of corporal punishment.[25]

Many public health programs to prevent child maltreatment promote protective factors that shield children from maltreatment. LHDs recognize that child maltreatment does not happen in a vacuum and often connect parents and caregivers to social services and supports that help mitigate risk factors for child maltreatment, such as young parental age, inadequate housing, substance abuse, and mental health problems.

Evidence-Based Child Maltreatment Programs

Evidence-based and evidence-informed public health interventions are critical to support reduction in child maltreatment. Table 2 describes select evidence-based child maltreatment prevention programs: Healthy Families America, Parent-Child Interaction Therapy, SafeCare®, Strengthening Families, and Triple P – Positive Parenting Program.

Table 2 | Descriptions of Select Evidence-Based Child Maltreatment Prevention Programs

PROGRAM	DESCRIPTION
Healthy Families America	Healthy Families America (HFA) is an evidence-based home visitation program designed for families that are at risk for adverse childhood experiences and may have histories of trauma, intimate partner violence, mental health issues, and substance abuse issues. HFA is a voluntary intervention that serves families three to five years after the birth of the baby. Additional information can be found at http://www.healthyfamiliesamerica.org.

PROGRAM	DESCRIPTION
Parent-Child Interaction Therapy	Parent-Child Interaction Therapy (PCIT) is an evidence-based experiential and education program for parents and children (ages two to seven) that teaches parents skills to address their children's significant behavioral health problems. The goal of PCIT is to positively change parent-child interactions, thereby reducing problematic behaviors and increasing attachment level between the caregiver and child. The two components of PCIT, Child-Directed Interaction and Parent-Directed Interaction, are implemented over the course of approximately 20 weekly sessions. During these sessions, families receive live feedback via earpiece during structured, observed parent-child interactions. Learn more at http://www.pcit.org.
SafeCare®	SafeCare® is a parent-training curriculum for parents (of children up to five years) with a history for maltreatment or with risk factors for maltreatment. SafeCare®-trained professionals conduct weekly one- to two-hour home visits for approximately 18–20 weeks to teach parents how to respond appropriately to child behaviors, how to plan and implement child activities, and how best to address health and safety. The priority populations for SafeCare® include pregnant women under 21 years; low-income families; families with a history of child abuse or neglect; parents with a history of substance abuse; parents of children with developmental delays or disabilities; and parents of low-achieving students. Learn more at http://safecare.publichealth.gsu.edu.
Strengthening Families	Strengthening Families, a substance abuse program for parents and children, aims to decrease substance abuse among youth. The target populations of the program are children of incarcerated parents, children with parents in substance abuse treatment, and children with behavioral and academic problems. During the course of a 14-session program, Strengthening Families provides training in parenting, children's social and life skills, and family relationship skills. Learn more at http://www.strengtheningfamiliesprogram.org.
Triple P – Positive Parenting Program	Triple P a multi-level system of education and support for parents and caregivers of children and adolescents (birth to age 16). The goals of Triple P are to promote the independence and health of families through the enhancement of parents' knowledge, skills, confidence, and self-sufficiency; promote the development of non-violent, protective, nurturing environments for children; promote the development, growth, health, and social competence of young children; and reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence. Learn more at http://www.triplep-parenting.net/glo-en/home.

LHD Implementation of Child Maltreatment Prevention Programs

LHDs are important stakeholders in child maltreatment prevention. The following section describes the implementation of select evidence-based programs through LHDs. Five LHDs—Douglas County Health Department (Omaha, NE), Deschutes County Health Services (Bend, OR), Cascade City-County Health Department (Great Falls, MT), Anne Arundel County Health Department (Annapolis, MD), and Cabarrus Health Alliance (Cabarrus County, NC)—provide useful information about program implementation, staffing and training, partnerships, evaluation, and the unique challenges faced by the LHD in implementing these evidence-based programs.

Healthy Families America

Douglas County Health Department

Community Overview

Douglas County Health Department (DCHD) in Omaha, NE, serves approximately 543,244 residents. DCHD's racial composition in 2013 was 81.6% White, 11.7% Hispanic or Latino, 11.6% Black, 3.1% Asian, 2.5% two or more races, and 1.1% American Indian and Alaska Native. The median household income is $53,325 and 17.8% of children (ages 0–17) live in poverty.

Douglas County has the highest child maltreatment rate in Nebraska. In FY2014, there were 1,083 substantiated victims of child maltreatment in the county. Increased rates of poor child health outcomes, infant mortality, and high poverty levels in DCHD's service area was the basis for implementing the nationally recognized home visiting program model, Healthy Families America (HFA). A needs assessment of Douglas County determined the necessity of a program that addressed child abuse, neglect, poverty, and self-sufficiency issues.

Program Implementation

An annual budget of $520,000 allows DCHD to serve a maximum of 90 families yearly. HFA aims to prevent child abuse and neglect and promote child well-being through home visiting services by building and sustaining community partnerships to systematically engage overburdened families in home visiting services, prenatally or at birth; cultivating and strengthening nurturing parent-child relationships; promoting healthy childhood growth and development; and enhancing family functioning by reducing risk and building protective factors.

Staffing and Training

Healthy Families America-Douglas County (HFA-DC) provides direct services through two local agencies, Lutheran Family Services and Nebraska Children's Home Society. HFA-DC has a staff of nine employees, comprising six home visitors, two program supervisors, and one program manager. All staff are required to complete the HFA-Parent Survey Core Training; 30 hours of additional home support trainings; annual child abuse and neglect and cultural sensitivity trainings; 15 additional hours of professional development annually; and database training to track clients and monitor quality assurance and quantify outcomes.

Partnerships

HFA-DC relies on internal and external partnerships to support implementation of HFA. Internally, HFA-DC staff formed relationships with Douglas County Women, Infants, and Children (WIC) offices and a local coalition that works to reduce infant mortality in the county. HFA-DC partners externally with local women's health clinics, social workers, and local childcare facilities to refer families to HFA.

Evaluation

DCHD has completed 2,765 home visits since November 2013 and has served over 168 mothers and infants since the program inception. HFA-DC has provided its families with over 307 referrals for supplemental services since January 2015.

Challenges

Supplemental funding and retaining program participants and staff members has proved difficult for HFA-DC. Since its inception, HFA-DC lost three home visitors and one program supervisor. HFA-DC has a 40% annual retention rate; turnover of home visitors was often associated with clients' ceasing participation in the program. Other reasons for the low retention rate can be attributed to the participants' lack of consistent methods of transportation and communication. To address these issues, HFA recommends that other LHDs focus not only on enrolling families but also on the satisfaction and retention of staff and participants.

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Parent-Child Interaction Therapy

Deschutes County Health Services

Community Overview

Deschutes County Health Services (DCHS), located in Bend, OR, serves approximately 170,388 residents. In 2013, Deschutes County's racial composition was predominantly White (94.8%), with 7.7% Hispanic or Latino, 2.4% two or more races, 1.1% American Indian and Alaskan Native, and 0.5% Black. The median household income is $53,397 and 22% of children (ages 0–17) in Deschutes County live in poverty.

The high rate of reported child abuse cases (8.4 abuse and neglect victims per 1,000), combined with high rates of substance abuse, intimate partner violence, and inadequate housing led to the need for implementation of Parent-Child Interaction Therapy (PCIT) in Deschutes County.

Program Implementation

With funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Linking Actions for Unmet Needs in Children's Health (LAUNCH) grant, DCHS established Parent-Child Interaction Therapy (PCIT) within the community in September 2009.

Staffing and Training

Approximately 10 Master's-level therapists are trained to implement PCIT and are actively using it. This work is overseen by a supervisor and a departmental manager. DCHS has three Master Trainers and 18 providers throughout the community who are trained by the University of California-Davis. PCIT providers must receive their PCIT therapist certification, which consists of an intensive three-day orientation and 40 hours of training from a PCIT Master Trainer.

Partnerships

DCHS worked closely with its Behavioral and Public Health Departments and its WIC program. PCIT also formed external relationships with existing community partners, including a local Relief Nursery.

Evaluation

Since its establishment, DCHS has increased the local capacity to deliver PCIT through seven new facilities throughout the county. Following the conclusion of the five-year LAUNCH grant, 15 therapists and clinicians continue to provide services in the community. DCHS also assisted the University of California-Davis in successfully piloting a PCIT online orientation, which provides a more cost- and time-effective option for future trainees. A total of 208 families participated in PCIT, all of whom met at least one of their treatment goals.

Challenges

Family retention was a significant problem that arose throughout the duration of the program. Even with incentives (e.g., gas gift cards), 61% of participants dropped out prior to the completion of PCIT. In addition, complexities in data sharing across agencies and restraints on clinician time and priorities resulted in limited data collection. Throughout the five-year grant, DCHS experienced challenges with high staff turnover, changes to the community infrastructure, and educating the community about the project and practices. As a result of this project, DCHS has learned that adaptability and creativity to respond to changing conditions is imperative to the success of PCIT implementation.

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SafeCare®

Cascade City-County Health Department

Community Overview

Located in Great Falls, MT, the Cascade City-County Health Department (CCHD) serves 59,351 residents, of whom 88.5% are White, 5.0% are American Indian and Alaskan Native, 3.8% are two or more races, 3.4% are Hispanic or Latino, 1.1% are Black, and 0.9% are Asian. The median household income is $43,822. The substantiated child abuse rate in 2011 was 4.6 per 1,000 children, compared to the statewide rate of 2.9 per 1,000 children. In FY 2011, 21.2% of children (ages 0–17) lived in poverty.

After five deaths due to neglect or abuse between 2010 and 2014 and being one of six communities in Montana with the highest child abuse and neglect rate, the county recognized the need for a home visitation program. Additionally, the county experienced high rates of teen pregnancy, low educational attainment, high rates of substance abuse, a high number of single parents, and high rates of intimate partner violence. The Montana Maternal, Infant, and Early Childhood Home Visiting (MIECHV) 2013 County Profile Risk Indicators showed the community was at higher risk for substantiated child abuse.

Program Implementation

As part of the Great Falls Early Childhood Coalition (GFECC), CCHD collaboratively applied for funding with the Center for Mental Health, the Great Falls Public School District Indian Education Department, and Big Sky Therapeutic Services to provide voluntary SafeCare® model services. In 2014, CCHD was awarded the grant and tasked with the coordination and execution of SafeCare® among the four agencies.

Staffing and Training

CCHD is the leading organization and its family health services division manager oversees three subcontractors at their respective locations. Each funded agency employs one home visitor. Home visitors in the SafeCare® program must have an early childhood/health-related four-year degree. Staff received training in motivational interviewing, domestic violence awareness, adverse childhood experiences, and trauma-informed care. Additionally, throughout a five-day SafeCare® workshop, staff received training in health, safety, parent-child interaction, communication, and structured problem-solving.

Partnerships

The partnerships with the GFECC, Center for Mental Health, Great Falls Public School District Indian Education Department, and Blue Sky Youth Center Group Home/Shelter Care made the implementation of this program possible.

Evaluation

CCHD did not enroll families until November 2014 and did not have program evaluation outputs at the time it was surveyed. Nonetheless, anecdotal evidence suggests that families that have completed the SafeCare® program responded positively. Additionally, the partnership with the Indian Education Department at Great Falls Public Schools has resulted in a full-time SafeCare® home visitor, housed in one of the area's "high risk" schools.

Challenges

Cross-agency service resulted in challenges with subcontractor oversight and hiring of staff. Home visitors at each agency had a supervisor within their agency in addition to the CCHD SafeCare® manager, causing complications with instruction and coordination. To address these issues, CCHD routinely repeated expectations regarding communication. The grant funding did not cover any additional supplies, training, or administrative expenses, which made providing support for families difficult and forced administrators to look elsewhere for additional funds. CCHD addressed challenges and successes, as they arose, through monthly partner meetings.

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Strengthening Families

Anne Arundel County Health Department

Community Overview

The Anne Arundel County Health Department (AACHD) is located in Annapolis, MD, and serves 560,133 residents. Anne Arundel County's racial composition is 76.5% White, 16.4% Black, 6.9% Hispanic or Latino, 3.7% Asian, 2.9% two or more races, and 0.4% American Indian and Alaskan Native. The median household income is $87,430 and in 2013, 9.3% of children (ages 0–17) lived in poverty.

AACHD determined the need for a child maltreatment prevention program based on community factors such as a high number of reported cases of child abuse, high rates of substance abuse, high number of single parents, high neighborhood poverty rates, inadequate housing, and insufficient access to healthcare and social services. Particularly, rising rates of underage alcohol consumption, opioid misuse, and overdose deaths led AACHD to implement Strengthening Families.

Program Implementation

AACHD has provided Strengthening Families services since 2003. The scope of activities within the program ranges from family activities and meetings to children's games and activity planning. Upon the completion of a minimum 10 of the 14 sessions, families graduate from the program and become eligible to attend post-program reunions. These biannual events promote continual program adherence and preserve the meaningful relationships the program has produced between the staff and participants.

Staffing and Training

Strengthening Families project staff at AACHD consists of two health educators, eight community health workers, two managerial workers, and three administrators. Completion of a two-day facilitator training is required for staff. In addition, AACHD has determined that interpersonal skills, particularly the ability to work with families, is vital to the success of the program.

Partnerships

Internally at AACHD, Strengthening Families project staff have partnered with the Adolescent and Family Services department, which provides outpatient mental health and addiction services to county children and their families; the health department's Adult Addiction methadone clinic; and other substance abuse assessment and referral services within the health department. Externally, AACHD partnered with Anne Arundel County Public Schools, and the Anne Arundel County Departments of Corrections, Social Services, and Juvenile Services. These partners support Strengthening Families implementation through family referrals and the provision of family community resources.

Evaluation

Since 2003, AACHD has served an estimated 700 families, including over 1,000 children. A 2010 evaluation on Strengthening Families in Anne Arundel County found statistically significant improvement in all family outcome measures, all parent outcome measures, and 75% of children's outcome measures.

Challenges

AACHD has experienced budget cuts due to decreases in government spending, which has impacted grant-funded programs. Moreover, new substance abuse strategies focused on environmental approaches instead of individual strategies (e.g., working one-on-one with program participants) has limited available funding for direct service programming, including Strengthening Families. Although Strengthening Families is labor intensive, AACHD suggests that serving an entire family results in incomparable positive family change that other LHDs can implement within their own communities.

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Triple P – Positive Parenting Program

Cabarrus Health Alliance

Community Overview

Located in Cabarrus County, NC, Cabarrus Health Alliance (CHA) serves approximately 192,103 residents. In 2013, the last year for which data was available, Cabarrus County's racial composition was primarily White (78.3%), with 16.5% Black, 9.8% Hispanic or Latino, 2.5% Asian, 1.9% two or more races, and 0.7% American Indian and Alaska Native. The median household income is $53,551 and 18.9% of Cabarrus County's children (ages 0–17) live in poverty. In FY2013, 583 cases of child maltreatment were substantiated, at a rate of 11.72 per 1,000 children.

In addition to high rates of child maltreatment, numerous community factors contributed to the need for child maltreatment prevention. These factors include a high number of reported child abuse cases, high rates of substance abuse, high rates of intimate partner violence, high rates of unemployment; inadequate housing, and inadequate access to healthcare and social services. These community-level factors led CHA to implement Triple P – Positive Parenting Program (Triple P).

Program Implementation

In 2012, CHA received $1.2 million from the North Carolina Department of Health and Human Services to implement Triple P. CHA implements Triple P to reduce out-of-home placements, substantiated child abuse cases, and hospitalizations or emergency room visits for child maltreatment-related injuries.

Staffing and Training

A project director and two program coordinators organize the implementation efforts for the project. Additional CHA staff who support Triple P implementation include three health educators, two social workers, and three home visitors. CHA has trained additional practitioners in agencies that work directly with parents and can deliver Triple P as part of their current service delivery system. Triple P providers must complete a one- to three-day training program, followed by demonstrations of knowledge and competence in program delivery through a skills-based accreditation process. Trained providers can participate in peer support, coordinated by CHA, to refine Triple P consultation and delivery skills and to foster cross-sector collaboration.

Partnerships

CHA has formed both internal and external partnerships to implement Triple P. Internally, Triple P staff collaborate with the WIC and Care Coordination for Children programs. CHA established external partnerships with education, social services, mental health, healthcare, non-profit, law enforcement, and faith-based organizations.

Evaluation

Statewide evaluation of Triple P is provided through the North Carolina Triple P Learning Collaborative, a group of Triple P coordinators. As of fall 2015, CHA had coordinated nine trainings for and accredited 103 practitioners. Since 2012, Triple P has impacted an estimated 2,723 children. Factors contributing to successful implementation included involving key partners at the start, providing adequate staffing for coordination, developing a shared evaluation plan, and planning for sustainability from the beginning.

Challenges

One challenge was that practitioners prioritized delivery of Triple P intervention below other mandated duties. To combat this challenge, CHA provided performance-based financial incentives for practitioners and their supervisors to be used to implement Triple P. Moreover, retaining participants proved challenging due to lack of transportation, disconnected phone lines, and co-occurring issues such as substance abuse, poverty, and domestic violence.

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Discussion

LHDs provide many services and programs that keep communities safe and healthy. While this report details just five examples of evidence-based programs that prevent child maltreatment, it highlights the scope of child maltreatment and provides real-world examples of how LHDs implement programs and services to prevent or lower rates of child abuse and neglect.

Child maltreatment is a complex public health problem to which hundreds of thousands of children fall victim each year. LHDs must continue to be funded to provide programs that prevent child maltreatment because they are on the front lines of public health and provide communities with vital services and programs that keep children, youth, and families safe. Expansion of parental education programs, whether through home visitation, coaching, or classes, is a highly successful mechanism for preventing child maltreatment, building community and individual resilience, and supporting SSNREs. These programs prevent many risk factors of child maltreatment and help parents and caregivers improve their behaviors or actions toward children.

Nonetheless, parental education is not enough to prevent child maltreatment. Collaboration and coordination of the entire public health system is needed to link families at risk for child maltreatment with available community resources. Additional community supports are imperative to addressing all risk factors of child maltreatment, including low educational attainment, substance abuse or mental health disorders, neighborhood poverty, high density of alcohol outlets, and cultural norms. Child maltreatment is preventable. More must be done to address community factors that increase the likelihood of maltreatment.

Acknowledgments

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Triple P

Cabarrus County, NC
Positive Parenting Program (Triple P)

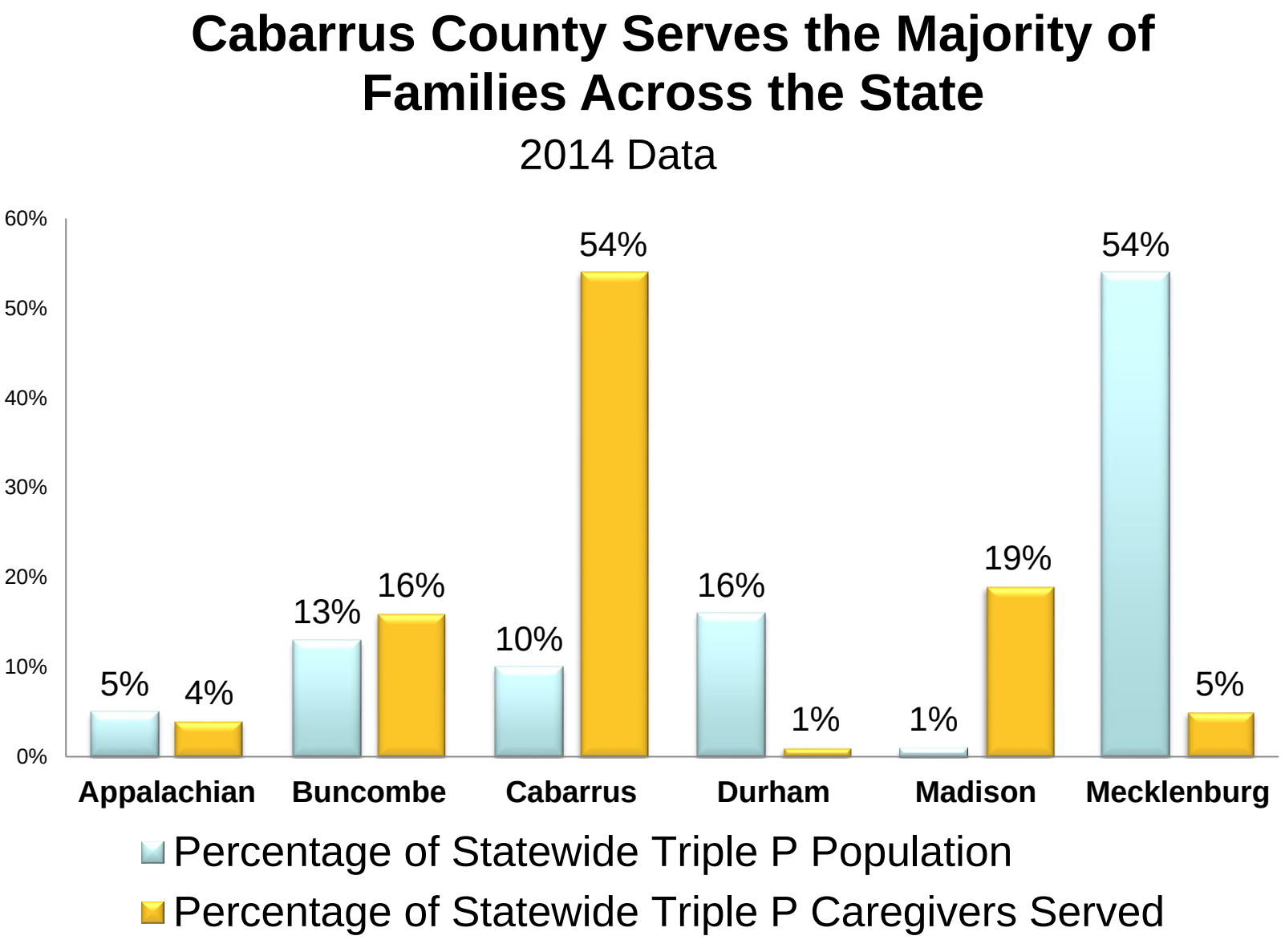
October to December 2015
Data Evaluation Results

Barbara Sheppard, Program Director
Amy Potoczny, Program Manager
Kristin Boatright, Program Coordinator
Clint Cresawn, Program Coordinator
Gina Hofert, Evaluator

CABARRUS HEALTH ALLIANCE

Triple P Positive Parenting Program for every parent

County Comparisons



Outcome Evaluation



- Providers are asked to:
  1. Submit completed packets to CHA (Quarterly)
  2. Complete a self-report via email link (Quarterly)



Evaluation

REPORTING PERIOD	DATA SUBMISSION DUE DATE
January 1 – March 31	**April 8**
April 1 – June 30	**July 8**
July 1 – September 30	**October 8**
October 1 – December 31	**January 8**

*An email reminder will be sent to providers
*Can submit anytime prior to deadline
*Incomplete interventions only need to submit the Caregiver Contact Record

EVALUATION MANUAL LINK:
http://www.cabarrushealth.org/153/Triple-P-Positive-Parenting-Program

Triple P
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for every parent

Evaluation Tools

- Data collected quarterly
- Parents complete surveys
- Providers submit surveys to CHA evaluator
- Results must take into account attrition:
  - Self-selection bias based on differential dropout
- Pre-Post Mean Scores



REACH

Based on Provider Self-Report Estimations: October – December 2015

- December 2015 deadline: **95%** Response Rate*

  *Of participating providers since March 2014

- Estimated Caregivers Reached: **6,323**
  - Cumulative # of caregivers that completed or partially completed intervention from grant start-June 2015. Duplication may exist due to services crossing over reporting periods until December 2014.

- Estimated Children Reached: **7,877**
  - Cumulative # of children under age 18 living in household of caregivers receiving Triple P services from grant start-June 2015. Duplication may exist due to services crossing over reporting periods until December 2014.



Triple P
Positive Parenting Program
for every parent

Provider Feedback Question

Providers feel Triple P provides them with additional tools for their job

“Has Triple P provided you with additional tools to better meet the needs of the families you serve?”

SCALE 1-7

1 No, definitely not

2

3 No, I don't think so

4

5 Yes, I think so

6

7 Yes, Definitely

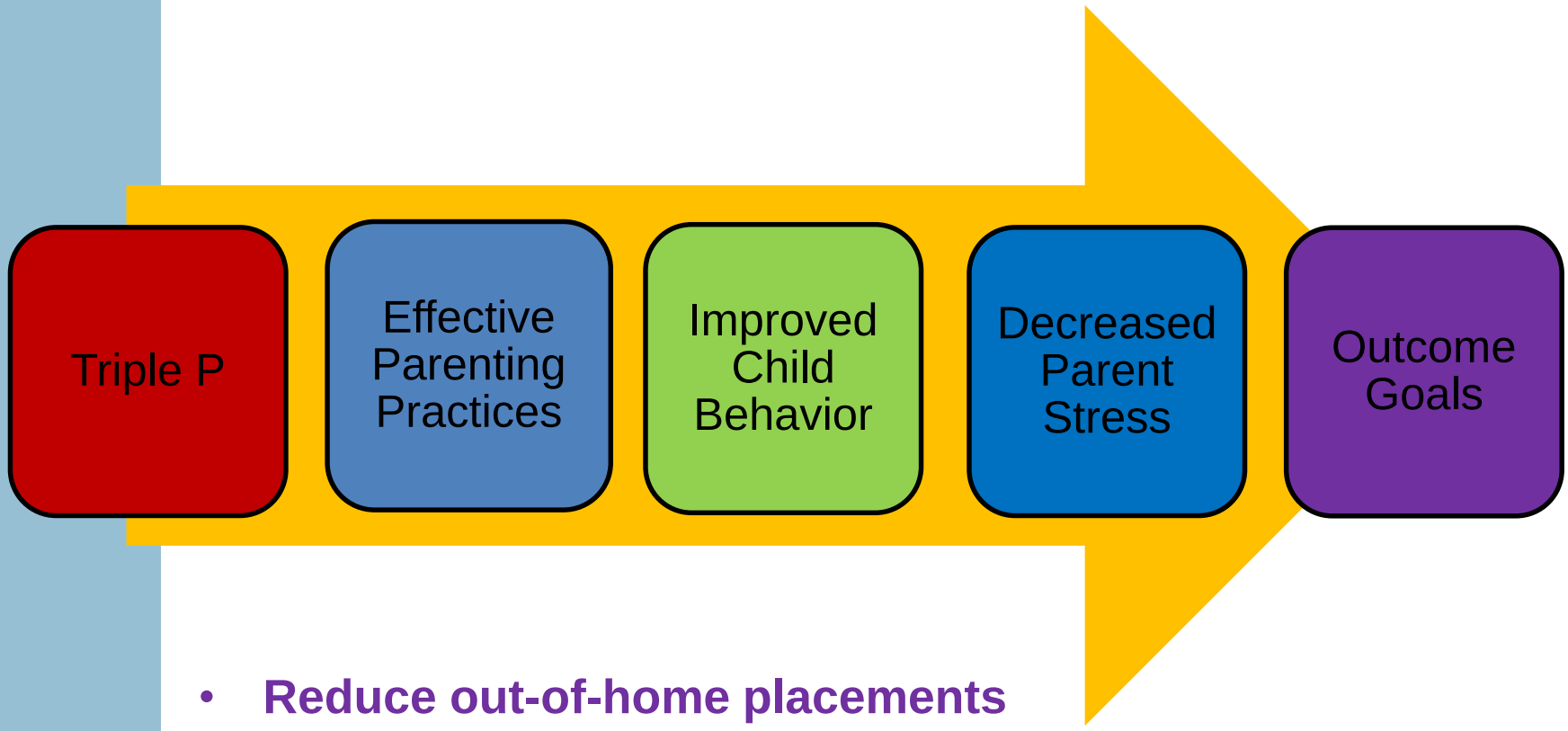


Mean Score: 6.01

Triple P Positive Parenting Program for every parent

Mechanism of Change

Developed by Dr. Romney – California Triple P



- **Reduce out-of-home placements**
- **Reduce substantiated child abuse cases**
- **Reduce hospitalization/ER visits for child maltreatment injuries**

Triple P Positive Parenting Program
for every parent

Data collected
Oct-Dec 2015

LEVEL 4
OUTCOME EVALUATION DATA

RESULTS SUMMARY for Level 4 SDQ:

Parents indicated that after completing Triple P:

- Child emotional symptoms decreased
- Child conduct problems decreased
- Child hyperactivity decreased
- Child peer problems decreased
- Child pro-social behavior increased
- Overall scores show improved child behavior

RESULTS SUMMARY for Level 4 Parenting Scale:

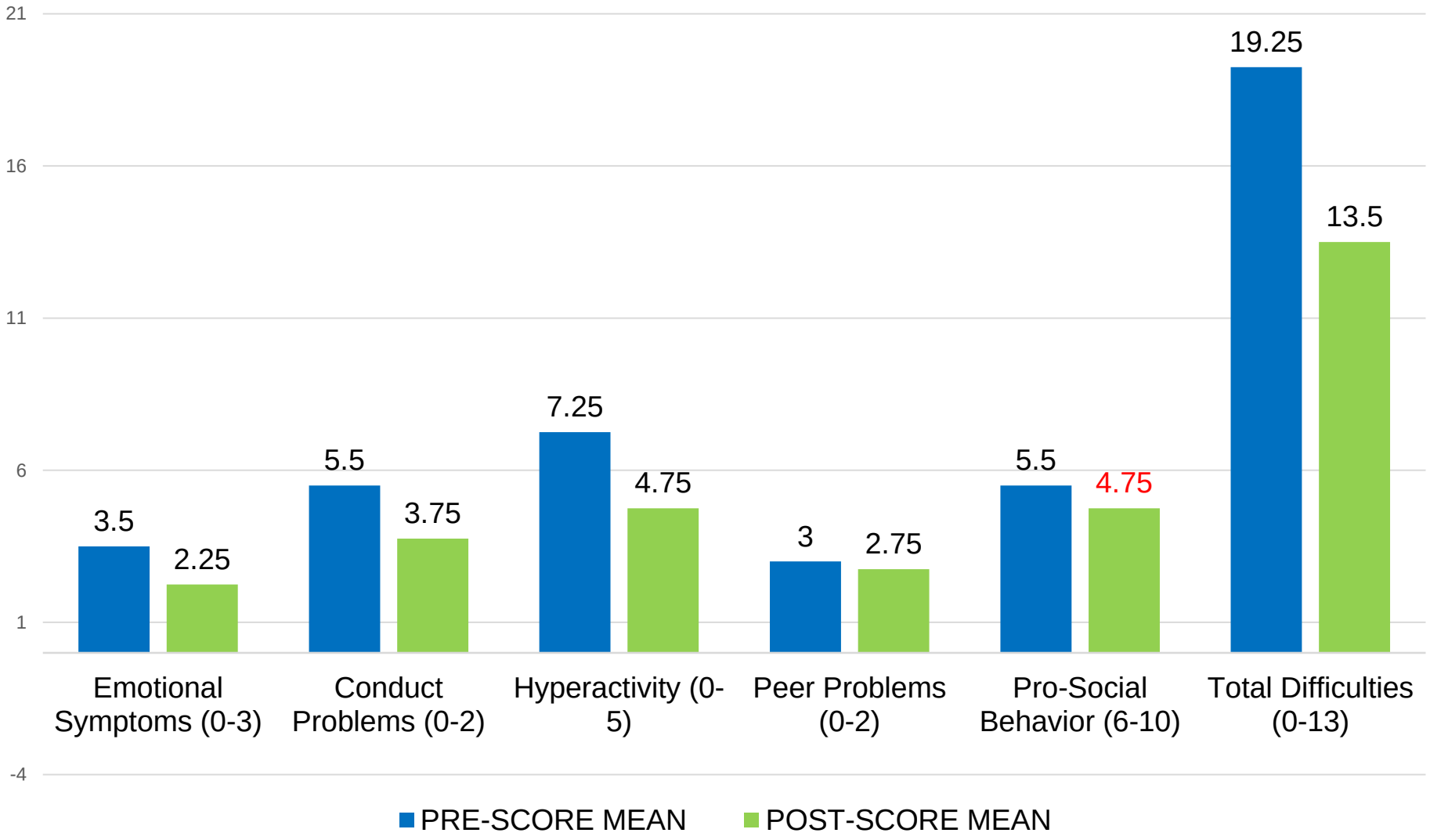
After completing Triple P:

- Parent laxness decreased
- Parent over-reactivity decreased
- Parent hostility decreased
- Overall scores show effective parenting practices improved

Data collected
Oct-Dec 2015

STRENGTH AND DIFFICULTIES QUESTIONNAIRE

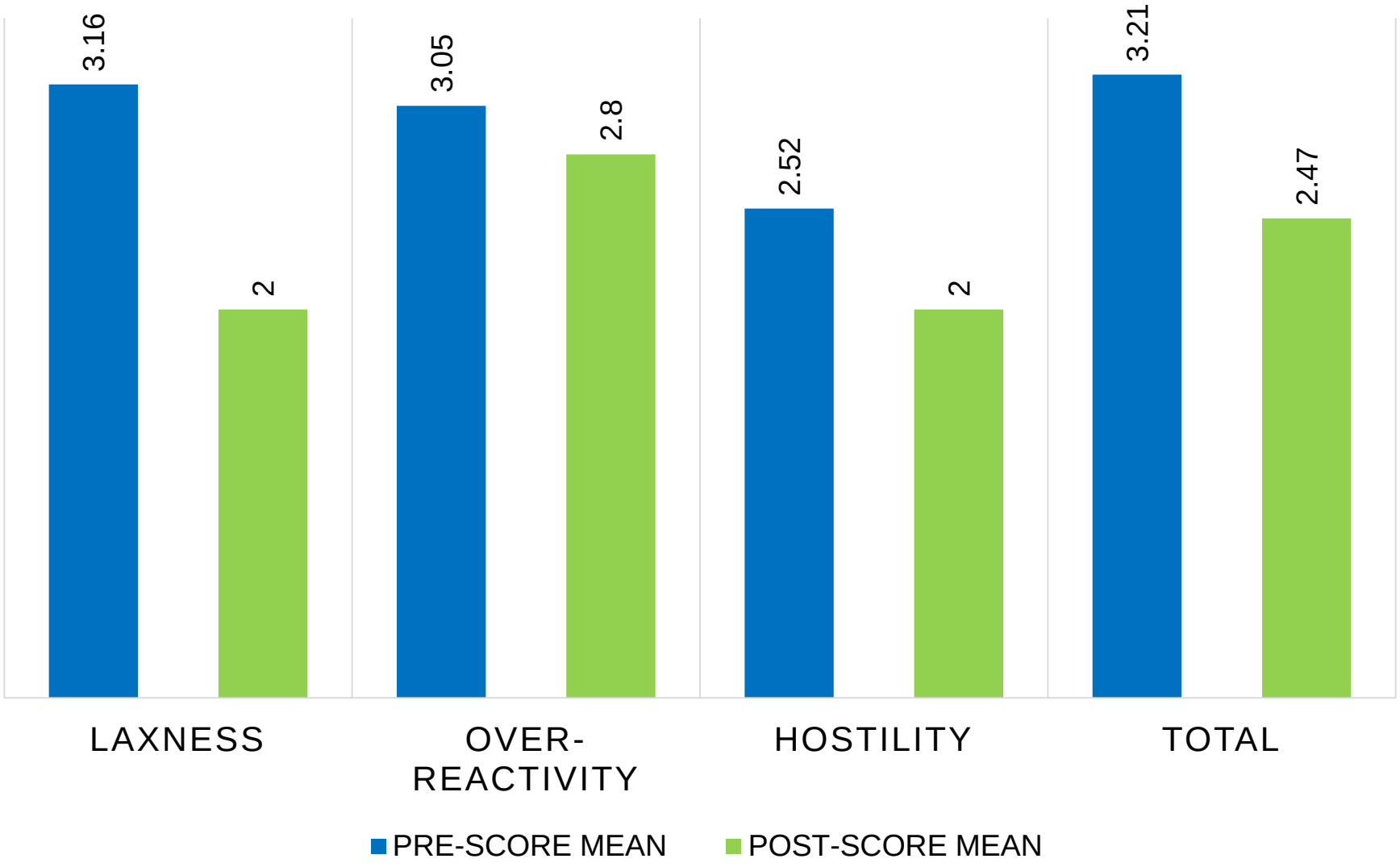
DECREASE in child difficulties & INCREASE in child strengths



Data collected
Oct-Dec 2015

PARENTING SCALE

DECREASE in dysfunctional parenting practices



Data collected
Oct-Dec 2015

LEVEL 3
OUTCOME EVALUATION DATA

RESULTS SUMMARY for Level 3 PES:

Parents indicate that after completing Triple P:

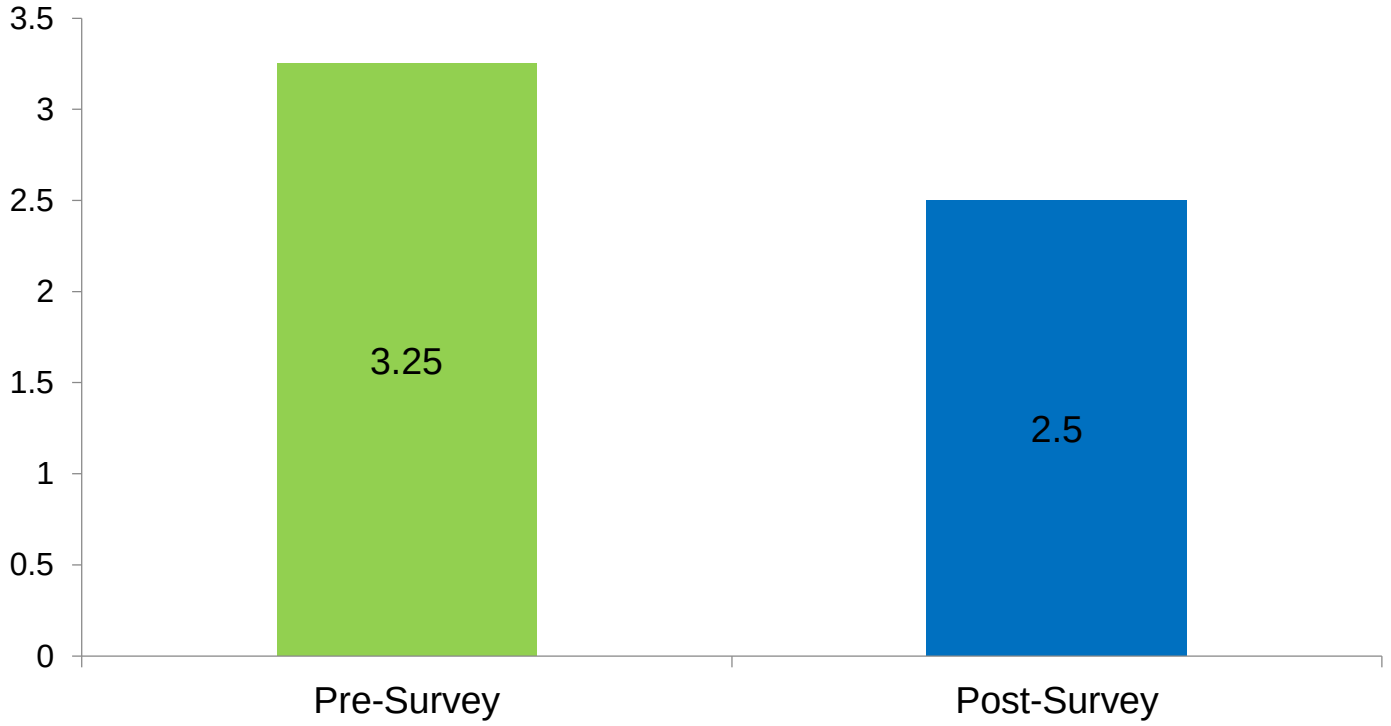
- Their child's behavior is less difficult
- Parenting is more rewarding
- Parenting is less demanding
- Parenting is less stressful
- Parenting is more fulfilling
- Parents feel more confident in parenting
- Parents feel more supported in their roles as parents

Decline in difficulty of child behavior

Data collected
Oct-Dec 2015

Item 1: In an overall sense, how <u>difficult</u> has your child's behavior been over the last 6 weeks?

1-not at all 2-slightly 3-moderately 4-very 5-extremely

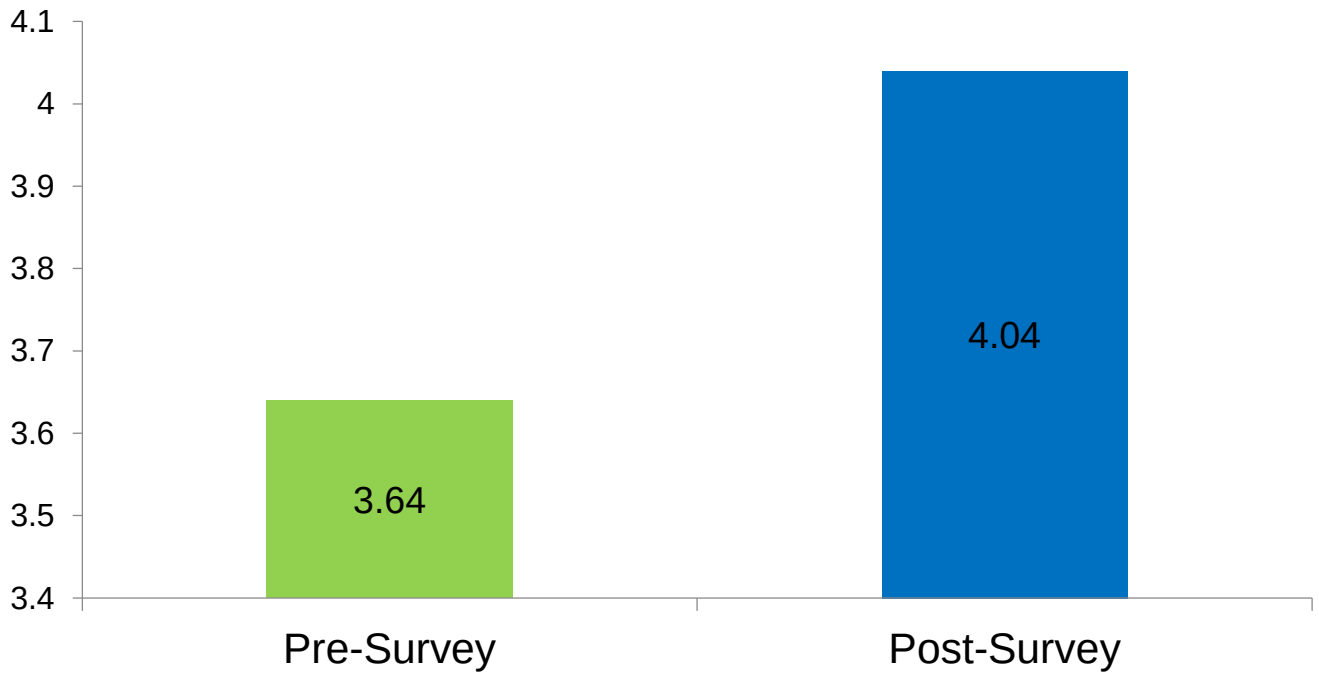


Parenting is more rewarding

Data collected
Oct-Dec 2015

Item 2a: Parenting is <u>rewarding</u>

1-not at all 2-slightly 3-moderately 4-very 5-extremely

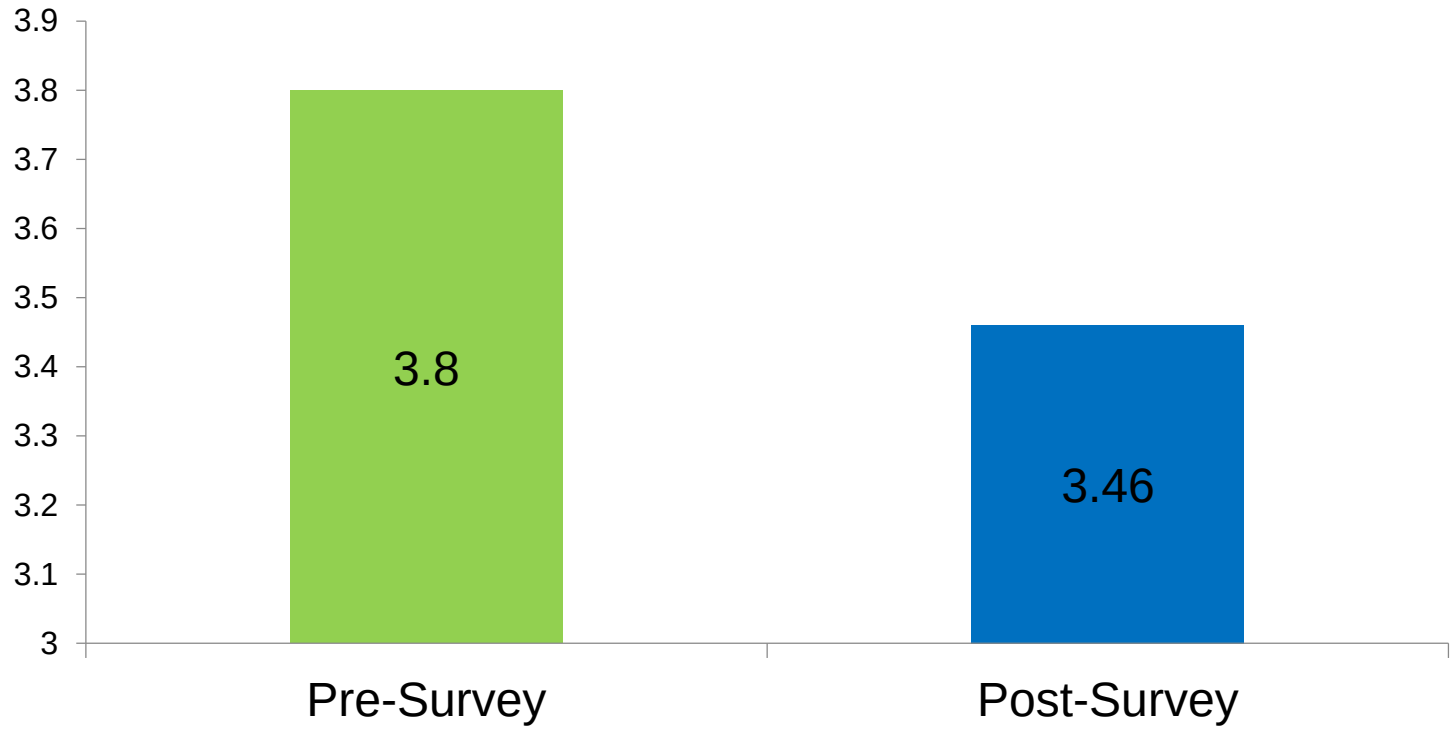


Parenting is less demanding

Data collected
Oct-Dec 2015

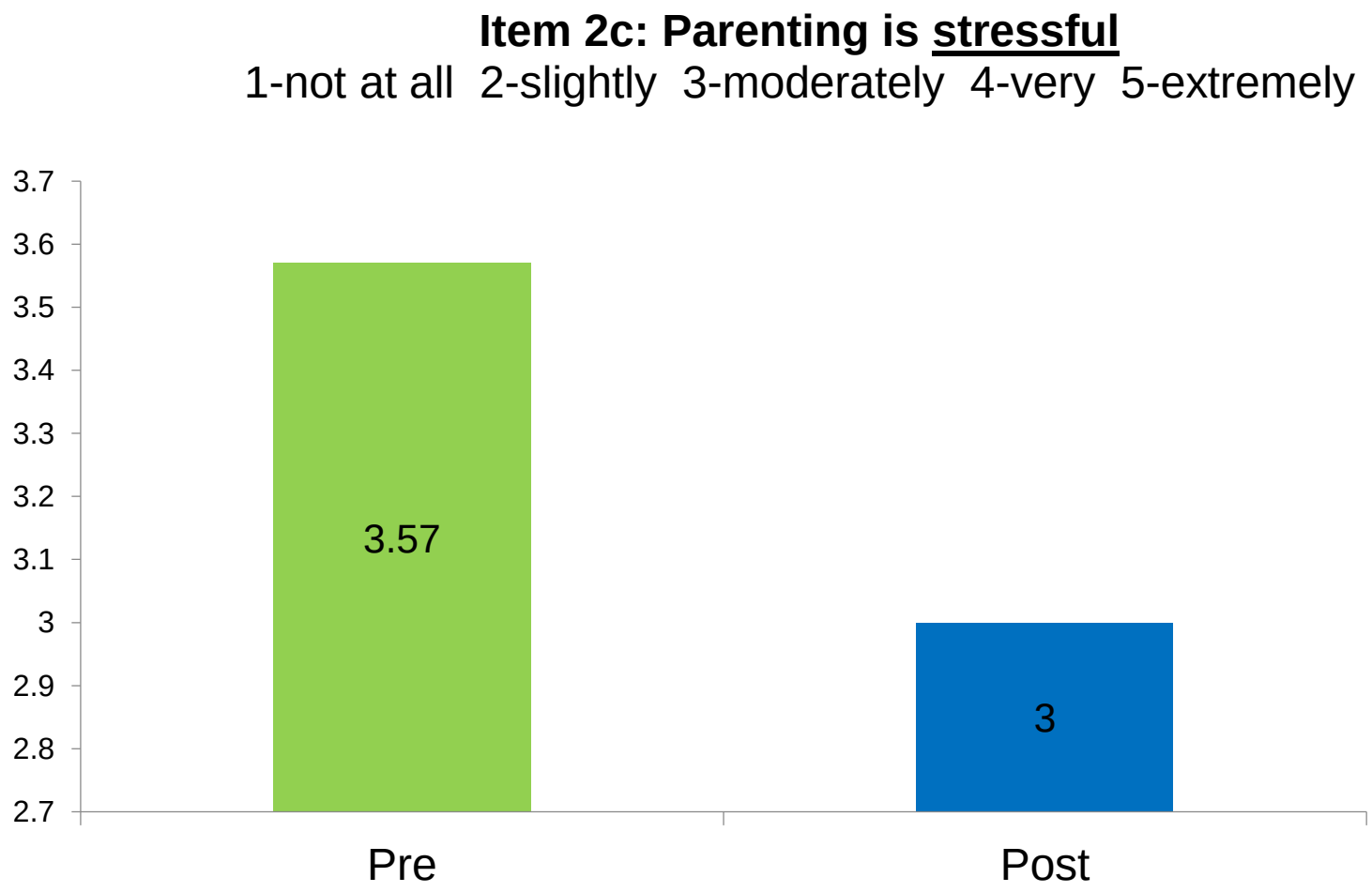
Item 2b: Parenting is <u>demanding</u>

1-not at all 2-slightly 3-moderately 4-very 5-extremely



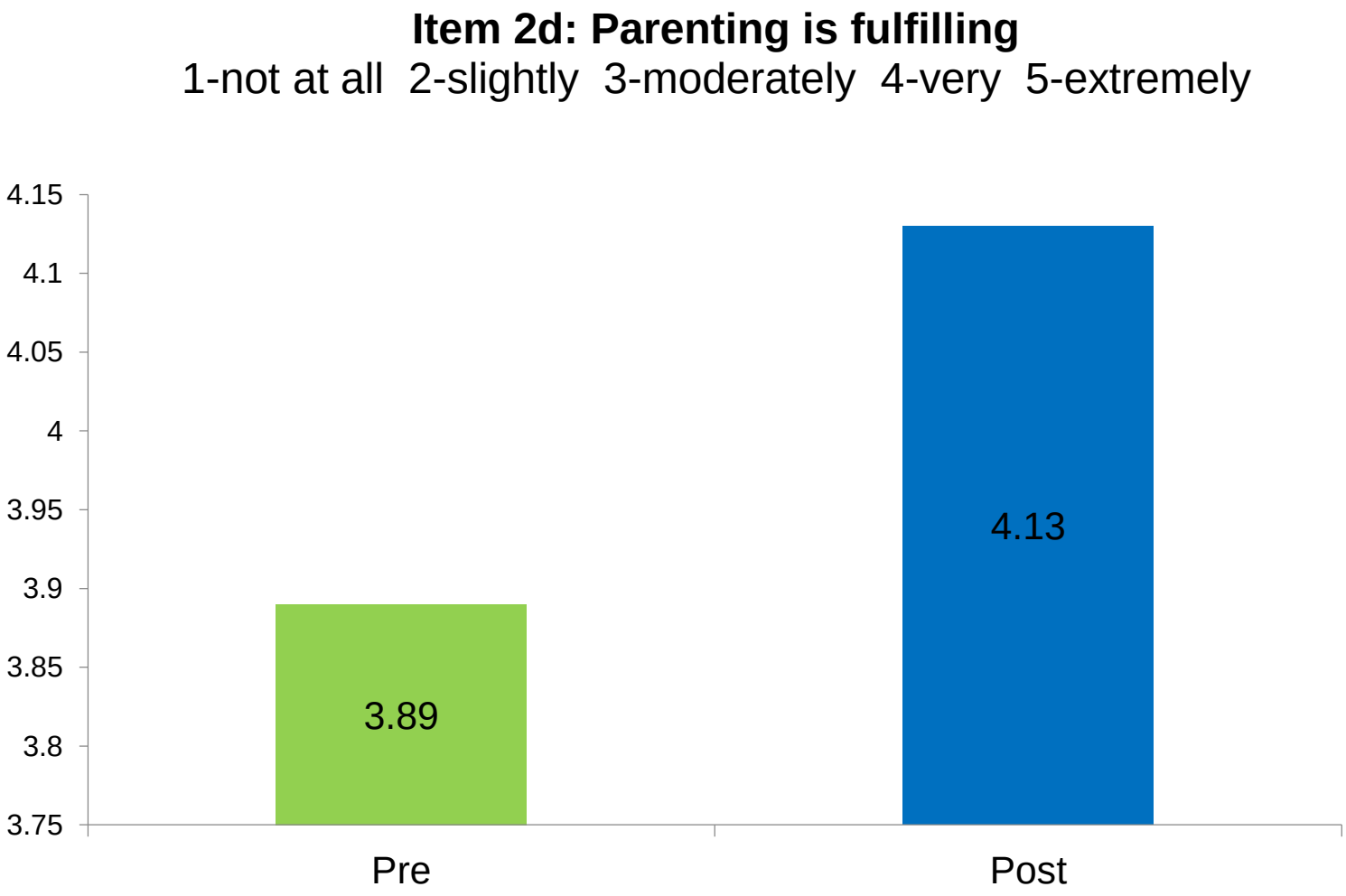
Parenting is less stressful

Data collected
Oct-Dec 2015



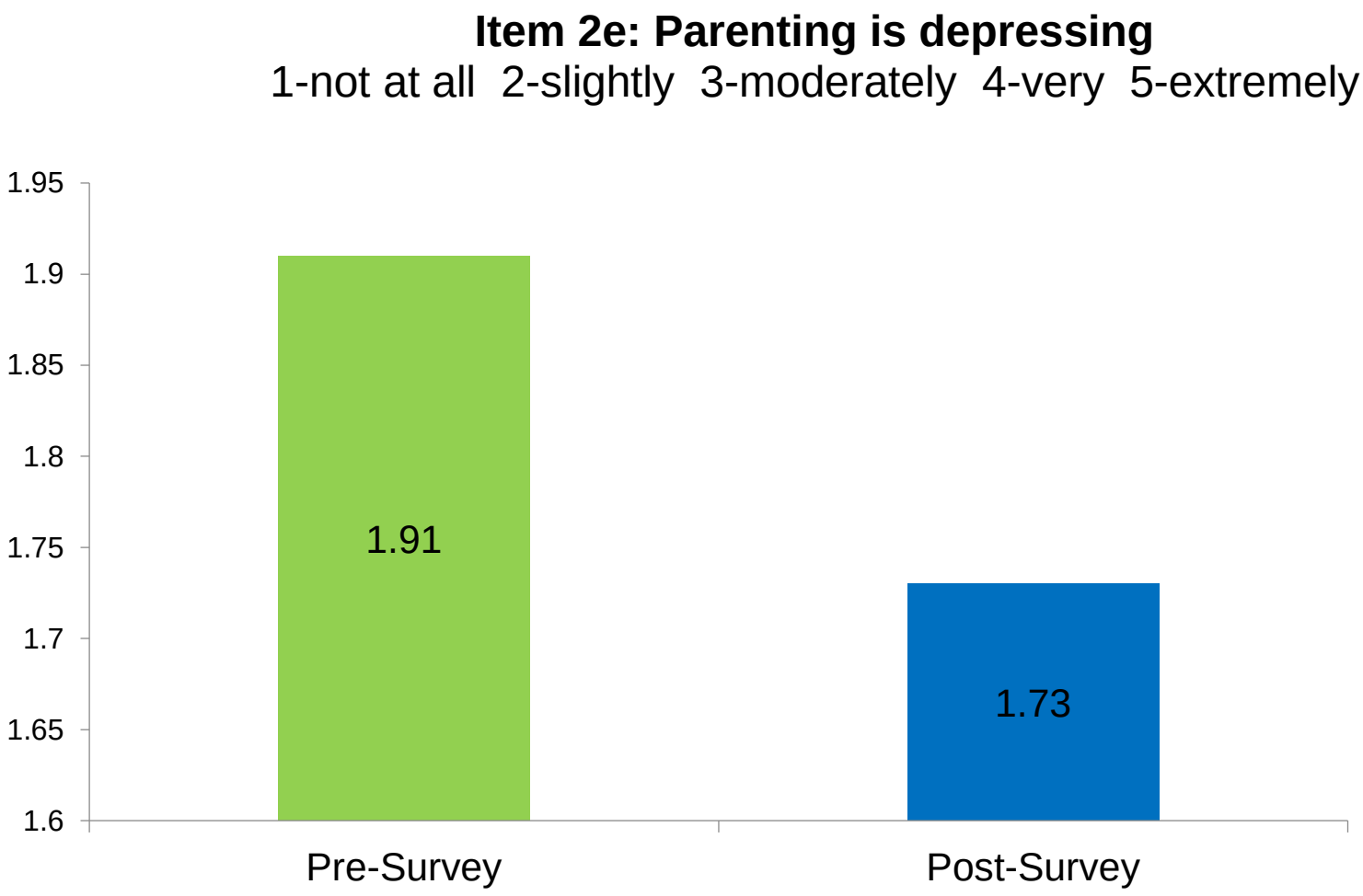
Parenting is more fulfilling

Data collected
Oct-Dec 2015



Parenting is less depressing

Data collected
Oct-Dec 2015

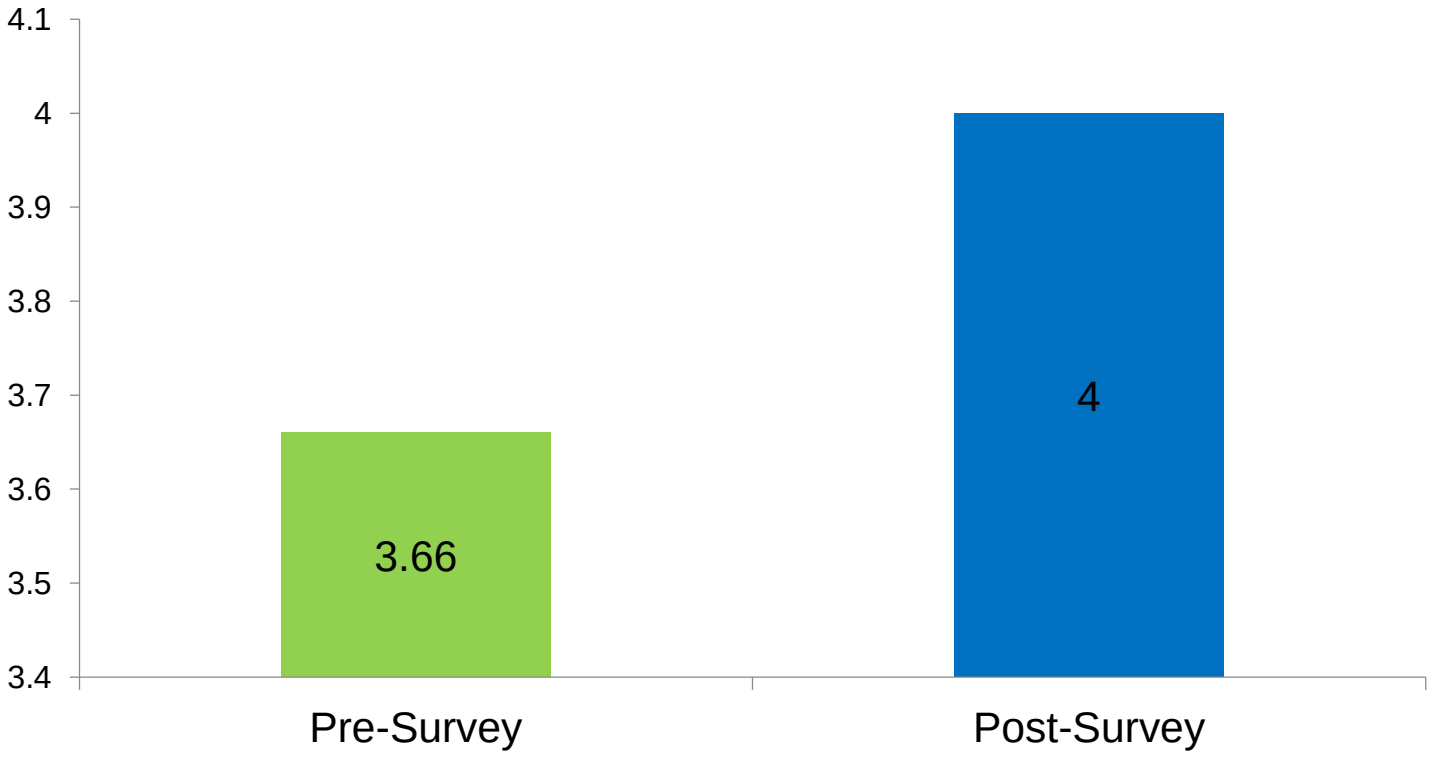


Parenting feels more confident

Data collected
Oct-Dec 2015

Item 3: In the last 6 weeks, how confident have you felt to undertake your responsibilities as a parent?

1-not at all 2-slightly 3-moderately 4-very 5-extremely

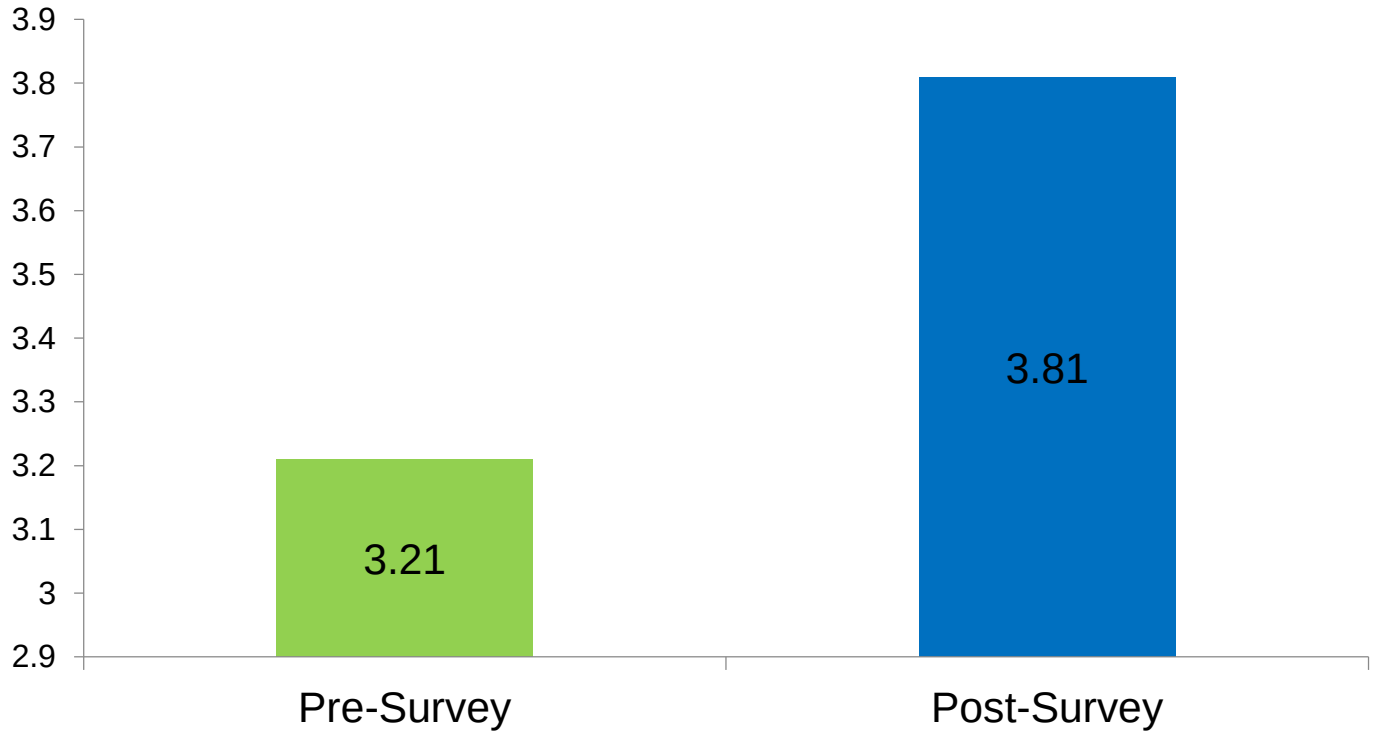


Parenting feels more supported

Data collected
Oct-Dec 2015

Item 4: How supported have you felt in your role as a parent over the last 6 weeks?

1-not at all 2-slightly 3-moderately 4-very 5-extremely



CLIENT SATISFACTION DATA

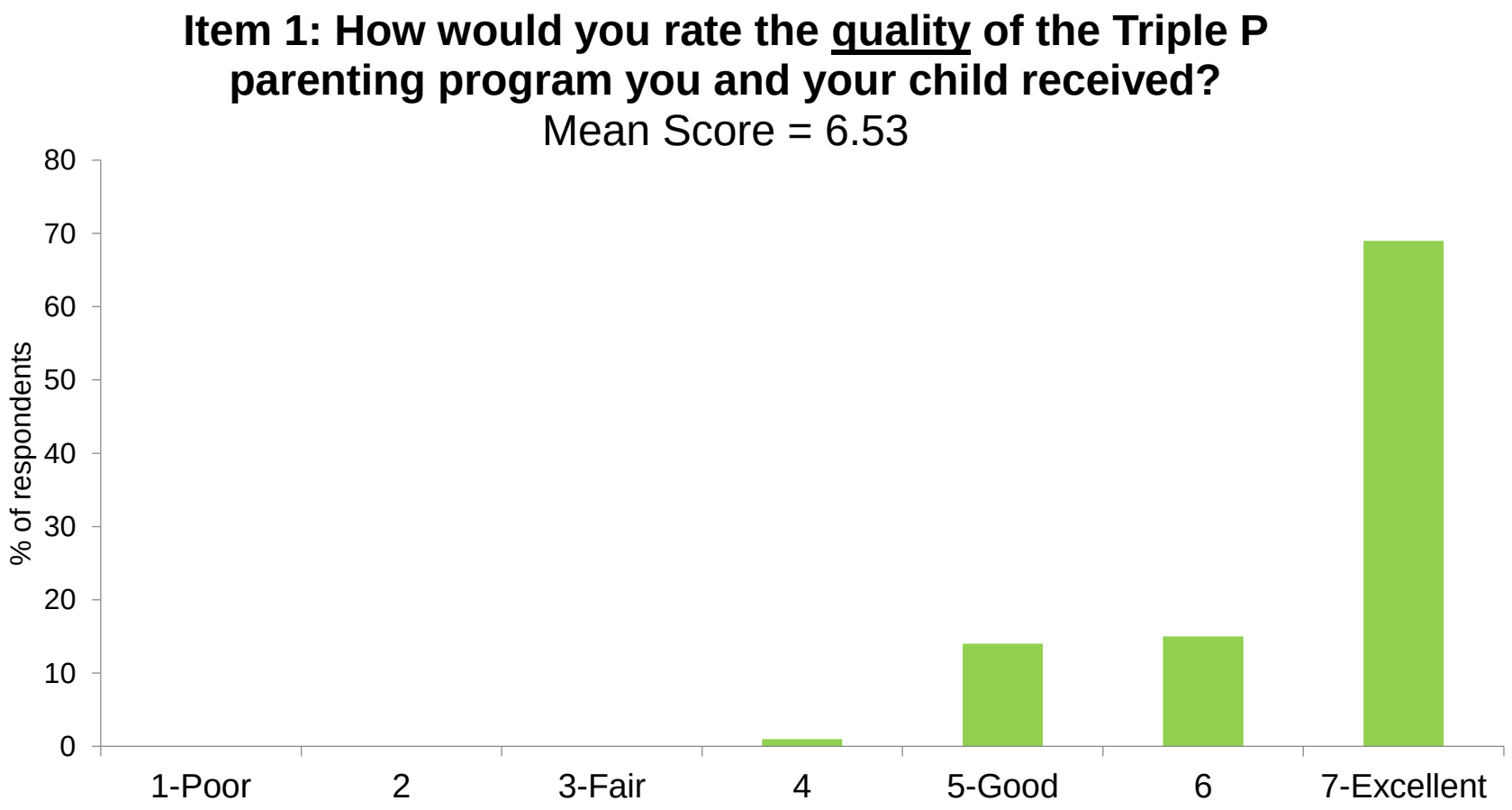
RESULTS SUMMARY for CSQ:

Parents indicate that after completing Triple P:

- The quality of Triple P is excellent
- Triple P helps parents more effectively deal with problem behavior
- Triple P helps parents more effectively deal with problems in family
- Parents would definitely return to Triple P in future
- Child's behavior is improved

Quality of program is excellent

Data collected
Oct-Dec 2015



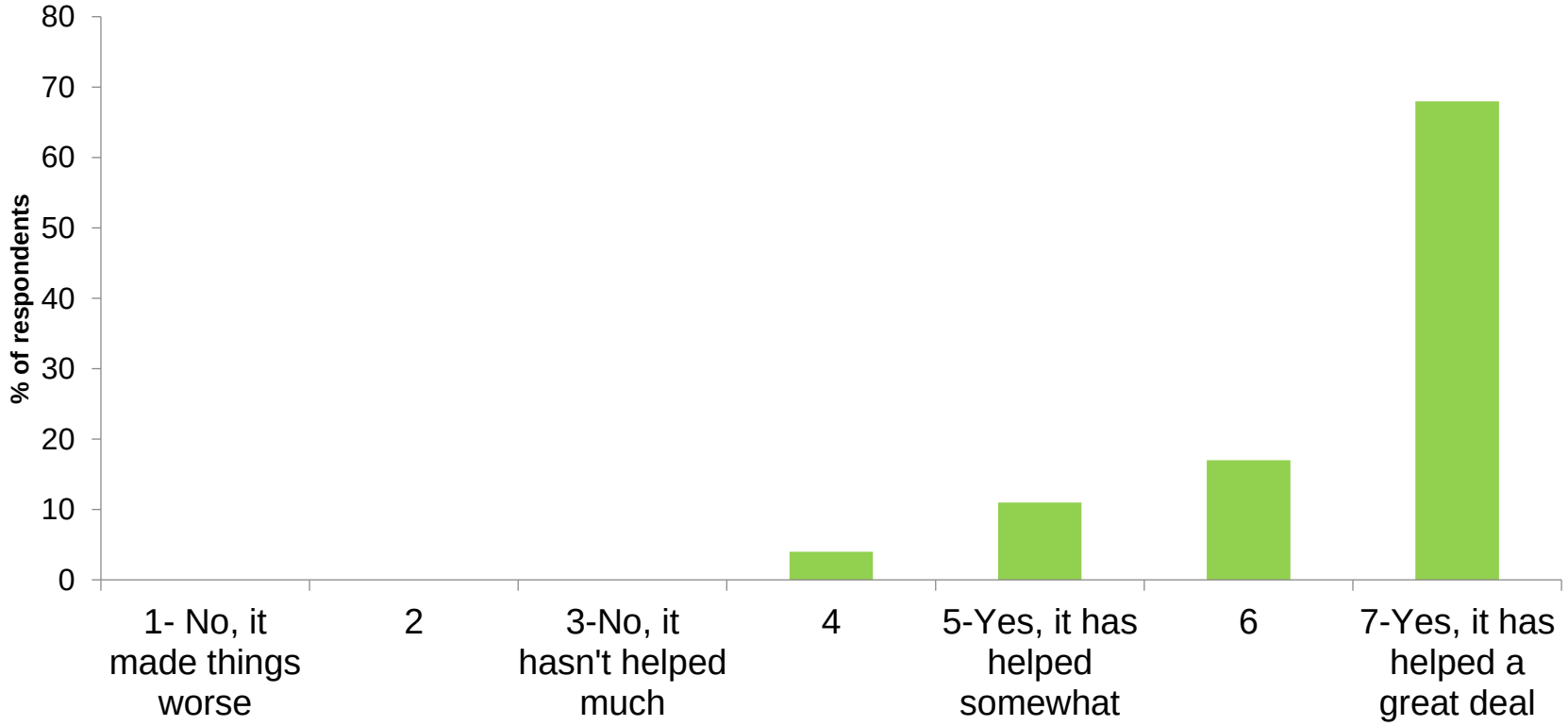
Client Satisfaction Questionnaire

Triple P helps deal with child behavior more effectively

Data collected
Oct-Dec 2015

Item 2: Has the Triple P parenting program helped you to deal more effectively with your child's behavior?

Mean Score = 6.49



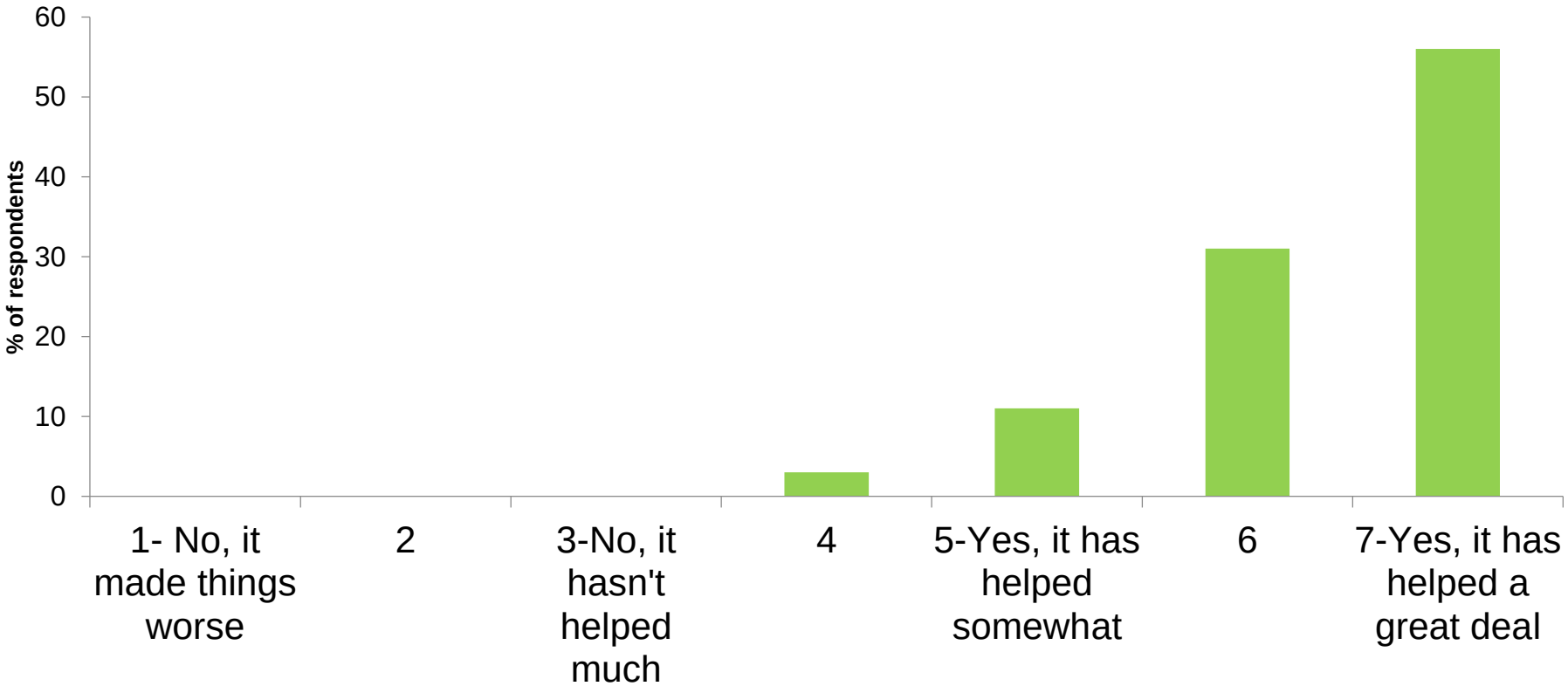
Client Satisfaction Questionnaire

Triple P helps deal with family problems more effectively

Data collected
Oct-Dec 2015

Item 3: Has the Triple P parenting program helped you to deal more effectively with problems that arise in your family?

Mean Score = 6.39



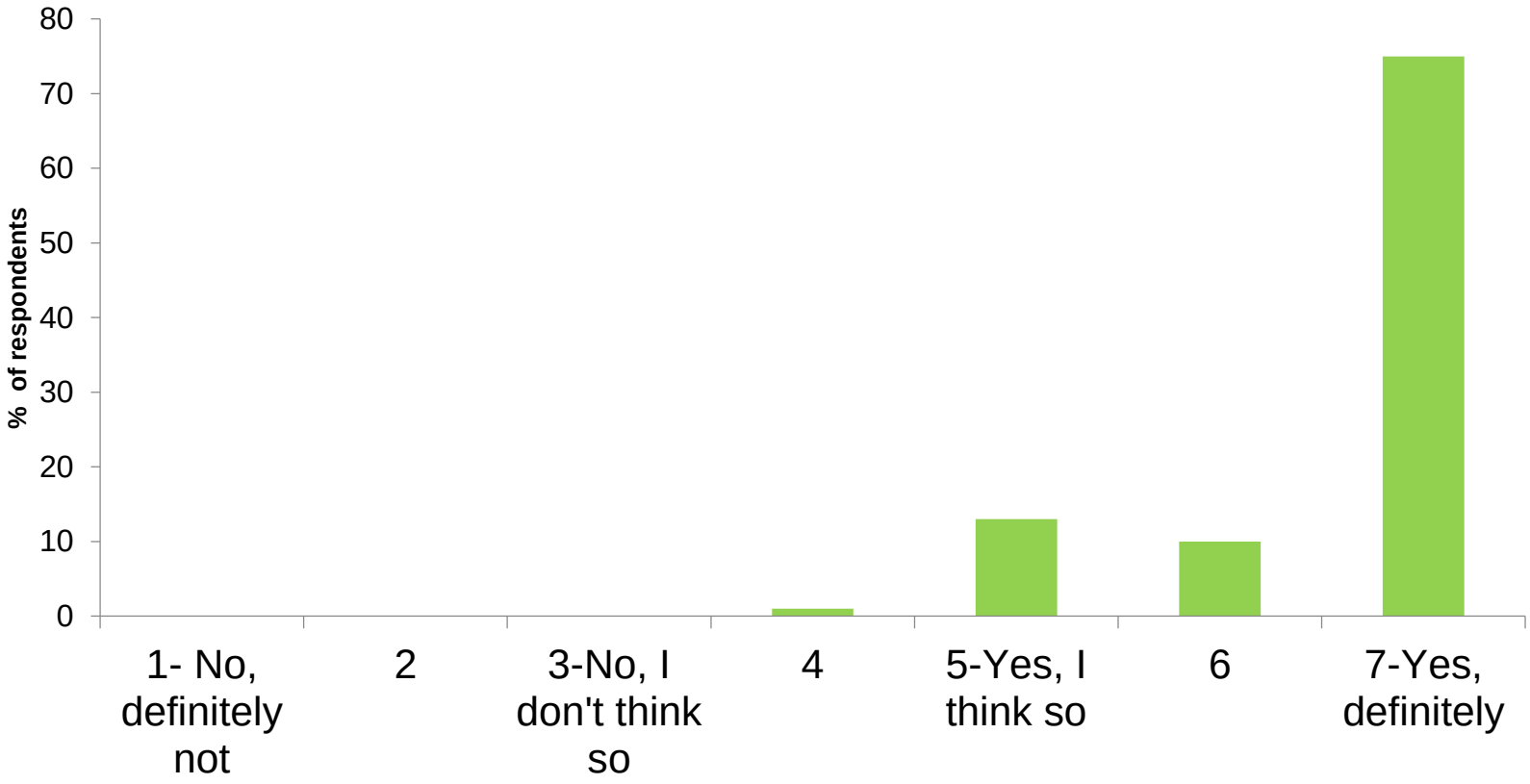
Client Satisfaction Questionnaire

Caregivers would definitely use Triple P again

Data collected
Oct-Dec 2015

Item 4: If you were to seek help again, would you come back to Triple P parenting program?

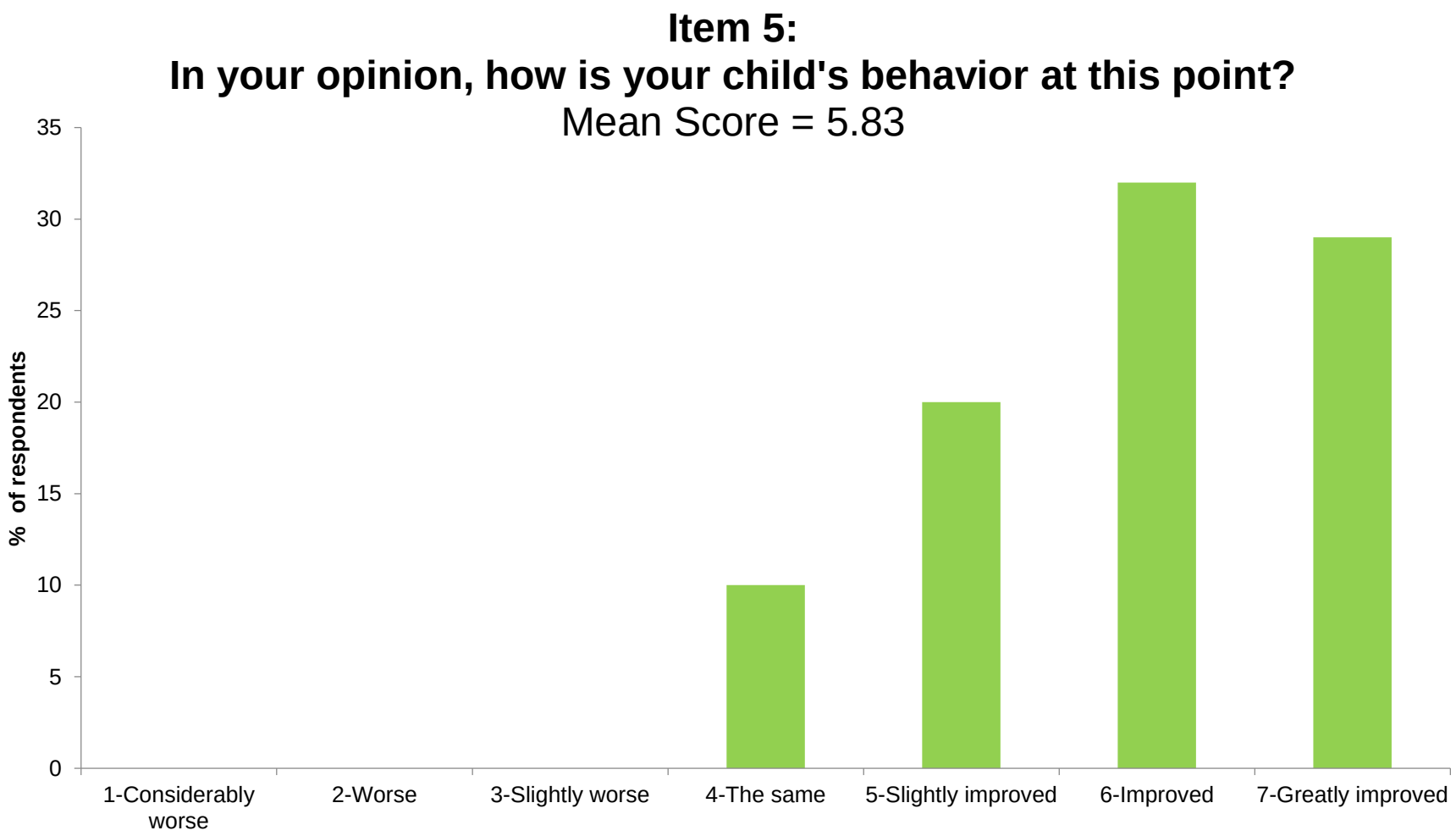
Mean Score = 6.61



Client Satisfaction Questionnaire

Parents note improvement in child behavior

Data collected
Oct-Dec 2015



Statistical analyses indicate statistically significant improvements in almost ALL indicators post intervention

- A paired t-test was run on SPSS to compare PRE and POST data for last 2.5 years (2013-2015)

- Parenting Experience Survey
  - Significant improvements in all 8 indicators
- Strength and Difficulties Questionnaire
  - Significant improvements in 5 out of 6 indicators
- Parenting Scale
  - Significant improvements in all 4 indicators

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for every parent



Cabarrus County

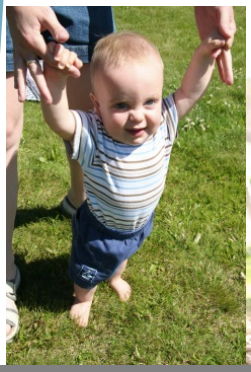
International Recognition



Cabarrus County staff have served as co-authors in the following presentations about the Triple P Cabarrus project at professional conferences worldwide since the beginning of the grant:

1. **Helping Families Change Conference 2014**: Sydney, Australia
2. **National Network of Public Health Institutes Annual Conference 2014**: New Orleans, LA
3. **Global Implementation Conference 2015**: Dublin, Ireland
4. **NACCHO Safe and Healthy Families Webinar 2015**: National Webinar on "Public Health Efforts to Prevent Child Maltreatment"
5. **American Public Health Association Conference 2015**: Chicago, IL

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Final Report & Recommendations

The Triple P Implementation Evaluation

Cabarrus and Mecklenburg Counties, NC

January 2016

Frank Porter Graham Child Development Institute
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL



UNC
FPG CHILD DEVELOPMENT INSTITUTE

THE DUKE ENDOWMENT

Acknowledgements & Disclosure

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Ron Prinz, Ph.D., is a paid consultant to Triple P International, which is the technology transfer entity commissioned by the University of Queensland to disseminate the Triple P system, and to the Centers for Disease Control and Prevention, which is involved in implementation/dissemination projects related to Triple P.

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Table of Contents

Executive Summary 3
Background 5
Purpose & Theoretical Foundations of the Triple P Implementation Evaluation 5
Participating County Characteristics 7
Evaluation Methods 8
County Implementation Capacity 8
Agency Implementation Infrastructure & Best Practices 11
Web-Based Triple P Practitioner Surveys 13
Professional Characteristics 13
Adherence to Triple P Session Content 13
Agency Implementation Climate 14
Data and Information Provided by County and State Evaluation Partners 14
Evaluation Results 14
County Implementation Capacity 14
Scope of the Triple P System of Interventions in Each County 15
Longitudinal PS-CCA-TP Results 17
Cabarrus County 17
Mecklenburg County 19
County Sustainability Planning 20
Agency Implementation Climate, Infrastructure, & Continuation 21
Agency Implementation Climate 21
Agency Implementation Infrastructure & Best Practices 23
Cabarrus County 23
Mecklenburg County 25
Agency Cohort Analyses 26
Agency Sustainability Planning 29
Predicting Continued Implementation of Triple P within Agencies 30
Practitioner Characteristics & Adherence 31
Practitioner Professional Characteristics 32
Practitioner Training Status 36
Practitioner Delivery of Triple P and Adherence to Session Content 36
Countywide Reach of Triple P Interventions & Family Wellbeing Indicators 40
Countywide Reach of Triple P Interventions 40
Countywide Family Wellbeing Indicators 40
Discussion and Recommendations 42
Recommendations 46
County-Level 47
County implementation capacity 47
County implementation policies and practices 47
Agency-Level 50
Agency implementation infrastructure 50
Agency implementation policies and practices 51
Other System Partners Supporting Triple P Scale-Up 52
References 53

Executive Summary

The purpose of the Triple P Implementation Evaluation project (TPIE), funded by The Duke Endowment, was to evaluate capacity and infrastructure for the *active* implementation of, and service delivery associated with, the Triple P system of interventions in two North Carolina counties to inform the planning process for impact and sustainability. Over a two-year period in Cabarrus and Mecklenburg counties, TPIE assessments targeted various levels of the Triple P delivery system, including county-level implementation capacity, agency implementation climate and infrastructure, practitioner adherence to intended Triple P session content, and the penetration of Triple P interventions within the county.

Longitudinal evaluation results suggest that each county had established a meaningful amount of county-level capacity to support the implementation and scale-up of Triple P, a diverse coalition of local agencies to deliver Triple P across multiple access points, a handful of strengths within agency infrastructure and best practices to support the growing number of practitioners to deliver Triple P, and in Cabarrus County, a promising reach of Triple P services into the county's population of children and families. Progress to date appears stronger on the organizational side of implementation (i.e., leadership and implementation teams at county and agency levels, county action planning and prevention system alignment, and organizational implementation drivers at county and agency levels) and in the development of infrastructure and best practices to support practitioner recruitment and selection and practitioner training in Triple P.

In addition to highlighting progress and achievements to date, TPIE evaluation results reveal gaps within county implementation capacity and agency implementation infrastructure that might be the target of future developmental efforts. For example, within each county, agency implementation infrastructure appeared to lag county implementation capacity. That is, just because a county had developed a county implementation team with the resources and abilities to work closely with local agencies did not ensure that agency implementation infrastructure and best practices were well in place across the county. This lag appeared greater in Mecklenburg County, where the county implementation team had historically lower capacity (particularly in terms of formally allocated time and effort), the county received substantially less state resources to support the scale-up of Triple P, and the county prevention system and population are much larger. The Mecklenburg County Triple P Coalition also evidenced higher rates of agency and practitioner attrition and lower rates of practitioners having yet delivered Triple P during the TPIE evaluation period, which also may have been associated with these factors.

Although agency implementation infrastructure and best practices showed slight signs of improvement over time across two cohorts of agencies in Mecklenburg County, overall, agency implementation infrastructure and practices did not show strong developmental gains across the evaluation period within either county. Though the reasons for this lack of development over time are unclear, agency leaders and implementation team members may benefit from more developmentally focused active implementation support from county implementation team members around building agency implementation infrastructure and best practices. Likewise, county implementation team members may need support from their purveyor – Triple P America – and other active implementation technical assistance providers to ensure they are well grounded in stage-based approaches to growing active implementation infrastructure and best practices to support Triple P.

TPIE evaluation results also suggest a need to increase agency implementation team capacity, both in terms of team membership numbers and in allocating formal time and effort to support

implementation. In fact, agency implementation capacity was positively associated with agencies' continuation of Triple P implementation across the two TPIE counties during the evaluation period. Increasing agency implementation team capacity may accelerate improvements related to the three organizational implementation drivers across agencies as well (decision-support data systems, facilitative administration, and systems intervention); agency leadership and implementation teams largely ensure best practices related to these organizational drivers.

Also positively associated with agency continuation of Triple P implementation across the evaluation period were the number of Triple P practitioners at the agency (only having one Triple P practitioner was associated with greater risk of agency discontinuation), having a favorable agency implementation climate for Triple P, and more formally developed agency sustainability plans to support the ongoing implementation of Triple P. Overall, both county and agency sustainability plans could benefit from additional development and documentation across both counties.

TPIE evaluation results clearly suggest that the two areas of greatest developmental need among county agencies are practitioner coaching and fidelity assessment infrastructure and best practices. Not only were best practices for practitioner coaching and fidelity assessment less in place at the agency-level, but county implementation teams also appeared to have fewer resources and abilities to work with local agencies to ensure such best practices. Addressing these two infrastructure gaps may be important not only to supporting county Triple P practitioners' delivery of Triple P interventions as intended, but also practitioners' use of Triple P interventions over time (Aarons, Fettes, Flores, & Sommerfeld, 2009; Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; Joyce & Showers, 2002). The support of staff from Triple P America and, potentially, Triple P researchers and program developers in the United States and abroad may be helpful to county Triple P coalitions in increasing the use of implementation best practices for coaching and for developing or acquiring practical, efficient, and multiple forms of fidelity assessments that can be used in the field.

Based on longitudinal evaluation results, TPIE evaluators offer a number of detailed recommendations for continuing to support scale-up of the Triple P system of interventions within and across Cabarrus and Mecklenburg counties. To support putting some or all of the recommendations into place, county leadership and implementation support staff will benefit from ongoing support from:

- their primary funder, the North Carolina Division of Public Health;
- their program purveyor, Triple P America; and
- local agency leadership and staff within agencies implementing Triple P.

In addition, they may benefit from the support of a full range of co-creation partners (e.g., Aldridge, Boothroyd, Fleming, Jarboe, Morrow, Ritchie, & Sebian, in press; Metz & Albers, 2014), including:

- Triple P researchers and developers in the United States and abroad;
- other local and state funders, including public agencies and private foundations (e.g., to diversify and sustain funding);
- local community partners, including youth and families being served by county Triple P services (e.g., to ensure ongoing cultural and community fit of Triple P interventions and implementation practices); and
- active implementation technical assistance providers (e.g., to increase county implementation team capacity to ensure the development of active implementation infrastructure and best practices across local agencies).

The purpose of the Triple P Implementation Evaluation project, funded by the Duke Endowment, was to evaluate capacity and infrastructure for the active implementation of, and service delivery associated with, the Triple P system of interventions in two North Carolina counties to inform planning for impact and sustainability.

Background

Purpose & Theoretical Foundations of the Triple P Implementation Evaluation

Over the past decade, the field of implementation science has shifted from passive approaches to supporting implementation, largely recognized as "diffusion" – or "letting it happen," and "dissemination" – or "helping it happen", to more active implementation strategies designed to "make it happen" (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004, p. 593). Implementation research has demonstrated that passive approaches to implementation are largely insufficient (e.g., Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Greenhalgh, et al., 2004; Joyce & Showers, 2002; Nutt, 2002; Wiltsey Stirman, Kimberly, Cook, Calloway, Castro, & Charns, 2012), whereas more active strategies hold promise for ensuring effective implementation and realization of intended benefits (e.g., Fixsen, Blase, Naoom, & Wallace, 2009; Fixsen, Blase, Timbers, & Wolf, 2001; Fixsen, et al., 2005; Joyce & Showers, 2002; Marzano, Waters, & McNulty, 2005; Meyers, Durlak, & Wandersman, 2012; Saldana & Chamberlain, 2012).

The purpose of the Triple P Implementation Evaluation project (TPIE), funded by The Duke Endowment, was to evaluate capacity and infrastructure for the *active* implementation of, and service delivery associated with, the Triple P system of interventions in two North Carolina counties to inform the planning process for impact and sustainability. Specifically, within Cabarrus and Mecklenburg counties, TPIE assessments targeted various levels of the Triple P delivery system, including county-level implementation capacity, agency implementation climate and infrastructure, practitioner adherence to intended Triple P session content, and the penetration of Triple P interventions within the county. Although not a primary focus of the current evaluation, TPIE evaluators also obtained and reviewed early longitudinal county data regarding child maltreatment rates and foster care placement rates in Cabarrus and Mecklenburg counties to inspect emerging trends possibly related to intervention impact. Altogether, these system levels form a cascading logic model of support (e.g., Metz & Bartley, 2012) from county implementation support staff through agency implementation supports to practitioners and, eventually, to parents and families (see Figure 1).

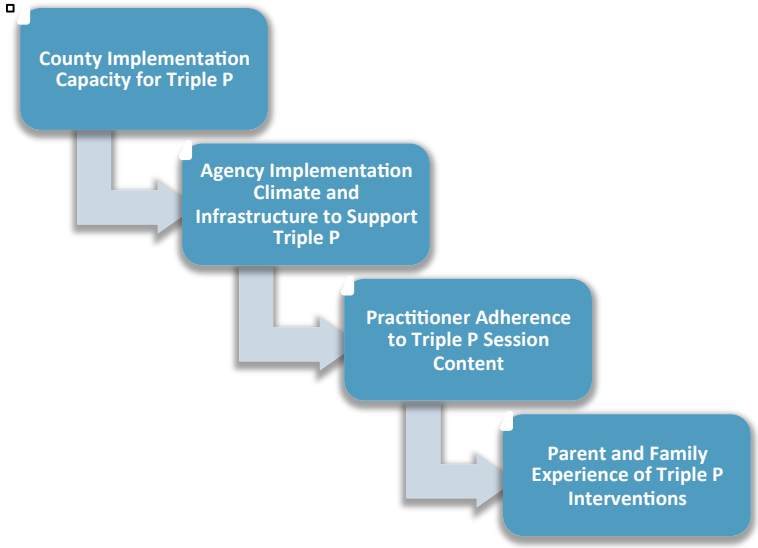


Figure 1. TPIE cascading logic model of implementation support.

The top level of the cascading logic model for the TPIE project was county implementation capacity. "Capacity" refers to a "set of abilities and resources to support a level of desired performance – whether by an individual or an organization of any size" (US AID and MEASURE Evaluation, 2012, slide 3). Implementation scientists and researchers generally agree that the capacity of county, regional, and state leadership and implementation teams to coordinate, manage, and support the implementation of interventions in local service agencies plays an important role in the viability, success, and sustainability of evidence-based practice scale-up (e.g., Fixsen, Blase, Metz, & Van Dyke, 2013; Hawkins, Catalano, & Arthur, 2002; Metz & Bartley, 2012; Rhoades, Bumbarger, & Moore, 2012; Wandersman, Duffy, Flaspohler, Nonnan, Lubell, Stillman, et al., 2008). Although of contextual interest, assessment of state implementation capacity for Triple P was outside the scope of the TPIE project.

Strong county implementation capacity is critical to support the next system level down, where local agencies must develop or acquire through partnerships the necessary implementation infrastructure to support practitioners' delivery of chosen interventions as intended. Fixsen and colleagues (2009) identified widely recognized active implementation infrastructure and best practices, or "drivers", that are necessary within service agencies to support practitioners' delivery of chosen interventions as intended (for an updated discussion of implementation drivers, see Metz & Bartley, 2012). Metz and colleagues (2014), in an evaluation of the implementation of an innovative practice model in a county child welfare system, observed that the presence of implementation drivers may be associated with the delivery of the practice model as intended (i.e., high fidelity). Metz and Albers (2014) note that building visible implementation infrastructure often requires close, stage-based collaboration among implementing sites, intervention developers and purveyors, and funders and policy-makers.

Also within the agency level of the prevention system, an important precursor to ensuring the presence, quality, and sustainability of implementation drivers is agency leaders' support for, and prioritization of, adopted interventions. Without support from agency leadership, the implementation of chosen interventions is unlikely to be successful or sustainable (e.g., Damanpour, 1991; Glisson & James, 2002; Klein & Sorra, 1996; Panzano, Seffrin, Chaney-Jones, Roth, Crane-Ross, Massatti, et al., 2004). Klein, Conn, and Sorra (2001) demonstrated that organizational implementation climate, as rated by organizational staff, was a key marker of organizational leadership support for, and prioritization of, implementing chosen innovations.

At the delivery end of the cascading logic model are practitioners' adherence to intended Triple P session content and family experience of Triple P interventions. The delivery of core *intervention* components as intended (i.e., with fidelity) and penetration of interventions into the target population are critical benchmarks for establishing confidence that intended child and family outcomes will be realized at scale (e.g., Blase & Fixsen, 2013; Chamberlain, 2003; Eames, Daley, Hutchings, Whitaker, Jones, Hughes, et al., 2009; Fixsen, et al., 2005; Forgatch, Patterson, & DeGarmo, 2005; Mihalic, 2004; Schoenwald, Sheidow, & Letourneau, 2004). Practitioner adherence to intended session content is a key component of intervention fidelity and may not only help determine whether anticipated outcomes can be expected, but also whether infrastructure and practices supporting practitioners' delivery of adopted interventions need to be strengthened (Mihalic, 2004; Blase & Fixsen, 2013).

This cascading logic model of implementation support, from county implementation support staff through agency implementation supports to practitioners and, eventually, to parents and families,

provided the framework through which TPIE evaluators examined Cabarrus and Mecklenburg county Triple P implementation supports for success and sustainability.

Participating County Characteristics

Cabarrus County (the yellow county in Figure 2) and Mecklenburg County (the blue county in Figure 2) are jointly located in the Piedmont region of North Carolina on and just north of the border with South Carolina. These two counties were selected for the Triple P Implementation Evaluation (TPIE) in consultation with the North Carolina Division of Public Health (NC DPH) and Triple P America. Selection criteria for being involved in TPIE included having an operational county coalition to oversee the scale-up of Triple P, having established a county Triple P coordinator, and having demonstrated responsiveness to state partners assisting with the scale-up of Triple P (e.g., Triple P America and NC DPH). A third county was initially approached for involvement in TPIE, though declined because the county Triple P coordinator had only recently been hired and because that county Triple P coalition reported to a local foundation not in partnership with the TPIE project. County agreements to participate in TPIE were made following informational phone calls between TPIE evaluators and county implementation support staff.

Cabarrus County, home to the cities of Kannapolis and Concord, offers a mix of urban and rural settings with an estimated population of 192,103 (U.S. Census Bureau, 2015a). The Cabarrus County Triple P Coalition was a member of the first cohort of counties to begin scaling-up the Triple P system of interventions in 2012 with funding from NC DPH. Cabarrus County was initially awarded $325,581 per year for three years to scale-up Triple P, with a fourth year later awarded at the same amount. Given Cabarrus' estimated population of youth under 18 (50,331; U.S. Census Bureau, 2015a), this translates into approximately **$6.47 per youth**.

Mecklenburg County, home to North Carolina's largest city – Charlotte, is North Carolina's largest county with an estimated population of 1,012,539 (U.S. Census Bureau, 2015b). The Mecklenburg County Triple P Coalition was a member of the *second* cohort of counties to begin scaling-up the Triple P system of interventions in 2013 with funding from NC DPH. Though Mecklenburg County was also initially awarded $325,581 per year for three years to scale-up Triple P, state budget changes and resulting fiscal decisions resulted in an actual award of $147,000 per year for three years. Given Mecklenburg's estimated population of youth under 18 (249,085; U.S. Census Bureau, 2015b), this translates into approximately **$0.59 per youth**, a substantially smaller amount than in Cabarrus County.

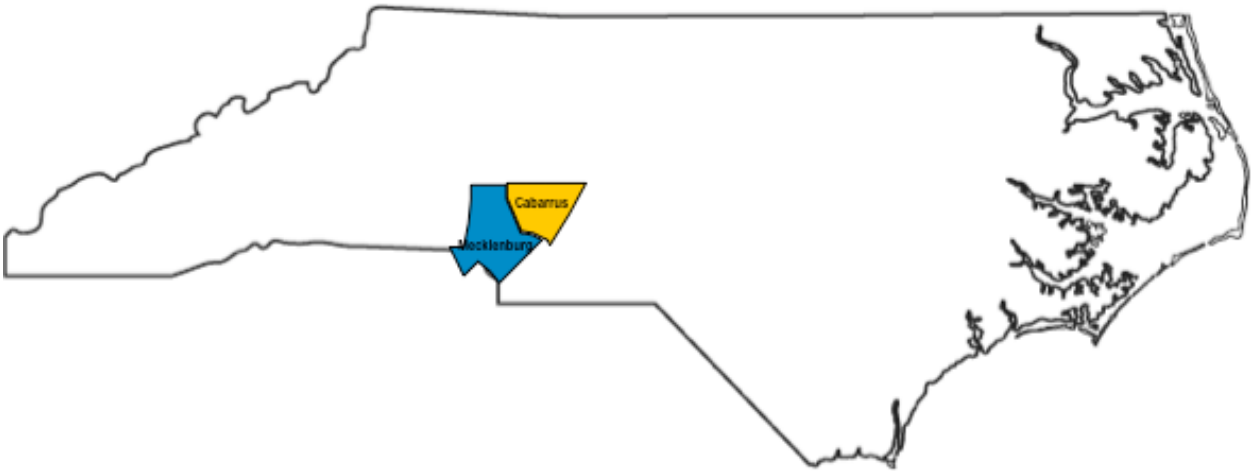


Figure 2. Location of Cabarrus (yellow) and Mecklenburg (blue) counties, North Carolina.

The county Triple P coalitions in both Mecklenburg and Cabarrus were led by each county's department of public health and involved a wide range of public and private organizations serving families with children and youth ages birth through 17. Each county Triple P coalition was an active participant in the North Carolina State Triple P Learning Collaborative during TPIE. The state learning collaborative met quarterly, bringing together key implementation support staff from Triple P counties across North Carolina, Triple P implementation consultants and program staff from Triple P America, and state funders. In addition to receiving program updates, professional support, and peer-support through the state learning collaborative, both Cabarrus and Mecklenburg counties received direct implementation support from implementation consultants associated with Triple P America during TPIE.

At the beginning of the project, TPIE evaluators and Triple P America implementation consultants agreed to not actively discuss emerging findings and recommendations from the evaluation, though semi-annual TPIE reports for each county were available to implementation consultants through each county Triple P coordinator. Likewise, TPIE evaluators agreed to refrain from providing any active implementation support directly to participating counties during the project, though county Triple P coordinators did receive a copy of semi-annual TPIE interim reports with county-specific data and findings that they could review and share at their discretion. While *county* implementation support staff regularly reported that they reviewed and made action plans based on these semi-annual reports (e.g., plans to strengthen fidelity assessment infrastructure, sustain Triple P services), the overwhelming majority of implementation support staff *within local service agencies* delivering Triple P did not. Therefore, we believe our assessments reflect a relatively unbiased picture of the natural implementation and scale-up of Triple P during the two-year evaluation period.

Evaluation Methods

The TPIE project ran from January 2014 through December 2015 with semi-annual assessments related to the project's primary aims in the spring and fall of each year. In the early stages of the project, TPIE evaluators recognized a need to further develop and tailor county implementation capacity and agency implementation infrastructure assessments to provide more valid and reliable data than was originally possible through the adoption and revision of existing instruments. Thus, TPIE county and agency implementation assessment instruments evolved across the two years of the project, with the largest evolution occurring between the Time 1 (spring 2014) and Time 2 (fall 2014) assessment periods. Due to the significant changes between Time 1 and Time 2 county and agency implementation assessments, data from Time 1 assessments were not comparable with later data and are thus excluded from this final report. For the interested reader, Time 1 county and agency implementation assessments and related findings are discussed in the first set of interim reports that emerged from the TPIE project (Aldridge, Boothroyd, Prinz, & Naoom, 2014a; Aldridge, Boothroyd, Prinz, & Naoom, 2014b).

County and agency implementation assessments used across Time 2 (fall 2014), Time 3 (spring 2015), and Time 4 (fall 2015) and other project evaluation methods used across all four assessment points are described below.

County Implementation Capacity

The ***Prevention System County Capacity Assessment for the Triple P System of Interventions*** **(PS-CCA-TP)** was developed by TPIE evaluators to provide an assessment of key abilities and related resources in counties implementing the Triple P system of interventions. The PS-CCA-TP was adapted from previous

assessment protocols used to measure the capacity of counties or school districts to effectively support the implementation and scaling of evidence-based interventions (i.e., Duda, Ingram-West, Tadesco, Putnam, Buenerostro, Chaparro, & Horner, 2012; Van Dyke, Fleming, Duda, Ingram-West, Tadesco, Putnam, et al., 2012). The PS-CCA-TP was heavily revised at Time 2 and then refined at Time 3 and Time 4 based on experience facilitating the assessment with county implementation support staff and existing theories of implementation infrastructure and best practice (e.g., Blase, Van Dyke, & Fixsen, 2013; Fixsen, Blase, Naoom, & Wallace, 2009; Metz & Bartley, 2012). Adjustments included clarified item language, simplified scales, and further alignment with identified implementation best practices (i.e., Blase, Van Dyke, & Fixsen, 2013). However, psychometric examination indicated that the measure yielded comparable data across the three time points presented, with very few exceptions.

The PS-CCA-TP is a facilitated group self-assessment. Intended participants include:

(1) county leaders with executive authority related to the scale-up of Triple P in the county;
(2) county-level staff who manage and support the day-to-day implementation and scale-up of Triple P interventions across the county;
(3) if applicable, county-level staff who are involved in identifying or selecting local agency practitioners to be trained in Triple P interventions;
(4) county-level staff who are coordinating or facilitating access to Triple P trainings;
(5) county-level staff who are coordinating or facilitating access to coaching supports for Triple P practitioners after Triple P training; and
(6) county-level staff who are involved in collecting or managing data relative to the implementation and scale-up of Triple P.

Some counties have more or fewer staff that participate in the PS-CCA-TP.

The PS-CCA-TP, as delivered at Time 4, includes 104 items across 11 scales related to county implementation support teams (County Leadership Team and County Implementation Team), the county's alignment of their prevention system to respond to parent and family needs with interventions from the Triple P system (Prevention System Alignment), the ability of the county to develop and carry out action plans to support the implementation and scaling of Triple P (Action Planning), and the ability of the county to support the development of core implementation infrastructure and best practices across local agencies implementing Triple P interventions (Recruitment & Selection, Training, Coaching, Fidelity Assessment, Decision-Support Data System, Facilitative Administration, and Systems Intervention). All PS-CCA-TP scale definitions are listed in Table 1.

During administration of the PS-CCA-TP, participants individually rate, and then come to group consensus on, each item using a three point scale, with "0" indicating "no activities or elements of this item are in place and/or these activities or elements have not yet been initiated," "1" indicating "some activities or elements of this item are in place and/or initiated," and "2" indicating "all activities or elements of the item are adhered to and there is clear evidence to support this." An example item in the County Implementation Team scale is, "there is a clearly identified County Implementation Team, consisting of three or more individuals, that is responsible for coordinating and supporting day-to-day Triple P implementation and scale-up activities across the county." An example Implementation Drivers item (from the Recruitment & Selection scale) is, "the County Implementation Team ensures that individuals making Triple P practitioner selection decisions have sufficient understanding of the key principles, skills, and abilities required to effectively deliver Triple P." Summing ratings for items in each

PS-CCA-TP Scale Definitions	
Scale	**Definition**
County Leadership Team	The county has formally and sustainably organized a leadership team from within the countywide prevention system that has the commitment and authority to lead Triple P scale-up across the county.
County Implementation Team	The county has formally and sustainably organized a team of three or more individuals, led by one or two identified leaders, that has the ability and capacity to coordinate and support day-to-day Triple P scale-up activities across the county.
Prevention System Alignment	The county has systematically assessed the wellbeing needs of children and families within the county and selects and aligns Triple P interventions responsively. In addition, the county has systematically assessed the strengths and needs of the countywide prevention system related to the scale-up of Triple P and selects and aligns agency partners responsively.
Action Planning	The county regularly obtains data and information about the ongoing implementation of Triple P across agencies and develops, updates, and carries out responsive action plans to advance implementation and scale-up efforts.
Recruitment & Selection	The county works closely with local service agencies to ensure the use of best practices for Triple P practitioner recruitment and selection.
Training	The county works closely with local agencies and Triple P America to ensure the use of best practices for training Triple P practitioners to deliver Triple P to the county's population.
Coaching	The county works closely with local agencies to ensure the use of best practices for coaching Triple P practitioners after their accreditation and as they deliver Triple P to children and families.
Fidelity Assessment	The county works closely with local agencies to ensure the use of best practices for assessing whether or not core Triple P components are delivered as intended by Triple P practitioners to children and families.
Decision-Support Data System	The county works closely with local agencies to use best practices to gather, use, and share implementation and intervention data for decision-making to improve the implementation of Triple P across the county.
Facilitative Administration	The county uses best practices to solicit, document, and use information about Coalition and agency policy and practice facilitators and barriers to improve the implementation of Triple P across the county.
Systems Intervention	The county works closely with local agencies and other key partners to solicit, document, and use information about Triple P successes and larger systems needs to improve and sustain the implementation and scale-up of Triple P across the county. Additionally, the county facilitates key Triple P system activities, including the Triple P Stay Positive media campaign and county referral networks.

Table 1. PS-CCA-TP scale definitions.

scale and dividing by the total points possible generates raw scale scores. A raw composite score is also calculated using all items in the instrument. Raw scores are then converted to percentage scores, allowing the results to be interpreted as *the percent to which capacity is in place*.

Across all TPIE assessment time points, PS-CCA-TPs were conducted on-site with county implementation support staff.

Agency Implementation Infrastructure & Best Practices

To assess the presence of active implementation infrastructure and best practices among local agencies to support the intended delivery of Triple P interventions, TPIE evaluators developed for Time 2 the ***Implementation Drivers Assessment for Agencies Implementing Triple P Interventions (IDA-TP)***. TPIE evaluators relied heavily on previously established implementation drivers assessments and technical assistance tools for the development of IDA-TP items and scales (i.e., Aldridge, Naoom, Boothroyd, & Prinz, 2014; Blase, Van Dyke, Duda, & Fixsen, 2011; Blase, Van Dyke, & Fixsen, 2013; Ogden, Bjørnebekk, Kjøbli, Patras, Christiansen, Taraldsen, et al., 2012; Van Dyke, Blase, Sims, & Fixsen, 2013). At Time 3 and Time 4, the IDA-TP was refined based on available reliability data, experience facilitating the assessment with agency implementation support staff, and existing frameworks of implementation infrastructure and best practices (e.g., Blase, Van Dyke, & Fixsen, 2013; Fixsen et al., 2009; Metz & Bartley, 2012). These later adjustments included clarified item language and further alignment with identified implementation best practices (i.e., Blase, Van Dyke, & Fixsen, 2013). With very few exceptions, these adjustments did not interfere with the comparability of data across these three time points.

The IDA-TP is a facilitated group self-assessment. Intended participants include:

(1) agency leaders with executive authority related to the implementation of Triple P interventions in the agency,
(2) agency staff who coordinate and manage day-to-day implementation support for Triple P interventions in the agency,
(3) agency staff who are involved in identifying or selecting agency practitioners to be trained in Triple P interventions,
(4) agency staff who are coordinating or facilitating agency practitioners' participation in Triple P trainings,
(5) agency staff who are providing or facilitating agency Triple P practitioners' participation in coaching after Triple P training, and
(6) agency staff who are involved in collecting or managing data relative to the delivery of Triple P interventions.

Some agencies have more or fewer staff that participate in the group interview. Triple P practitioners who focus solely on delivering Triple P interventions and who are not involved in any of the roles described above are usually not respondents for the IDA-TP.

The IDA-TP, as delivered at Time 4, includes 83 items across an Agency Implementation Capacity scale and seven Implementation Drivers scales (Recruitment & Selection, Training, Coaching, Fidelity Assessment, Decision-Support Data Systems, Facilitative Administration, and Systems Intervention). Agency Implementation Capacity items are designed to assess the resources and abilities within agencies to use active implementation strategies to support Triple P interventions. Implementation Drivers items are designed to assess the presence and quality of active implementation infrastructure and best practices to support the delivery of Triple P interventions as intended within local service agencies. IDA-TP scale definitions are listed in Table 2.

With the support of a trained TPIE facilitator, IDA-TP participants individually rate, and then come to group consensus on, each item using a three-point scale, with "0" indicating "no activities or elements of

IDA-TP Scale Definitions	
Scale	**Definition**
Agency Implementation Capacity	The agency has formally and sustainably organized and aligned leadership and team-based staff support with the authority, capacity, and abilities to coordinate and support day-to-day Triple P implementation activities within the agency.
Recruitment & Selection	The agency uses best practices for the recruitment and/or selection of practitioners to deliver Triple P to the agency's target population.
Training	The agency uses best practices for training Triple P practitioners to deliver Triple P to the agency's target population.
Coaching	The agency uses best practices for coaching Triple P practitioners as they deliver Triple P interventions to children and families.
Fidelity Assessment	The agency uses best practices for assessing whether or not core Triple P components are delivered as intended by Triple P practitioners to children and families.
Decision-Support Data System	The agency uses best practices to gather, use, and share implementation and intervention data for decision-making to improve the implementation of Triple P within the agency.
Facilitative Administration	The agency uses best practices to solicit, document, and use information about agency policy and practice facilitators and barriers to improve the implementation of Triple P within the agency.
Systems Intervention	The agency uses best practices to solicit, document, and use information about Triple P successes and larger systems needs to improve and sustain the implementation of Triple P within the agency. Additionally, the agency participates in key Triple P system activities, including the Triple P Stay Positive media campaign and county referral networks.

Table 2. IDA-TP scale definitions.

this item are in place and/or these activities or elements have not yet been initiated," "1" indicating "some activities or elements of this item are in place and/or initiated," and "2" indicating "all activities or elements of the item are adhered to and there is clear evidence to support this." An example item in the Agency Implementation Capacity scale is, "the agency has clearly identified an Agency Implementation Team, consisting of three or more individuals, that is responsible for coordinating and supporting the day-to-day implementation of Triple P." An example Implementation Drivers item (from the Recruitment & Selection scale) is, "individuals who are making Triple P practitioner selection decisions have sufficient understanding of the key principles, skills, and abilities required to effectively deliver Triple P." Summing ratings for items in each scale and dividing by the total points possible generates raw *scale scores*. A raw *Implementation Drivers Composite score* (incorporating items across the seven implementation drivers scales) is also calculated. Raw scores are then converted to percentage scores, allowing results to be interpreted as *the percent to which implementation infrastructure and best practices are in place*.

Across TPIE assessments, IDA-TPs were generally conducted on-site with agency leaders and implementation support staff, though phone assessments were occasionally conducted when on-site meetings were not possible. In such cases when an agency supplied only one respondent for the IDA-TP, TPIE facilitators and the respondent either determined that the individual had sufficient knowledge of the agency's Triple P implementation infrastructure and practices to reliably complete the assessment,

or the TPIE facilitator followed-up with other agency staff to incorporate additional needed perspectives.

At Time 4, internal consistency for the **Implementation Drivers Composite** scale in both the Cabarrus and Mecklenburg samples was strong (Cabarrus α = 0.96, Mecklenburg α = 0.96). Where enough score variability was present to test internal consistency among IDA-TP scales, internal consistency was good to strong (**Agency Implementation Capacity** – Cabarrus α = 0.83, Mecklenburg α = 0.84; **Recruitment & Selection** – Mecklenburg α = 0.75; **Coaching** – Cabarrus α = 0.77, Mecklenburg α = 0.76; **Fidelity Assessment** – Cabarrus α = 0.92, Mecklenburg α = 0.89; **Decision-Support Data System** – Cabarrus α = 0.81, Mecklenburg α = 0.88; **Facilitative Administration** – Cabarrus α = 0.91, Mecklenburg α = 0.91; and **Systems Intervention** – Cabarrus α = 0.88, Mecklenburg α = 0.81). Sample variance was insufficient in the Cabarrus Time 4 sample to test internal consistency for the Recruitment & Selection scale (*m* = 86%, *sd* = 12%) and in both county Time 4 samples to test internal consistency for the **Training** subscale (Cabarrus *m* = 96%, *sd* = 6%, Mecklenburg *m* = 91%, *sd* = 10%). Internal consistency among IDA-TP scales for county samples at Time 2 and Time 3 assessments are reported in prior TPIE interim reports (Aldridge, Murray, & Prinz, 2014; Aldridge, Murray, Prinz, & McManus, 2014; Aldridge, Murray, Prinz, & McManus, 2015a; Aldridge, Murray, Prinz, & McManus, 2015b).

Web-Based Triple P Practitioner Surveys

Semi-annual web-based Triple P practitioner surveys were sent to active Triple P practitioners in each county at roughly the same time that TPIE evaluators were conducting on-site county and agency implementation assessments. At Time 1, the TPIE project manager emailed tailored links to active county Triple P practitioners using contact information provided by implementation support staff in Cabarrus and Mecklenburg counties. At Times 2, 3, and 4, each County Triple P Coordinator embedded, on behalf of the TPIE project, a general link to the TPIE Triple P practitioner survey within a regular quarterly data collection email being sent by county implementation support staff to county Triple P practitioners. This shift in administration protocol was made at Time 2 to reduce the amount of emails county Triple P practitioners were getting in relation to their Triple P activities and responsibilities.

Practitioner surveys included three sections: practitioner professional characteristics, adherence to Triple P session content, and agency implementation climate.

Professional Characteristics

Several items were included in the practitioner survey related to practitioner professional characteristics, including county and agency affiliation, professional affiliation, number of years practicing child and family services, number of years working at current agency, and participation in county Triple P trainings and Triple P accreditations.

Adherence to Triple P Session Content

Triple P presently makes available to trained practitioners, and encourages the use of, "session checklists" for tracking adherence to intended session content for Triple P interventions. These tools provide a standardized way for Triple P practitioners and agencies implementing Triple P to assess whether Triple P content is being delivered as intended within and across Triple P intervention sessions.

As part of TPIE's online practitioner survey, county Triple P practitioners were asked to report which Triple P session, from which Triple P intervention, they most recently completed, even if the Triple P session, as designed, required more than one family meeting to complete. Respondents were then

presented with the Triple P session checklist matching this report. Survey respondents were encouraged to refer to their session notes, family reports, or other service documentation that would help them retrospectively recall which components of the session they covered and which components were skipped. TPIE evaluators then calculated the percentage of possible session components that were completed during delivery of the session. These scores were averaged across practitioners within Triple P interventions and sessions (different Triple P interventions and sessions have different numbers of core content components). Asgary-Eden & Lee (2011, 2012) previously used this methodology for assessing adherence to Triple P interventions in an examination of factors associated with adherence in a large Triple P scale-up initiative in Canada.

Agency Implementation Climate

TPIE evaluators adapted a seven-item measure of implementation climate originally developed by Klein, Conn, and Sorra (2001). Language modifications were made to tailor the measure for the implementation of Triple P interventions in local service agencies. Each item is rated on a 5-point Likert scale ranging from (1) not true to (5) true. An example item is, "People at this organization think that the implementation of Triple P is important." A scale score is calculated by averaging scores across all items; lower scores represent a less favorable implementation climate and higher scores represent a more favorable implementation climate. For interpretation of evaluation results, agencies were considered to have hospitable implementation climates if the mean scale score for the agency was equal to or greater than the scale midpoint (3). At Time 4, internal consistency for the scale in both the Cabarrus and Mecklenburg samples was good (Cabarrus α = 0.88, Mecklenburg α = 0.86). Internal consistency for county samples at Time 1, Time 2, and Time 3 assessments were similarly strong, and are reported in prior TPIE interim reports (Aldridge, et al., 2014a; Aldridge, et al., 2014b; Aldridge, Murray, & Prinz, 2014; Aldridge, Murray, Prinz, & McManus, 2014; Aldridge, et al., 2015a; Aldridge, et al., 2015b).

Data and Information Provided by County and State Evaluation Partners

County implementation support staff supplied TPIE evaluators with semi-annual data regarding **local agency participation status** within the county Triple P coalition, **county Triple P practitioner training and activity statuses**, and the **reach of Triple P intervention delivery** within each county. These data corresponded to each of the four TPIE assessment points. County implementation support staff also provided support materials related to the county's implementation and scale-up of Triple P (e.g., strategic plans, training reports, local evaluation measures, status updates) to TPIE evaluators as requested and available during the evaluation project.

In the final months of the TPIE project, evaluation staff at the North Carolina Division of Public Health provided TPIE evaluators with SFY09-10 through SFY14-15 **child maltreatment and foster care placement data** for Cabarrus and Mecklenburg counties and the state as a whole. Although TPIE evaluators had hoped to obtain similar data regarding child maltreatment injuries, these data were not available in time for this final project report.

Evaluation Results

County Implementation Capacity

Participants in each county's administration of the PS-CCA-TP across the 2nd, 3rd, and 4th assessment time points (those for which PS-CCA-TP data are comparable) are listed in Table 3. These participants

PS-CCA-TP Participants			
	Name	**Agency**	**Role**
Cabarrus	Barbara Sheppard	Cabarrus Health Alliance	Health Initiatives Director
	Gina Hofert	Cabarrus Health Alliance	Triple P Director & Evaluator
	Megan Shuping (T3-T4 only)	Cabarrus Health Alliance	Triple P Program Coordinator
	Amy Bartlett	Cabarrus Health Alliance	Triple P Program Coordinator
Mecklenburg	Cathy Henderson	Mecklenburg County Health Dept.	Triple P Coordinator
	Michael Kennedy	Mecklenburg County Health Dept.	Triple P Advisory Board
	Hannah Sawyer	Mecklenburg County Health Dept.	Management Analyst, MCHD
	Crystal Stilwell	Mecklenburg County Health Dept.	Sr. Manager, MCHD

Table 3. County Capacity Assessment participants for Time 2 (fall 2014), Time 3 (spring 2015) and Time 4 (fall 2015) assessments.

constituted all key county-level staff that were responsible for leading and managing the day-to-day implementation of the Triple P system of interventions within each county.

Scope of the Triple P System of Interventions in Each County

In preparation for the PS-CCA-TP, respondents were asked to report all Triple P interventions being implemented or planned for implementation in their county. Given the nature of the Triple P system of interventions as a public health approach to parenting and family support, implementing a wide array of Triple P interventions may be important for achieving optimal system reach and intended population-level outcomes. In addition, knowing the variety of Triple P interventions being implemented and planned for implementation is important for understanding the amount of capacity that may be needed from the county to support scale-up. A stage-based view of Triple P intervention implementation for each county at Time 4 (fall 2015) is reported in Table 4. Triple P intervention implementation at Time 1 (spring 2014), Time 2 (fall 2014), and Time 3 (spring 2015) are reported in prior TPIE interim reports (Aldridge, et al., 2014a; Aldridge, et al., 2014b; Aldridge, Murray, & Prinz, 2014; Aldridge, Murray, Prinz, & McManus, 2014; Aldridge, et al., 2015a; Aldridge, et al., 2015b).

A few shifts in the staging of Triple P interventions within each county since Time 3 are noteworthy. First, Mecklenburg County implementation support staff reported that Level 3 Discussion Group had reached full implementation. The **full implementation stage** is achieved when the majority of county practitioners intended to be trained are delivering interventions with fidelity and agencies have accommodated these interventions as part of business as usual (e.g., Fixsen et al., 2013; Metz & Bartley, 2012). County implementation coordinators in each county reported using data and information such as *short-term family outcome data*, *reviews of county Triple P practitioners' contact records with county families*, and *handfuls of practitioner self-report of high fidelity delivery* to judge whether an intervention had reached full implementation.

Second, several Triple P interventions in each county had progressed to the initial implementation stage. The **initial implementation stage** is often characterized by new practice behaviors among practitioners, new administrative behaviors among agency leaders, identifying and addressing implementation

Stage of Implementation for County Triple P Interventions				
	Exploration	**Installation**	**Initial Implementation**	**Full Implementation**
Cabarrus County	L3 Discussion Group Teen	L2 Brief Primary Care Teen[1]	L2 Seminar[1]	L3 Primary Care
	L5 Family Transition	L5 Group Lifestyle	L2 Brief Primary Care[1]	L3 Primary Care Teen
		L5 Enhanced[1]	L3 Discussion Group	L3 Primary Care Stepping Stones
			L4 Standard	
			L4 Triple P Online[1]	
Mecklenburg County	L3 Primary Care Stepping Stones	L3 Discussion Group Teen[1]	L2 Seminar	L3 Primary Care
	L4 Standard Stepping Stones	L5 Group Lifestyle[1]	L2 Seminar Teen[1]	L3 Primary Care Teen
	L4 Group Stepping Stones[1]	L5 Enhanced[1]	L4 Standard[1]	L3 Discussion Group[1]
	L5 Family Transitions		L4 Group	
			L4 Group Teen	
			L5 Pathways[1]	

Table 4. A stage-based overview of Triple P intervention implementation in Cabarrus & Mecklenburg Counties, fall 2015.

barriers, maintaining practitioner and stakeholder buy-in, and early data collection and use for quality improvement (e.g., Fixsen et al., 2013; Metz & Bartley, 2012). In Cabarrus County, Level 2 Seminar, Level 2 Brief Primary Care, and Level 4 Triple P Online had each advanced to initial implementation. In Mecklenburg County, Level 2 Seminar Teen, Level 4 Standard, and Level 5 Pathways had moved to the initial implementation stage.

Finally, some Triple P interventions in each county had progressed to the installation stage. The **installation stage** is characterized by initial expenditure of county resources, practitioner training and accreditation processes, and agency preparation to begin delivering interventions to families (e.g., Fixsen et al., 2013; Metz & Bartley, 2012). In Cabarrus County, practitioners were being trained in Level 2 Brief Primary Care Teen and Level 5 Enhanced for the first time. In Mecklenburg County, practitioners were being trained in Level 3 Discussion Group Teen, Level 5 Group Lifestyle, and Level 5 Enhanced for the first time.

Overall, it is noteworthy that both counties had made investments to newly install or advanced several Triple P interventions across their counties since last spring. In fact, **this marks a significant expansion of the Triple P systems in each county for the first time since the fall 2014 assessment period (Time 2)**.

[1] These interventions had advanced stages of implementation since spring 2015.

Longitudinal PS-CCA-TP Results

County PS-CCA-TP scale and composite scores for Time 2, Time 3, and Time 4 are depicted in Figures 3 and 4. The nature of revisions to the Coaching scale between Time 2 and Time 3 assessments prevents a direct comparison of scale results and, likewise, interpretation of changes in this area between this assessment point and later ones.

When interpreting *county capacity to support the development of active implementation infrastructure and best practices across local agencies* (the blue bars in Figures 3 and 4), it is important to keep in mind that implementation drivers are considered compensatory (Fixsen et al., 2005; Fixsen et al., 2009). That is, strengths in one area of implementation infrastructure and practice at the agency level (e.g., coaching) may compensate for deficits in other areas (e.g., training). **It is unlikely that local service agencies would need to be near perfect across all implementation drivers to support the effective implementation of Triple P**.

Cabarrus County

Several patterns are noteworthy in the PS-CCA-TP results for Cabarrus County. First, county implementation capacity remained relatively stable across the evaluation period, though a pattern of slight improvement was observed from Time 3 to Time 4, resulting in the county reporting that implementation capacity was at its highest as the TPIE evaluation period closed. Results suggest that the county had *consistent and strong resources and abilities* (conceptualized as above 80% in place) across its county leadership team and county implementation team to support the implementation and scale-up of Triple P across the county (the red bars in Figure 3). Of particular note is that PS-CCA-TP respondents reported **the county implementation team had grown from four members with a combined 2.675 FTE at Time 3 to five members with a combined 3.25 FTE by Time 4**. County PS-CCA-TP respondents indicated for the first time at Time 4 that they believed the amount of dedicated time and effort among county implementation team members was ideal to fully support the scale-up of Triple P across the county.

Cabarrus PS-CCA-TP results also suggest that the county had *consistent and strong resources and abilities* to support alignment of the county prevention system to implement Triple P; to conduct regular action plans to advance the scale-up of Triple P; to work closely with local agencies to ensure the use of implementation drivers best practices for training practitioners in Triple P and for gathering and using data for decision-making; and to solicit and use information about Triple P successes and larger systems needs to improve and sustain the scale-up of Triple P (systems intervention). Furthermore, results suggest that, by the end of the TPIE evaluation period, the county had *good resources and abilities* (conceptualized as between 70-80% in place) to solicit and use information about the County Triple P Coalition's and agencies' policy and practice facilitators and barriers to improve the scale-up of Triple P (facilitative administration).

It is noteworthy that almost all of Cabarrus County's strengths are in areas related to organizational teams (County Leadership Team, County Implementation Team), organizational processes (Prevention System Alignment, Action Planning), and organizational implementation drivers (Decision Support Data System, Facilitative Administration, Systems Intervention). The lone exception to this pattern is the county's strong resources and abilities to work with local agencies to ensure the use of training best practices, which was likely bolstered by the county's partnership with Triple P America to conduct all Triple P training for chosen practitioners. The county's strong resources and abilities to work with local

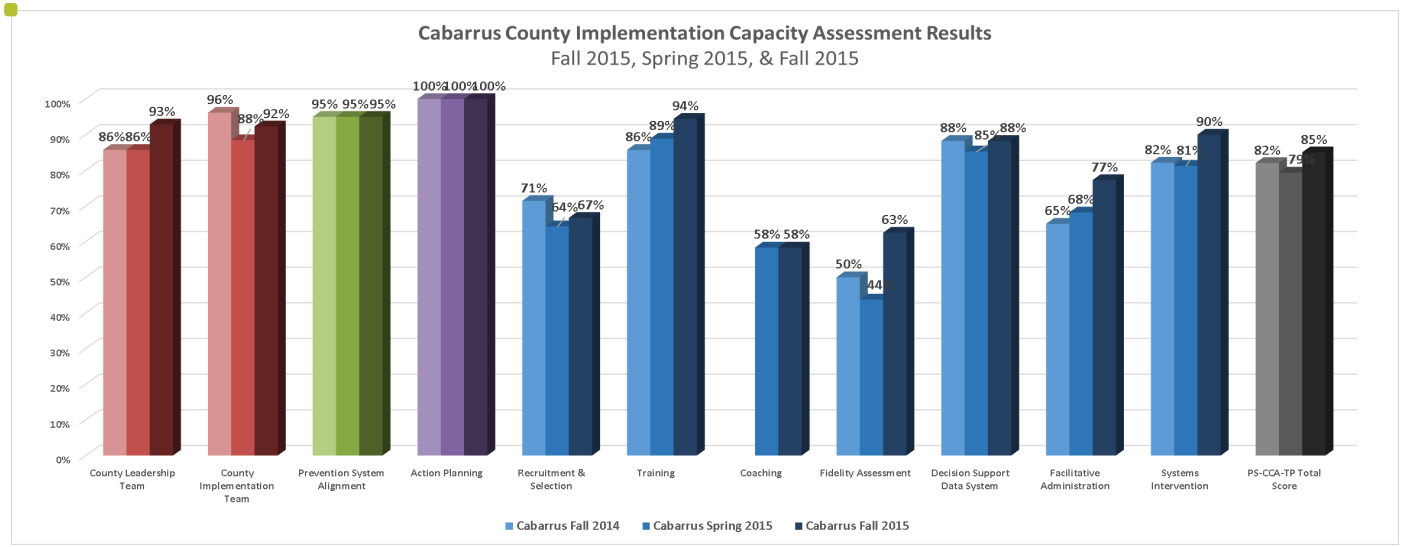


Figure 3. County implementation capacity assessment results for Cabarrus County, fall 2014 - fall 2015.

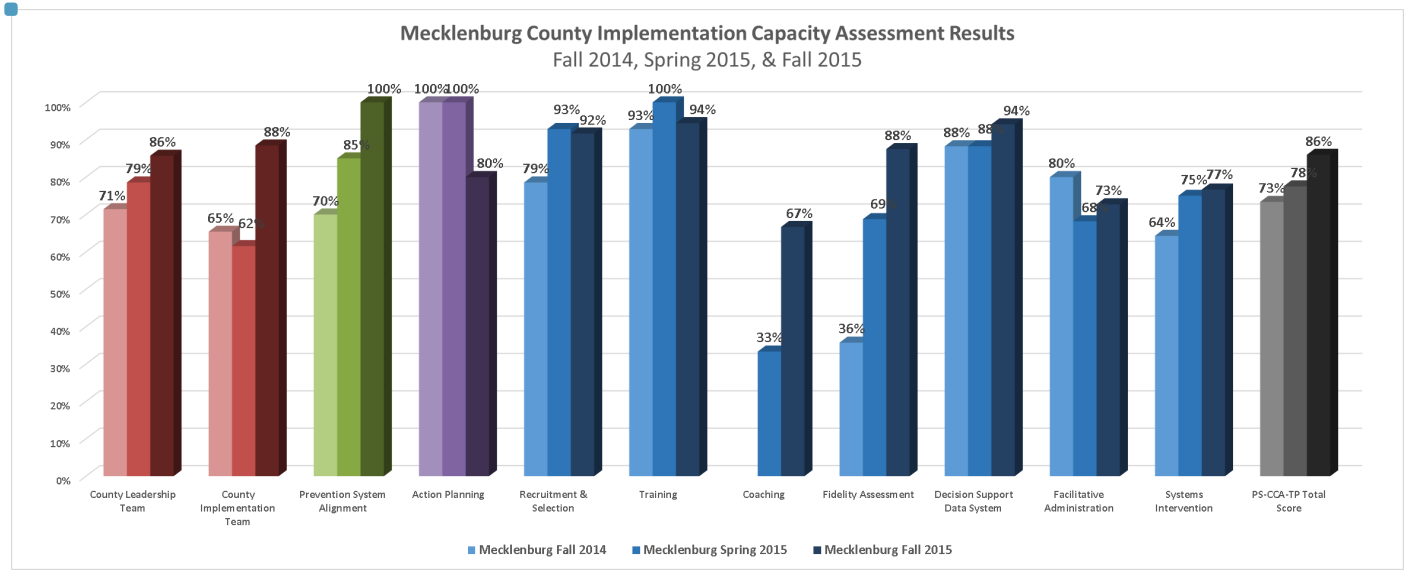


Figure 4. County implementation capacity assessment results for Mecklenburg County, fall 2014 - fall 2015.

agencies to ensure data collection and use during decision-making was likely strengthened by the county's participation in statewide Triple P evaluation activities, which brought shared intervention measures and expectations for quarterly data reporting to the county.

Despite these strengths, PS-CCA-TP results consistently suggest that the county's resources and abilities to work with local agencies to ensure the use of implementation drivers best practices for Triple P practitioner recruitment and selection, coaching, and fidelity assessment may *benefit from additional development* (conceptualized as below 70% in place). In contrast to the capacity strengths Cabarrus appears to have related to *organizational* factors, each of these three developmental needs fit within the *competency* implementation drivers (Recruitment and Selection, Training, Coaching, Fidelity Assessment): implementation infrastructure and best practices to ensure practitioners' competence and confidence to deliver Triple P as intended. Again, the lone exception to this pattern was the county's resources and abilities to work with local agencies to ensure the use of training best practices.

Mecklenburg County

Several patterns are likewise noteworthy in the PS-CCA-TP results for Mecklenburg County. First, where there was initially room to grow at Time 2, there was an overall pattern of improvement by Time 4. The four exceptions to this pattern – Action Planning, Training, Decision Support Data System, and Facilitative Administration – were each in areas already reflecting strong resources and abilities at Time 2. This pattern of improvement is typified by results that suggest, by Time 4, the county had developed *strong resources and abilities* across its county leadership team and county implementation team to support the implementation and scale-up of Triple P across the county (the red bars in Figure 4). Of particular note is that PS-CCA-TP respondents reported **the county implementation team had grown from four members with a combined 1.25 FTE at Time 3 to five members with a combined 2.04 FTE by Time 4**. However, this was largely achieved through the very recent addition of one new county implementation team member at 0.75 FTE at Time 4. In addition to the time and support the new member may need to fully step into the work of the county implementation team, this overall dedicated FTE was still shy of the 2.12 to 2.5 FTE that county PS-CCA-TP respondents indicated would be ideal to fully support the scale-up of Triple P across the county.

Mecklenburg PS-CCA-TP results also suggest that the county had fairly *consistent and strong resources and abilities* to conduct regular action plans to advance the scale-up of Triple P and, through Time 3 and into Time 4, had developed *strong resources and abilities* to support alignment of the county prevention system to implement Triple P (the purple and green bars in Figure 4, respectfully). Though it is notable that county resources and abilities to action plan dropped from Time 3 to Time 4, additional longitudinal data would be helpful to see if the trend becomes concerning.

Regarding county capacity to work with local agencies to ensure the use of implementation best practices related to the competency drivers (the first four sets of blue bars in Figure 4), results suggest that Mecklenburg had *consistent and strong resources and abilities* related to practitioner recruitment and selection and practitioner training. As in Cabarrus County, Mecklenburg County capacity to work with local agencies to ensure best practices for training was likely bolstered by the county's partnership with Triple P America to conduct all Triple P training for selected practitioners. Results further suggest that the county's most dramatic capacity improvements during the TPIE evaluation period were related to supporting the other two competency implementation drivers: Coaching and Fidelity Assessment. As in Cabarrus County, early results indicated that these were the areas originally in need of the most

development in Mecklenburg County. Though still likely in *need of additional development*, the county's resources and abilities to work with local agencies to ensure coaching best practices were twice as developed at Time 4 as they were at Time 3. Similarly, county resources and abilities to work with local agencies to ensure fidelity assessment best practices more than doubled from Time 2 and became a *strength* by Time 4.

Finally, regarding county capacity to work with local agencies to ensure the use of implementation best practices related to the organizational drivers (the last three sets of blue bars in Figure 4), results suggest that Mecklenburg had *consistent and strong resources and abilities* to ensure best practices for gathering and using data for decision-making. As in Cabarrus County, capacity in this area was likely strengthened by Mecklenburg County's participation in statewide Triple P evaluation activities. At Time 4, PS-CCA-TP results also suggested that Mecklenburg had *good resources and abilities* to solicit and use information about the County Triple P Coalition's and agencies' policy and practice facilitators and barriers to improve the scale-up of Triple P (facilitative administration) and, likewise, to solicit and use information about Triple P successes and larger systems needs to improve and sustain the scale-up of Triple P (systems intervention).

County Sustainability Planning

The PS-CCA-TP includes three items that tap into the presence of sustainability plans to support county leadership and implementation team capacity and the overall implementation of Triple P beyond the initial grant awards from the State of North Carolina. Although **these three items should not be considered a full assessment of the sustainability of Triple P implementation**, they do provide helpful information toward this end. For each of these three items, a response of "2" on the PS-CCA-TP zero-to-two response scale carried an additional criteria that the sustainability plan must be in documented form, which provides greater confidence towards sustainability than an assumed or informal plan. Cabarrus and Mecklenburg County responses for these three items across Time 2, Time 3, and Time 4 assessments are reported in Tables 5 and 6.

Responses for PS-CCA-TP Sustainability Plan Items – Cabarrus County				
Item	**Response Range**	**Fall 2014 Response**	**Spring 2015 Response**	**Fall 2015 Response**
(CLT7) There is a documented plan to sustain the County Leadership Team's involvement in the implementation and scale-up of Triple P beyond the county service grant.	0-2	1 – "Partially in Place"	1 – "Partially in Place"	1 – "Partially in Place"
(CIT13) There is a documented plan to sustain the positions on the County Implementation Team (including the County Implementation Coordinator) beyond the county service grant.	0-2	0 – "Not in Place"	1 – "Partially in Place"	1 – "Partially in Place"
(SI15) The county has a documented plan to sustain the necessary financial and programmatic resources needed to support the ongoing implementation of Triple P beyond the county service grant.	0-2	1 – "Partially in Place"	1 – "Partially in Place"	1 – "Partially in Place"

Table 5. Cabarrus County responses to PS-CCA-TP items assessing the presence of sustainability plans.

Responses for PS-CCA-TP Sustainability Plan Items – Mecklenburg County				
Item	Response Range	Fall 2014 Response	Spring 2015 Response	Fall 2015 Response
(CLT7) There is a documented plan to sustain the County Leadership Team's involvement in the implementation and scale-up of Triple P beyond the county service grant.	0-2	0 – "Not in Place"	1 – "Partially in Place"	2 – "Fully in Place
(CIT13) There is a documented plan to sustain the positions on the County Implementation Team (including the County Implementation Coordinator) beyond the county service grant.	0-2	0 – "Not in Place"	0 – "Not in Place"	1 – "Partially in Place"
(SI15) The county has a documented plan to sustain the necessary financial and programmatic resources needed to support the ongoing implementation of Triple P beyond the county service grant.	0-2	0 – "Not in Place"	1 – "Partially in Place"	1 – "Partially in Place"

Table 6. Mecklenburg County responses to PS-CCA-TP items assessing the presence of sustainability plans.

Generally, response patterns suggest limited progress developing sustainability plans within each county across the evaluation period. The one exception to this is for Mecklenburg County's leadership team, for which PS-CCA-TP respondents indicated, for the first time, the presence of documented sustainability plans at Time 4.

Agency Implementation Climate, Infrastructure, & Continuation

Agency implementation climate and infrastructure results are reported in aggregate – across all participating agencies in each county. Thus, an understanding of agencies' participation, across the evaluation period, in their respective county Triple P coalitions and TPIE assessments is helpful for interpreting results. This information is reported in Table 7. Three observations are made. First, agencies in Cabarrus County had a higher rate of continuing participation in their county's Triple P coalition than agencies in Mecklenburg County. Second, the rate of active agencies' participation in IDA-TP assessments remained at or above 90% across the evaluation period, suggesting confidence in the representativeness of IDA-TP results at each assessment point. Likewise, sample sizes of active agencies represented within TPIE implementation climate datasets at each assessment point suggest confidence in the representativeness of climate results across the evaluation period.

Agency Implementation Climate

When interpreting implementation climate scores across agencies, which were derived from web-based Triple P practitioner survey data, it is important to keep in mind that the number of Triple P practitioners in each agency varied. Some agencies only had one Triple P practitioner at any given assessment point. At Time 4, one agency had as many as fourteen. The number of practitioners, by agency, participating in web-based Triple P practitioner surveys at Time 4 is reported later in this report. Similar descriptive numbers from prior assessment points are reported in prior TPIE interim reports (Aldridge, et al., 2014a; Aldridge, et al., 2014b; Aldridge, Murray, & Prinz, 2014; Aldridge, Murray, Prinz, & McManus, 2014; Aldridge, et al., 2015a; Aldridge, et al., 2015b).

	Agency Participation Active and inactive agencies in county Triple P coalitions		**IDA-TP Participation** % of *active* agencies that participated in IDA-TPs		**Hospitable Implement. Climates** % of *active* agencies with hospitable implementation climates (N = sample size from total active)	
	Cabarrus	**Mecklenburg**	**Cabarrus**	**Mecklenburg**	**Cabarrus**	**Mecklenburg**
Spring 2014 (Time 1)	11 Active	10 Active	Not applicable	Not applicable	91% (N = 11)	100% (N = 10)
Fall 2014 (Time 2)	18 Active	20 Active	94%	90%	94% (N = 18)	72% (N = 18)
Spring 2015 (Time 3)	19 Active	15 Active 5 Inactive	100%	93%	89% (N = 18)	85%[2] (N = 13)
Fall 2015 (Time 4)	23 Active 3 Inactive	18 Active 8 Inactive	96%	94%	81%[2] (N = 21)	94%[2] (N = 17)

Table 7. Agency participation in county Triple P coalitions, IDA-TP participation, and hospitable implementation climates across all four TPIE assessment points.

The percentages of active agencies surveyed that had hospitable implementation climates at each assessment point are reported in Table 7. Although clear trends are not evident from a cursory review of the data, a more detailed analysis does suggest interpretable patterns. As noted in Table 7, the percentages of active agencies surveyed at Time 4 in Cabarrus and at Time 3 and Time 4 in Mecklenburg, by definition, did not include the agencies that were no longer active in their county's Triple P coalition. Among the five agencies that discontinued participation in the Mecklenburg County Triple P Coalition by Time 3, at least three had unfavorable implementation climates at Time 2 (m = 2.71, 2.14, and 1.57). Practitioners from the other two agencies did not participate in the Time 2 web-based Triple P practitioner survey, which might likewise have indicated that Triple P was a low priority in these agencies. Categorizing these five inactive agencies as "not hospitable," only 61% of all agencies surveyed or inactive in Mecklenburg might have been considered "hospitable" for Triple P at Time 3.

Similar analyses can be useful when examining Time 4 agency implementation climate data. In Cabarrus County, one of the three agencies that discontinued participation in the Cabarrus County Triple P Coalition by Time 4 had an unfavorable implementation climate at Time 3 (m = 2.21). Practitioners from another did not participate in the Time 3 web-based Triple P practitioner survey. The third – a new agency at Time 4 – closed due to financial problems before being able to participate in TPIE assessments. Categorizing the first two inactive agencies as "not hospitable" and excluding the last due to missing data and participation, only 74% of all agencies surveyed or inactive in Cabarrus might have been considered "hospitable "for Triple P at Time 4. In Mecklenburg County, one of the four additional agencies that discontinued participation in the Mecklenburg County Triple P Coalition by Time 4 had an unfavorable implementation climate at Time 3 (m = 2.43). Survey data from Triple P practitioners within the other three agencies suggested that these agencies were "hospitable" for Triple P at Time 3.

[2] These percentages do not take into account the agencies that were no longer active in their county's Triple P coalition at the time of assessment, the implications of which are discussed in the text of this section.

Categorizing these agencies accordingly and adding in the four still inactive agencies from Time 3, each categorized as "not hospitable" from Time 2, only 76% of agencies surveyed or inactive in Mecklenburg might have been considered "hospitable" for Triple P at Time 4.

With these additional analyses, clearer patterns emerge within each county across the evaluation period. **In Cabarrus County, the percentage of agencies surveyed or inactive that might have been considered "hospitable" for Triple P appears to be declining across the final three assessment points. In Mecklenburg County, though starting at a perfect 100%, the percentage dramatically dropped at Time 2, continued to decline at Time 3, and then rebounded when seven new agencies were added at Time 4. At the end of the TPIE evaluation period, data suggests that about three-quarters of agencies ever involved in each county Triple P coalition might be considered "hospitable" for Triple P.**

Agency Implementation Infrastructure & Best Practices

As a reminder, when interpreting results about the infrastructure and best practices to support the implementation of Triple P across local agencies, it is important to keep in mind that implementation drivers are considered compensatory (Fixsen et al., 2005; Fixsen et al., 2009). That is, strengths in one area of implementation infrastructure (e.g., coaching) may compensate for deficits in other areas of implementation infrastructure (e.g., training). **It is unlikely that local service agencies would need to be near perfect across all implementation drivers to support effective implementation of Triple P**.

County IDA-TP scale and implementation drivers composite scores for Time 2 (fall 2014), Time 3 (spring 2015), and Time 4 (fall 2015) are depicted in Figures 5 and 6. The nature of revisions to the Agency Implementation Capacity scale and Coaching scale between Time 2 and Time 3 assessments prevents a direct comparison of scale results and, likewise, interpretation of changes in these areas between these time points and later ones.

Cabarrus County

Several patterns are noteworthy in the IDA-TP results for Cabarrus County. First, like its counterpart county implementation capacity results, local agency implementation infrastructure and best practices remained relatively stable across the evaluation period. Results suggest that agencies across the county had consistent leadership and implementation team capacity (the red bars in Figure 5)*, though it may still benefit from additional development* (conceptualized as below 70% in place). Notably, at Time 4 **only seven of the 22 participating agencies (32%) had clearly identified teams of three or more staff members fully in place to manage and coordinate day-to-day Triple P implementation activities**. Nine agencies had only one individual in such a role (i.e., an implementation coordinator). In addition, IDA-TP respondents at Time 3[3] reported that agency implementation team members across the county were allocated an average of 7.10% time and effort for agency implementation support activities. **When asked what the ideal allocation of time and effort would be for agency implementation team members, respondents – on average – nearly doubled the allocation** to 13.90%. Among the 48 agency

[3] Because of the large number of new agencies joining the Cabarrus County Triple P Coalition at Time 4 (N = 7) compared to Time 3 (N = 1), TPIE evaluators chose to report here only Time 3 data related to agency implementation team member time and effort. Though Time 4 data regarding agency implementation team member time and effort followed similar patterns, agencies that had just joined the Triple P coalition at Time 4 were likely still developing a full sense of the time and effort needed to support all Triple P implementation activities within their agencies.

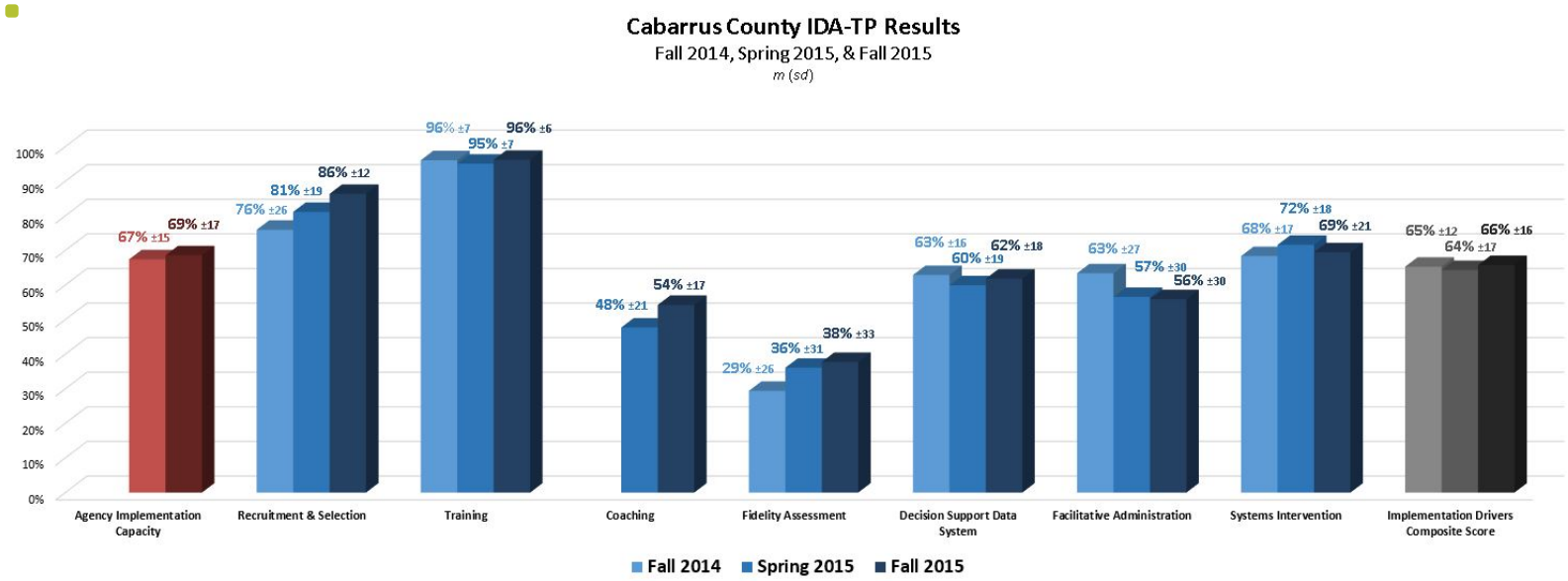


Figure 5. Agency implementation drivers assessment results for Cabarrus County, fall 2014 - fall 2015.

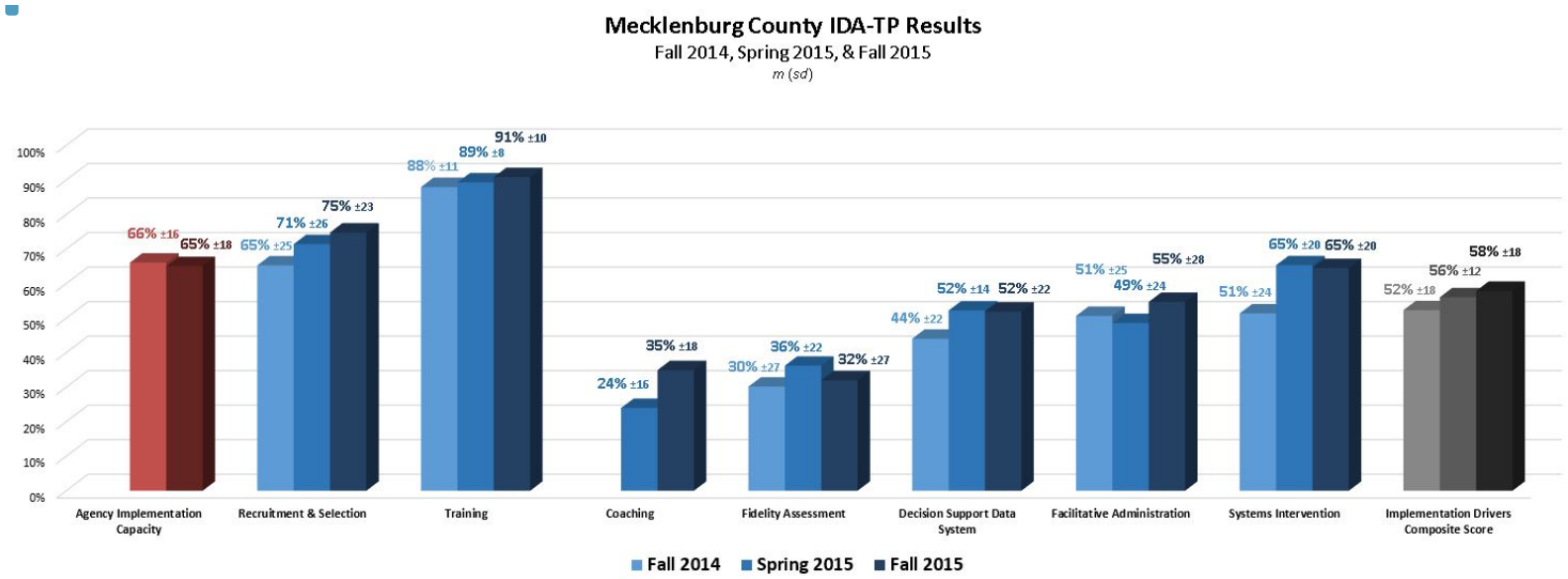


Figure 6. Agency implementation drivers assessment results for Mecklenburg County, fall 2014 - fall 2015.

implementation team members across Cabarrus County at Time 3, **IDA-TP respondents suggested that an increase in FTE would be ideal 70.80% of the time**.

Regarding agency implementation infrastructure and best practices to support practitioner competence and confidence to use Triple P as intended (the first four sets of blue bars in Figure 5), results suggest that Cabarrus County agencies had *strong infrastructure and practices* (conceptualized as above 80% in place) related to practitioner selection and practitioner training. In fact, despite relative consistency in most other areas, the recruitment and selection driver appeared to strengthen across the evaluation period. As with county-level implementation capacity, infrastructure and best practices for practitioner training were likely bolstered by the county's partnership with Triple P America to conduct all Triple P training for county practitioners. Despite these strengths, *the agency implementation infrastructure and practices in most need of additional development across the county* were related to the other two competency implementation drivers: practitioner coaching and fidelity assessment. Though some gains were apparent related to these two implementation drivers across the evaluation period, they remain the least in place.

Finally, results suggest that Cabarrus agencies' infrastructure and practices to provide hospitable organizational and systems environments for the continuous improvement of Triple P implementation (the last three sets of blue bars in Figure 5) *were generally in need of additional development* across the evaluation period. Of these implementation drivers, agency practices to solicit, document, and use information about Triple P successes and larger systems needs to improve and sustain the implementation of Triple P (systems intervention) were the most in place. On the other hand, agency practices to solicit, document, and use information about agency policy and practice facilitators and barriers to improve the implementation of Triple P (facilitative administration) appeared to be slightly slipping across the evaluation period.

Mecklenburg County

Several patterns are likewise noteworthy in the IDA-TP results for Mecklenburg County. First, although agency implementation infrastructure and best practices across the county were generally less in place compared to Cabarrus County, a pattern of slight improvement was evident across the TPIE evaluation period. Though this interpretation is complicated given the amount of agency attrition witnessed across Time 3 and Time 4 in Mecklenburg (i.e., it is possible that those agencies with less well-developed implementation infrastructure were discontinuing their involvement in the county Triple P coalition), the pattern of improvement resembles the same pattern of improvement that was evident across county-level implementation capacity in Mecklenburg during the evaluation period.

Regarding individual scales, results suggest that agencies across the county had consistent leadership and implementation team capacity (the red bars in Figure 6), though – as in Cabarrus County – *it may still benefit from additional development*. Notably, at Time 4 **only three of the 17 participating agencies (18%) had clearly identified teams of three or more staff members fully in place to manage and coordinate day-to-day Triple P implementation activities**. Seven agencies had only one individual in such a role (i.e., an implementation coordinator). In addition, Time 3[4] IDA-TP respondents reported that

[4] Because of the large number of new agencies joining the Mecklenburg County Triple P Coalition at Time 4 (N=7) compared to Time 3 (N = 0), TPIE evaluators chose to report here only Time 3 data related to agency implementation team member time and effort. Though Time 4 data regarding agency implementation team member time and effort followed similar patterns, agencies that had just joined the Triple P coalition at Time 4

agency implementation team members across the county were allocated an average of 8.49% time and effort for agency implementation support activities. **When asked what the ideal allocation of time and effort would be for agency implementation team members, respondents – like their Cabarrus County counterparts – nearly doubled the allocation** to 16.34% on average. Similarly, among the 29 agency implementation team members across Mecklenburg County at Time 3, **IDA-TP respondents suggested that an increase in FTE would be ideal 75.90% of the time**.

Regarding agency implementation infrastructure and best practices to support practitioner competence and confidence to use Triple P as intended (the first four sets of blue bars in Figure 6), results suggest that Mecklenburg County agencies had *good implementation infrastructure and practices* (conceptualized as between 70%-80% in place) related to practitioner recruitment and selection and *strong implementation infrastructure and practices* (conceptualized as above 80% in place) related to practitioner training. As in Cabarrus County, the recruitment and selection driver showed some of the best gains across the evaluation period and practitioner training was likely bolstered by the county's partnership with Triple P America to conduct all Triple P training in the county. Also like agencies across Cabarrus County, *the agency implementation infrastructure and practices in most need of additional development* were related to the other two competency implementation drivers: practitioner coaching and fidelity assessment. Though some meaningful gains were apparent related to the coaching driver across the last two assessment points of the evaluation period, both of these implementation drivers remain the least in place.

Finally, results suggest that Mecklenburg agencies' infrastructure and practices to provide hospitable organizational and systems environments for the continuous improvement of Triple P implementation (the last three sets of blue bars in Figure 6) *remained in need of additional development* across the evaluation period. Similar to agencies across Cabarrus County, Mecklenburg agency practices to solicit, document, and use information about Triple P successes and larger systems needs to improve and sustain the implementation of Triple P (systems intervention) were the most in place among the organizational implementation drivers. The systems intervention driver also showed the most improvement of any implementation driver across the evaluation period.

Agency Cohort Analyses

Because the length of time that an agency has been implementing interventions may influence the development of agency implementation infrastructure and best practices, TPIE evaluators examined Time 4 IDA-TP results individually, accounting for agencies' length of time supporting Triple P implementation.

For these analyses, Time 4 Cabarrus County agencies were split into three cohorts. Agencies in Cohort 1 (N = 9) first trained practitioners in 2013 and had a mean length of time of 944 days (*sd* = 148 days) since first sending an agency practitioner to a Triple P training. Agencies in Cohort 2 (N = 7) first trained practitioners in 2014 and had a mean length of time of 513 days (*sd* = 73 days) since first sending an agency practitioner to a Triple P training. Agencies involved in Cohort 3 (N = 6) first trained practitioners in 2015 and had a mean length of time of 191 days (*sd* = 48 days) since first sending an agency practitioner to a Triple P training. Cabarrus County fall 2015 IDA-TP scale and Implementation Drivers Composite means by cohort, represented as percentage scores, are depicted in Figure 7.

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were likely still developing a full sense of the time and effort needed to support all Triple P implementation activities within their agencies.

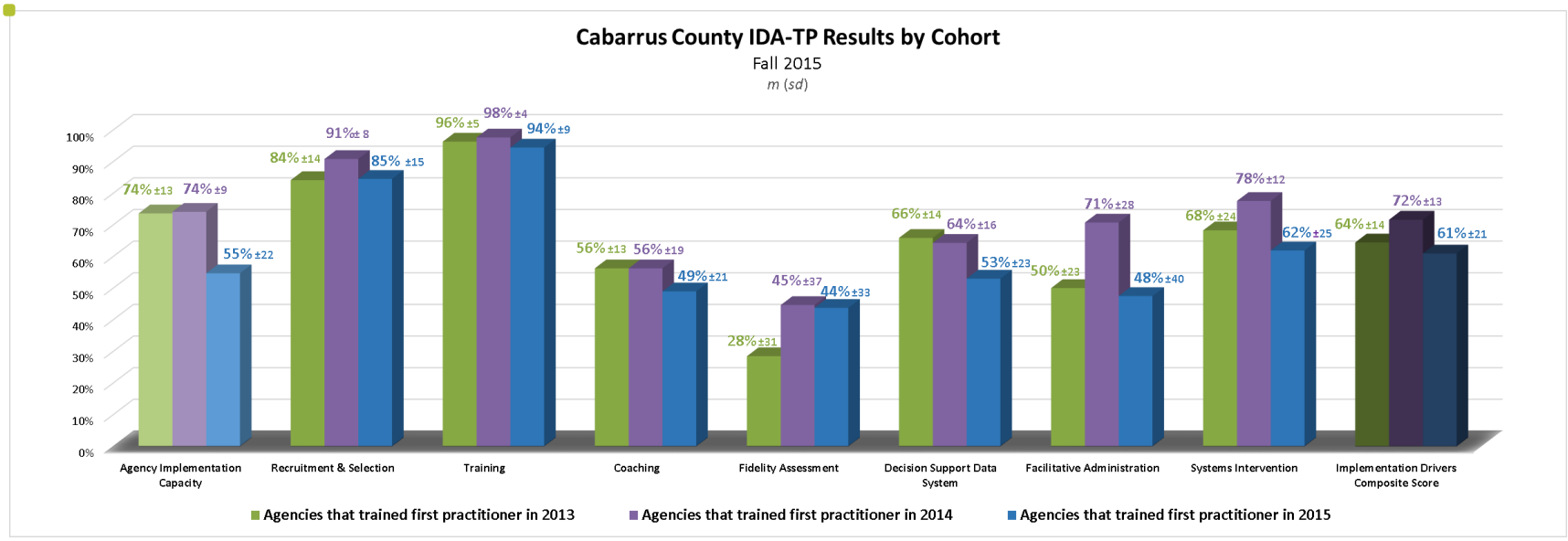


Figure 7. Agency implementation drivers assessment results for Cabarrus County by agency cohort, fall 2015.

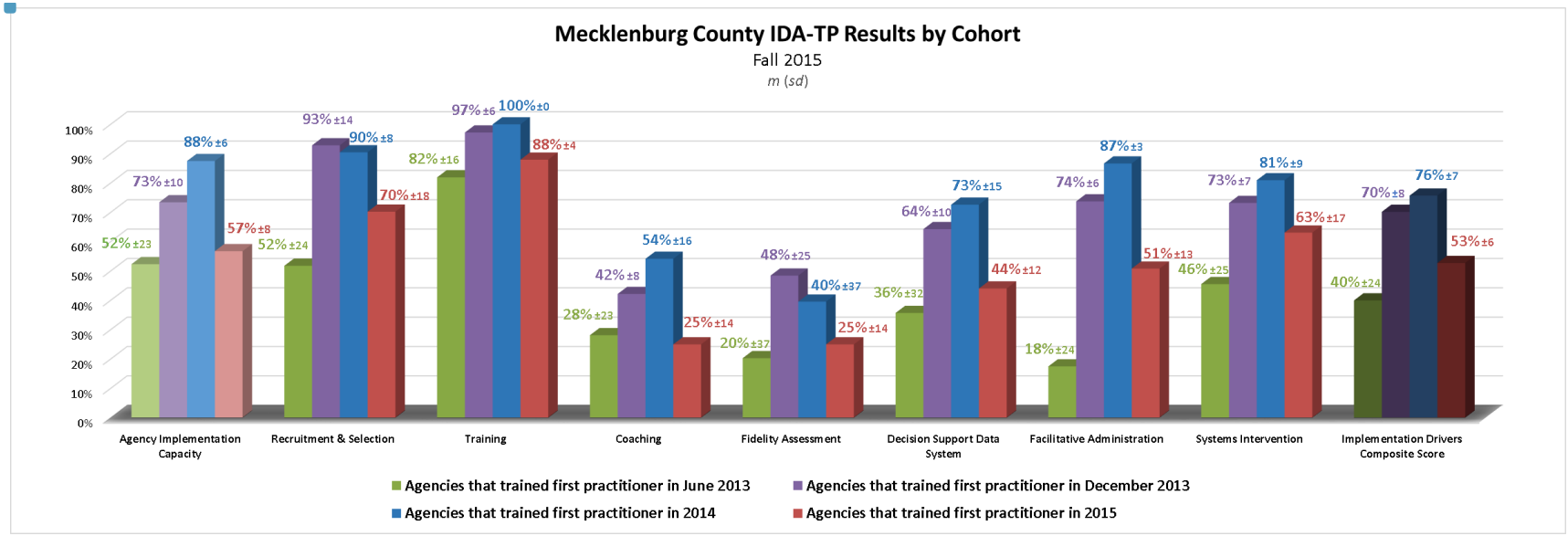


Figure 8. Agency implementation drivers assessment results for Mecklenburg County by agency cohort, fall 2015.

Statistically significant differences among the overall profile of scale scores between agencies assigned to Cohorts 1, 2, and 3 in Cabarrus did not emerge [Wilks' λ = .252, *F* (16, 24) = 1.49, *p* = .18, partial eta squared = 0.498], though the sample size of 22 agencies that participated in fall 2015 TPIE agency assessments yielded only modest power for these analyses (power = 0.67). Notwithstanding the modest power and given that a visual inspection of the scales and composite score suggests few potentially meaningful differences between cohorts, TPIE evaluators conservatively decided not to examine univariate tests for differences among Cabarrus agency cohorts.

Similarly, Time 4 Mecklenburg County agencies were split into four cohorts. Agencies in Cohort 1 (N = 4) first trained practitioners in June 2013 and had a mean length of time of 871 days (*sd* = 1 day) since first sending an agency practitioner to a Triple P training. Agencies involved in Cohort 2 (N = 4) first trained practitioners in December 2013 and had a mean length of time of 688 days (*sd* = 1 day) since first sending an agency practitioner to a Triple P training. Agencies involved in Cohort 3 (N = 3) first trained practitioners in August 2014 and had a mean length of time of 455 days (*sd* = 1 day) since first sending an agency practitioner to a Triple P training. Agencies involved in Cohort 4 (N = 6) first trained practitioners in 2015 and had a mean length of time of 168 days (*sd* = 43 days) since first sending an agency practitioner to a Triple P training. Mecklenburg County fall 2015 IDA-TP scale and Implementation Drivers Composite means by cohort, represented as percentage scores, are depicted in Figure 8.

Statistically significant differences among the overall profile of scale scores between agencies assigned to Cohorts 1, 2, 3, and 4 in Mecklenburg did not emerge [Wilks' λ = .084, *F* (24, 18) = 1.01, *p* = .50, partial eta squared =0.562], though these analyses were *substantially* underpowered (power = 0.43) with the sample size of 17 agencies that participated in fall 2015 TPIE agency assessments. Given this lack of power at the multivariate level and that a visual inspection of the scale and composite score differences *suggests possible meaningful differences* between cohorts, TPIE evaluators decided to cautiously examine univariate tests.

Significant univariate main effects for cohort were obtained for the **Agency Implementation Capacity** [*F* (3, 13) = 5.26, p <.05, partial eta square = .548], **Recruitment and Selection** [*F* (3, 13) = 4.53, p <.05, partial eta square = .511], **Training** [*F* (3, 13) = 3.58, p <.05, partial eta square = .45], **Facilitative Administration** [*F* (3, 13) = 16.39, p <.01, partial eta square = .791], and **Implementation Drivers Composite** scales [*F* (3, 13) = 5.92, p <.01]. Post-hoc tests revealed the following significant differences:

- between the Cohort 3 mean (higher) and Cohorts 1 and 4 means for Agency Implementation Capacity (Tukey HSD $p < 0.05$ for both comparisons);
- between the Cohort 2 (higher) and Cohort 1 means for Recruitment and Selection (Tukey HSD $p < 0.05$);
- between the Cohort 3 (higher) and Cohort 4 means for Training (Games-Howell $p < 0.01$);
- between the Cohorts 2, 3, and 4 means (higher) and the Cohort 1 mean for Facilitative Administration (Tukey HSD $p < 0.01$, $p < 0.01$, and $p < 0.05$ respectively);
- between the Cohort 3 (higher) and Cohort 4 means for Facilitative Administration (Tukey HSD $p < 0.05$); and
- between the Cohorts 2 and 3 means (higher) and Cohort 1 mean for the Implementation Drivers Composite scale (Tukey HSD $p < 0.05$ for both comparisons).

Taken together and alongside a visual inspection of other scale differences in Figure 8, **these results suggest that Mecklenburg agencies in Cohorts 2 and 3 had better developed implementation infrastructure and best practices than Mecklenburg agencies in Cohorts 1 and 4** as the TPIE evaluation period closed. Furthermore, when TPIE evaluators visually examined changes over time *within* Mecklenburg agency cohorts, it was observed that **agency implementation capacity, infrastructure, and practices were generally falling out of place among Cohort 1 agencies as the evaluation period progressed**. This was in contrast to the observation that **agency implementation capacity, infrastructure, and practices were generally better developed across Cohort 2 and Cohort 3 agencies as the evaluation period progressed**.

Agency Sustainability Planning

The IDA-TP includes three items that tap into the presence of agency sustainability plans to support agency leadership and implementation team capacity and the overall implementation of Triple P interventions within agencies beyond the initial grant awards from the State of North Carolina. Although **these three items should not be considered a full assessment of the sustainability of Triple P implementation within local agencies**, they do provide helpful information toward this end. For each of these three items, a response of "2" on the zero-to-two response scale carried an additional criteria that the sustainability plan must be in documented form, which provides greater evidence of sustainability than an assumed or informal plan. Time 2, Time 3, and Time 4 IDA-TP item means and standard deviations across county agencies for these three items are reported in Tables 8 and 9.

Results suggest that sustainability plans were "partially in place" among local agencies implementing Triple P interventions in both counties as the TPIE evaluation period closed. It may be noteworthy that the presence of sustainability plans appeared to be increasing across time among Cabarrus agencies while their progression was observed to stall at the final assessment point among Mecklenburg agencies.

Descriptives for Sustainability Plan Items – Cabarrus Agencies				
IDA-TP Item	**Response Range**	**Fall 2014 Mean (*sd*)**	**Spring 2015 Mean (*sd*)**	**Fall 2015 Mean (*sd*)**
(AIC4) There is a documented plan to sustain the involvement of executive leaders in the implementation of chosen Triple P interventions in the agency beyond the county service grant.	0-2	0.65 (0.70)	0.84 (0.69)	1.00 (0.76)
(AIC16) There is a documented plan to sustain the positions on the Agency Implementation Team (including the Agency Implementation Coordinator) beyond the county service grant.	0-2	0.71 (0.69)	0.58 (0.77)	1.09 (0.75)
(SI14) A sustainability plan has been developed to continue the necessary financial and programmatic resources to support the implementation and delivery of chosen Triple P interventions beyond the county service grant.	0-2	0.71 (0.59)	0.89 (0.57)	1.05 (0.72)

Table 8. Response ranges, means, and standard deviations for items assessing the presence of implementation sustainability plans. Wording was slightly, though not significantly, altered between IDA-TP versions for fall 2014, spring 2015, and fall 2015.

Descriptives for Sustainability Plan Items- Mecklenburg Agencies				
IDA-TP Item	Response Range	Fall 2014 Mean (*sd*)	Spring 2015 Mean (*sd*)	Fall 2015 Mean (*sd*)
(AIC4) There is a documented plan to sustain the involvement of executive leaders in the implementation of chosen Triple P interventions in the agency beyond the county service grant.	0-2	0.61 (0.70)	1.14 (0.77)	1.00 (0.87)
(AIC16) There is a documented plan to sustain the positions on the Agency Implementation Team (including the Agency Implementation Coordinator) beyond the county service grant.	0-2	0.67 (0.77)	1.14 (0.86)	1.06 (0.90)
(SI14) A sustainability plan has been developed to continue the necessary financial and programmatic resources to support the implementation and delivery of chosen Triple P interventions beyond the county service grant.	0-2	0.78 (0.65)	1.14 (0.66)	1.00 (0.87)

Table 9. Response ranges, means, and standard deviations for items assessing the presence of implementation sustainability plans. Wording was slightly, though not significantly, altered between IDA-TP versions for fall 2014, spring 2015, and fall 2015.

TPIE evaluators considered the influence that the length of time that an agency had been implementing Triple P interventions might have on the presence of sustainability plans. Though not reported in detail here, these cohort analyses – using the same Time 4 agency cohort assignments described above – generally replicated the patterns of findings from Time 4 agency cohort analyses regarding IDA-TP scales. That is, no significant results emerged when comparing the presence of sustainability plans between cohorts of agencies in Cabarrus County. However, among cohorts of agencies in Mecklenburg County, the presence of sustainability plans among Cohort 3 agencies was generally higher than the presence of sustainability plans among Cohort 1 and Cohort 4 agencies. Furthermore, when TPIE evaluators visually examined changes over time *within* Mecklenburg agency cohorts, it was observed that **agency sustainability plans appeared to be falling out of place among Cohort 1 agencies by the end of the evaluation period**. This was in contrast to the observation that **agency sustainability plans appeared to be better developed across Cohort 2 and Cohort 3 agencies as the evaluation period progressed**.

Predicting Continued Implementation of Triple P within Agencies

As reported above, though the majority of local agencies continued active implementation of Triple P interventions and participation in their county Triple P coalition throughout the TPIE evaluation period, some agencies in each county did not. This number was higher for Mecklenburg County at both Time 3 (Mecklenburg N = 5, Cabarrus N = 0) and at Time 4 (Mecklenburg N = 8, Cabarrus N = 3). TPIE evaluators were interested in factors that may be related to agencies' continued implementation of Triple P and examined four variables.

TPIE evaluators examined predictors of continuation in a combined sample of 50 agencies across the two counties to increase reliability of results. Of the 39 agencies implementing Triple P interventions for

at least six months prior to Time 4 assessments, 11 had become inactive (28%)[5]. **Agencies that continued active Triple P implementation had significantly more trained practitioners** (3.96 vs. 1.27; t = 4.35, p = .000), **greater evidence of sustainability plans** (52% in place vs. 10.5% in place; t = 6.16, p = .002), **and more well developed agency leadership and implementation teams** (72.5% in place vs. 52% in place; t = 3.58, p = .001) as measured by the IDA-TP Agency Implementation Capacity scale. There was a trend suggesting that agencies continuing active implementation of Triple P were more likely to have a positive implementation climate as rated by agency practitioners ($m \geq 3$ on 1-5 scale; X^2 = 3.66, p = .056). Odds ratios indicated that **agencies with only 1 practitioner were 9.8 times more likely to become inactive** and **those with low climate scores were 4.8 times more likely to become inactive**.

For Cabarrus County specifically, 2 of 19 (10.5%) agencies implementing more than six months had become inactive by Time 4 assessments. **Of the 23 agencies that remained actively implementing Triple P interventions at Time 4, 12 (52%) had at least one categorical risk factor for becoming inactive** (7 agencies had only 1 Triple P practitioner; 4 agencies had unfavorable implementation climates; 1 agency had both risk factors).

For Mecklenburg County specifically, 9 of 20 (45%) agencies implementing more than six months had become inactive by Time 4 assessments. **Of the 18 agencies that remained actively implementing Triple P interventions at Time 4, 5 (28%) had at least one categorical risk factor for becoming inactive** (4 agencies with only 1 Triple P practitioner; 1 agency had an unfavorable implementation climate). It should be noted, however, that implementation climate data was missing from three active Mecklenburg agencies at Time 4 assessments.

Practitioner Characteristics & Adherence

An understanding of Triple P practitioners' active delivery of Triple P interventions through their county Triple P coalitions and their response rates for TPIE's web-based Triple P practitioner surveys is helpful for interpreting results related to county Triple P practitioner characteristics and adherence to Triple P. This information is reported in Table 10. Two observations are made. First, across the last three assessment points, practitioners in Cabarrus County had higher rates of active Triple P delivery through their county Triple P coalition than practitioners in Mecklenburg County. Although a practitioner may have continued to deliver Triple P after discontinuing their participation in their county Triple P coalition (e.g., because the practitioner left their agency or their agency discontinued their participation in the county Triple P coalition), they would have been doing so without the system of implementation monitoring and support created by their county Triple P coalition (which offered, for example, access to additional Triple P trainings, peer support networks, data collection and analysis, agency consultation, etc.). Second, the percentages of active county Triple P practitioners who responded to TPIE's web-based Triple P practitioner surveys remained at or above 75% across the evaluation period, suggesting confidence in the representativeness of practitioner survey results at each assessment point.

[5] This calculation involves one agency that changed from active to inactive at the Time 3 assessment point and then changed back from inactive to active at the Time 4 assessment point. During analyses of factors related to agencies' continued implementation of Triple P, this agency was included as an inactive agency. Because it had not been more than six months that this agency had restarted their implementation of Triple P by Time 4, they were not *additionally* included in these analyses as an agency actively implementing Triple P interventions for more than six months.

	Active Practitioner Rate % of trained practitioners who were actively or intending to deliver Triple P		Survey Response Rate % of active practitioners who responded to the survey with usable data (N = sample size from total active)	
	Cabarrus	Mecklenburg	Cabarrus	Mecklenburg
Spring 2014 (Time 1)	89% (42 of 47)	95% (36 of 38)	88% (N = 37)	75% (N = 27)
Fall 2014 (Time 2)	86% (72 of 84)	79% (50 of 63)	81% (N = 58)	82% (N = 41)
Spring 2015 (Time 3)	84% (71 of 85)	66% (43 of 65)	87% (N = 62)	84% (N = 36)
Fall 2015 (Time 4)	78% (96 of 123)	70% (74 of 106)	79% (N = 76)	78% (N = 58)

Table 10. Active practitioner and survey response rates for Cabarrus & Mecklenburg counties across the TPIE evaluation period.

With some exceptions where longitudinal data are helpful for interpretation, descriptive statistics are reported only from Time 4 below. Similar descriptive statistics from prior assessment points are reported in prior TPIE interim reports (Aldridge, et al., 2014a; Aldridge, et al., 2014b; Aldridge, Murray, & Prinz, 2014; Aldridge, Murray, Prinz, & McManus, 2014; Aldridge, et al., 2015a; Aldridge, et al., 2015b).

Practitioner Professional Characteristics

TPIE's web-based Triple P practitioner survey inquired about several professional characteristics, including county and agency affiliation, professional identification, and practice longevity. In the **Time 4 Cabarrus County practitioner sample, 22 of the 23 active local service agencies** and **six private practitioners** were represented (see Table 11). Time 4 Cabarrus survey respondents indicated that they had been **working at their current service agency on average 7.6 years** (N = 67; *sd* = 5.76 years; range was less than 1 year to 31 years). Beyond their current agency tenures, respondents indicated that they had been **practicing child and family services on average 12.28 years** (N = 64; *sd* = 9.14 years; range was less than 1 year to 38 years).

In the **Time 4 Mecklenburg County practitioner sample, each of the 18 active local service agencies** and **three private practitioners** were represented (see Table 12). Time 4 Mecklenburg survey respondents had been **working at their current service agency on average 5.8 years** (N = 50; *sd* = 7.57 years; range was less than 1 year to 39 years). Additionally, respondents had been **practicing child and family services on average 12.31 years** (N = 50; *sd* = 8.60 years; range was less than 1 year to 37 years).

The professional identifications of survey respondents within each county sample are reported in Tables 13 and 14. **Nearly half of respondents** in each county sample identified as either a **mental health provider or social worker**. Given the role of Triple P interventions in preventing and intervening in child social, emotional, and behavioral disorders and child abuse and neglect, these professional clusters are not unexpected.

Fall 2015 Sample of Cabarrus County Practitioners – Agency Affiliation		
Agency	**Count**	**Percent of Sample**
Cabarrus County Schools	9	11.8%
Cabarrus Department of Human Services	4	5.3%
Cabarrus Health Alliance	13	17.1%
Cabarrus Rowan Community Health Center	1	1.3%
Carolina Counseling	4	5.3%
Carolina Counseling and Consultation (FKA Nazareth Children's Home)	1	1.3%
Children's Advocacy Center, Jeff Gordon's Children's Hospital at CMC - NorthEast	1	1.3%
Carolina Parenting Solutions	6	7.9%
CDSA	2	2.6%
Community Specialized Services, Inc.	1	1.3%
Conflict Resolution Center	1	1.3%
Cooperative Christian Ministry	1	1.3%
Daymark Recovery Services	4	5.3%
Developmental and Behavioral Pediatrics of the Carolinas	2	2.6%
Hope, Heal, and Peace Center	2	2.6%
Kannapolis City Schools	7	9.2%
Kids Interactive Developmental Services	2	2.6%
Kids Korner Child Development	1	1.3%
RHA Behavioral Health Services	2	2.6%
Sims Consulting and Counseling	3	3.9%
Suburban Pediatrics	1	1.3%
Thompson Child & Family Focus	2	2.6%
Private Practice	6	1.3%
TOTAL	76	100%

Table 11. Agency affiliations among the sample of Cabarrus County Triple P practitioners who completed the TPIE fall 2015 online practitioner survey.

Fall 2015 Sample of Mecklenburg County Practitioners – Agency Affiliation		
Agency	**Count**	**Percent of Sample**
Access Family Services	1	1.7%
Charlotte Family Housing	2	3.5%
Children's Home Society	1	1.7%
Department of Social Services	4	7.0%
Mental Health Assn. of Central Carolinas	6	10.4%
Community Services Association (FKA First Baptist Church West)	1	1.7%
New Opportunity Mentoring Program	3	5.3%
The Learning Collaborative	1	1.7%
Alexander Youth Network	4	6.9%
Mecklenburg County Health Department	14	24.1%
Against All Odds	2	3.5%
Community Care Partners of Greater Mecklenburg	3	5.3%
Alternative Living Solutions	1	1.7%
Cano Family Services	2	3.5%
Renaissance West Initiative	3	5.2%
First Presbyterian Church	4	6.9%
Provisions Counseling Services, Inc.	1	1.7%
Novant Health Developmental & Behavioral Pediatrics	1	1.7%
Private Practitioners	3	5.2%
TOTAL	57[6]	100%

Table 12. Agency affiliations among the sample of Mecklenburg County Triple P practitioners who completed the TPIE fall 2015 online practitioner survey.

[6] One participant did not indicate their agency affiliation.

Cabarrus County Practitioners – Professional Identification		
Title	**Count**	**Percent of Sample**
Social Worker	18	23.7%
Law Enforcement Officer	1	1.3%
Physician/Health Care Provider	4	5.3%
Nurse/Medical Staff Clinical Support	8	10.5%
Counselor/Psychologist/Mental Health Provider	25	32.9%
Daycare/Preschool Worker	1	1.3%
Program Administrator/Coordinator	2	2.6%
Other	9[7]	11.8%
Early Childhood Inclusion Specialist (1)		
Parent Liaison/Family Support (2)		
Developmental Play Therapist (1)		
Child Life (1)		
Graduate Student (1)		
School Counselor (1)		
Truancy Liaison Counselor (1)		
Missing	8	1.3%
TOTAL	76	100%

Table 13. Professional identification among the Cabarrus County Triple P practitioner sample, fall 2015.

Sample of Mecklenburg County Practitioner – Professional Identification		
Title	**Count**	**Percent of Sample**
Social Worker	11	19%
Teacher/aid	3	5.2%
Nurse/medical staff/clinical support	7	12.1%
Counselor/Psychologist/Mental Health Provider	12	20.7%
Public health educator/community outreach worker/care manager	4	6.9%
Program Administrator/Coordinator	6	10.3%
Other	7[7]	12.1%
Certified Family Support (1)		
Family Involvement Specialist (1)		
Health Check Coordinator (1)		
Peer Family Support Partner (1)		
Trainer (1)		
Youth Engagement (1)		
Missing	8	13.8%
TOTAL	58	100%

Table 14. Professional identification among the Mecklenburg County Triple P practitioner sample, fall 2015.

[7] One practitioner in each county sample indicated "other" but then did not specify their professional identification.

Practitioner Training Status

Training participation, accreditation, and active status at Time 4 for all county Triple P practitioners by Triple P intervention are reported in Table 15. In some cases, special accreditation was provided in lieu of attending a full separate training, as is recommended by the developer (e.g., for Primary Care Teen Triple P after Primary Care Triple P was completed). By the end of the TPIE evaluation period, **a total of 123 unique practitioners were trained in Cabarrus County** and a **total of 106 unique practitioners were trained in Mecklenburg County.** It is important to note that more than 40% of the practitioners in each county had been trained in more than one intervention (Mecklenburg = 41%; Cabarrus = 50%).

Fall 2015 County Practitioners – Triple P Training, Accreditation, and Active Status						
Triple P Intervention	Cabarrus			Mecklenburg		
	Trained	Accredited	Active	Trained	Accredited	Active
Primary Care (0-12)	74	60	57	95	90	65
Primary Care Teen	50	40	37	29	29	19
Selected Seminar	6	--	6	12	10	8
Pathways	--	--	--	1	1	0
Standard (0-12)	20	19	16	13	12	10
Discussion Group	10	10	8	9	9	6
Group (0-12)	--	--	--	4	4	3
Group (Teen)	--	--	--	2	2	1
Brief Primary Care (0-12)	20	19[8]	20	--	--	--
Primary Care Stepping Stones	20	20	17	--	--	--

Table 15. Training participation, accreditation, and active status at Time 4 for all county Triple P practitioners by Triple P intervention.

Practitioner Delivery of Triple P and Adherence to Session Content

In considering practitioners' adherence to the delivery of intended Triple P session content across Triple P interventions, it is helpful to take into consideration the longevity of practitioners' experience with Triple P. All of the survey respondents in Cabarrus County who had delivered Triple P by Time 4 provided information on the month and year in which they were initially trained in Triple P and the date of completion of their last Triple P session. Results indicated that, **on average, 377 days (N = 52; *sd* = 294; range of 35 to 948 days) had passed between practitioners' initial Triple P training and completion of their last Triple P session**. In the Mecklenburg County Time 4 practitioner sample, nearly half respondents who had started delivering Triple P (26 of 56; 46%) provided information on the month and year in which they were initially trained in Triple P and the date of completion of their last Triple P session. Results indicated that, **on average, 427 days (N = 26; *sd* = 256; range of 92 to 863 days) had passed between practitioners' initial Triple P training and completion of their last Triple P session**.

[8] The one Brief Primary Care Triple P practitioner in Cabarrus County who was not yet accredited by Time 4 assessments has since completed her accreditation process.

Most notable here is the significant range in experience of practitioners, which is understandable given the number of separate cohorts trained.

Longitudinal data regarding practitioners' active delivery of, and adherence to, Triple P sessions are reported in Table 16. An important observation is that, across all four assessment points, **a higher percentage of active Cabarrus County Triple P practitioners had delivered Triple P interventions than among active Mecklenburg County Triple P practitioners**. Of course, the percentages reported in Table 16 reflect only the percentage of *active* practitioners surveyed who had delivered Triple P at all. When both *active* and *inactive* practitioners are considered, the percentage of *total trained practitioners* who were delivering Triple P interventions through their county Triple P coalition at Time 4 is much smaller. For example, at Time 4, Cabarrus County had 60 active practitioners who indicated they had delivered Triple P out of the 123 total practitioners trained in Triple P since the start of the county Triple P coalition. This translates into **approximately a 49% rate of delivering Triple P through the Cabarrus County Triple P Coalition among all trained Cabarrus County Triple P practitioners**. Similar methodology among the Mecklenburg County practitioner sample results in **approximately a 32% (34 out of 106) rate of delivering Triple P through the Mecklenburg County Triple P Coalition among all trained Mecklenburg County Triple P practitioners** at Time 4. These rates are approximate because TPIE evaluators do not know whether or not the Time 4 active practitioners that did *not* respond to the TPIE web-based Triple P practitioner survey at Time 4 had delivered Triple P.

Despite these differences in the active delivery of Triple P among Cabarrus and Mecklenburg county Triple P practitioners, **practitioners' self-reported adherence to Triple P session content was very similar in both counties,** with the exception of the final assessment point. At Time 4, the self-reported adherence among Mecklenburg County Triple P practitioners was noticeably higher than at previous assessment points. It is unclear, at this time, what factors might have contributed to this increased self-report of session content adherence. Additional longitudinal data would be helpful to see if the trend continues.

	Delivery **% of *active* practitioners surveyed who had delivered Triple P at all** (N = sample size from total active)		**Delivery Adherence** **Among surveyed practitioners delivering Triple P within last 6 months, average completion of session checklist items** (N = sample size from total delivering)	
	Cabarrus	**Mecklenburg**	**Cabarrus**	**Mecklenburg**
Spring 2014 (Time 1)	92% (N = 37)	56% (N = 27)	84% (N = 34)	84% (N = 15)
Fall 2014 (Time 2)	93% (N = 57)	63% (N = 40)	87% (N = 53)	84% (N = 25)
Spring 2015 (Time 3)	84% (N = 62)	78% (N = 36)	86% (N = 46)	86% (N = 27)
Fall 2015 (Time 4)	81% (N = 74)	59% (N = 58)	79% (N = 46)	96% (N = 32)

Table 16. Overall delivery and average adherence to Triple P session content across all four TPIE assessment points in Cabarrus & Mecklenburg Counties.

The breakdown of Time 4 practitioner adherence data by Triple P intervention and session are reported in Tables 17 and 18. It is noteworthy that, although Cabarrus County Triple P practitioners' self-reported fairly high adherence for most Triple P sessions, there were a few sessions for which more than one practitioner reported lower adherence to session content (average session adherence less than 70%). These included Primary Care Triple P session 1 and Standard Triple P sessions 1 and 2. Though the small

Cabarrus County Practitioners – Self-reported Adherence during Last Triple P Session				
Last Triple P Session Delivered	**Count**	**Percent of Sample**	**Percent of Possible Session Components Completed**	***SD***
Primary Care Triple P	**22**	**29.7%**		
Session 1	4	5.4%	66%	.12
Session 2	7	935%	96%	.06
Session 3	1	1.4%	69%	n/a
Session 4	10	13.5%	Unavailable[9]	n/a
Primary Care Teen Triple P	**5**	6.8%		
Session 1	2	2.7%	86%	.20
Session 2	1	1.4%	100%	n/a
Session 4	2	2.7%	90%	.14
Primary Care Stepping Stones	**4**	5.4%		
Session 1	1	1.4%	78%	n/a
Session 2	1	1.4%	78%	n/a
Session 3	1	1.4%	60%	n/a
Session 4	1	1.4%	100%	n/a
Standard Triple P	**10**	13.5%		
Session 1	2	2.7%	54%	.23
Session 2	2	2.7%	50%	.21
Session 4	3	4.1%	86%	.15
Session 8	1	1.4%	100%	n/a
Session 10	2	2.7%	100%	.00
Discussion Group	**1**	1.4%		
Session 1	1	1.4%	61%	n/a
Brief Primary Care	**14**	18.9%		
Session 1	4	5.4%	77%	.14
Session 2	10	13.5%	76%	.12
No delivery of Triple P to date	**14**	18.9%		
Delivery more than 6 months ago	**4**	5.4%		
TOTAL	74	100%		

Table 17. Self-reported adherence to intended Triple P session content during practitioners' most recent Triple P session, Cabarrus County, fall 2015.

[9] Although 10 practitioners in Cabarrus County indicated that Primary Care Triple P session 4 was their last session delivered, an error in the TPIE web-based practitioner survey design at Time 4 prevented those practitioners from providing their adherence data.

Mecklenburg County Practitioners – Self-Reported Adherence during Last Triple P Session				
Last Triple P Session Delivered	**Count**	**Percent of Sample**	**Percent of Possible Session Components Completed**	***SD***
Primary Care Triple P	**22**	37.9%		
Session 1	13	22.4%	91%	.11
Session 2	5	8.6%	78%	.27
Session 3	2	3.5%	92%	.00
Session 4	2	3.5%	100%[10]	n/a
Primary Care Teen Triple P	**2**	3.5%		
Session 3	1	1.7%	100%	n/a
Session 4	1	1.7%	100%	n/a
Selected Seminar (0-12)	**1**	1.7%		
Seminar 1	1	1.7%	100%	n/a
Standard (0-12)	**4**	6.9%		
Session 3	2	3.5%	96%	.06
Session 4	2	3.5%	97%	.04
Discussion Group	**1**	1.7%		
Session 8	1	1.7%	100%	n/a
Group Triple P (0-12)	**2**	3.5%		
Session 2	1	1.7%	97%	n/a
Session 3	1	1.7%	98%	n/a
No delivery of Triple P to date	**24**	41.3%		
Delivery more than 6 mo. ago	**2**	3.5%		
TOTAL	58	100%		

Table 18. Self-reported adherence to intended Triple P session content during practitioners' most recent Triple P session, Mecklenburg County, fall 2015.

sample size and limited scope of the current evaluation make it difficult to know why adherence was lower for some sessions than others, on the handful of occasions that respondents provided optional notes about their service delivery or reasons that session activities were not completed, they noted that some aspects of the session were not applicable, had been reviewed in prior interactions with the parent, or had to be modified due to parent need. For example, Time 4 Cabarrus practitioner comments described parents who were experiencing multiple stressors that weren't all related to parenting, running out of time to complete all items designed for a given session, and parents' noncompliance with the completion of assessment material intended for review during the session. A few practitioners also noted that a child was present and acting out during the session, which made completion of all session agenda items difficult.

[10] Although two practitioners in Mecklenburg County indicated that Primary Care Triple P session 4 was their last session delivered, an error in the TPIE web-based practitioner survey design at Time 4 prevented one of these practitioners from providing their adherence data.

Countywide Reach of Triple P Interventions & Family Wellbeing Indicators

Countywide Reach of Triple P Interventions

When interpreting the number of families served by county Triple P practitioners, the size of each county's population is important context. 2014 U.S. Census county population estimates (the latest population estimates available at the time of this report) and the reach of Triple P interventions within each county by the fall of 2015 are reported in Table 19. Reach data include the number of caregivers that Triple P practitioners had contact with and the number of children in the houses of those caregivers since the launch of the Triple P coalitions in each county. County implementation support staff sharing these data with TPIE evaluators cautioned that some duplication may be present due to methods used early in the state's Triple P data reporting process, though an investigation by both counties' support staff indicated that duplication was minimal. For Cabarrus County, data suggest that Triple P interventions may have made a modest, but possibly meaningful reach to county children and families. On the other hand, Mecklenburg County is still in the process of establishing a meaningful reach of Triple P interventions to children and families in their sizable population.

	2014 County Population Estimates and Reach of Triple P by Fall 2015	
	Cabarrus	Mecklenburg
Overall Population	192,103	1,012,539
Children under 5	12,102	70,878
Children under 18	50,331	249,085
# children in the households of caregivers contacted by Triple P practitioners as of fall 2015	**6374** (12.6%)	**8012** (3.2%)
Approximate families[11]	26,490	131,097
# caregivers contacted by Triple P practitioners as of fall 2015	**4686** (17.7%)	**2943** (2.2%)

Table 19. 2014 County population estimates (Cabarrus population estimates: U.S. Census Bureau, 2015a; Mecklenburg Population estimates: U.S. Census Bureau, 2015b) and reach of Triple P interventions through fall 2015, as provided by county implementation support staff.

Countywide Family Wellbeing Indicators

Population prevalence rates for child maltreatment related indicators are tracked over time for each county in North Carolina. Examination of trends over time provides a glimpse of how Cabarrus and Mecklenburg counties are doing on such indicators (e.g., child maltreatment substantiations, foster care placements). **However, the TPIE evaluation team strongly cautions that in the absence of randomization and adequate controls, it is not possible to make legitimate causal inferences from the observed trends in the population prevalence rates (i.e., after onset of implementation and scale-up of the Triple P intervention system in each of the two counties).** Yearly data pertain to children in the birth to 17-year-old range (which matches the target age ranges for the county Triple P coalitions in Cabarrus and Mecklenburg counties) and are available for each fiscal year.

[11] "Approximate families" calculated using the assumption of 1.9 children per family in the United States (U.S. Census Bureau, 2015c).

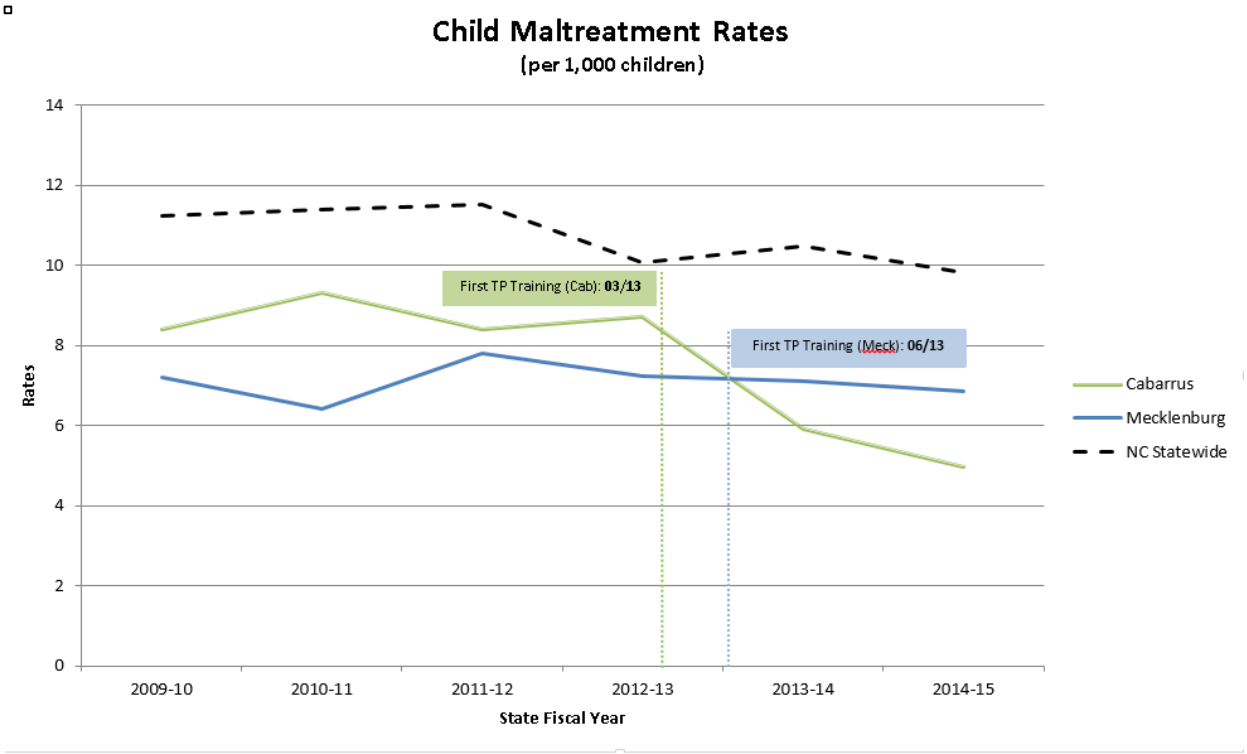


Figure 9. Child maltreatment rates for Cabarrus and Mecklenburg counties and statewide for North Carolina, State Fiscal Years 2009-10 through 2014-15.

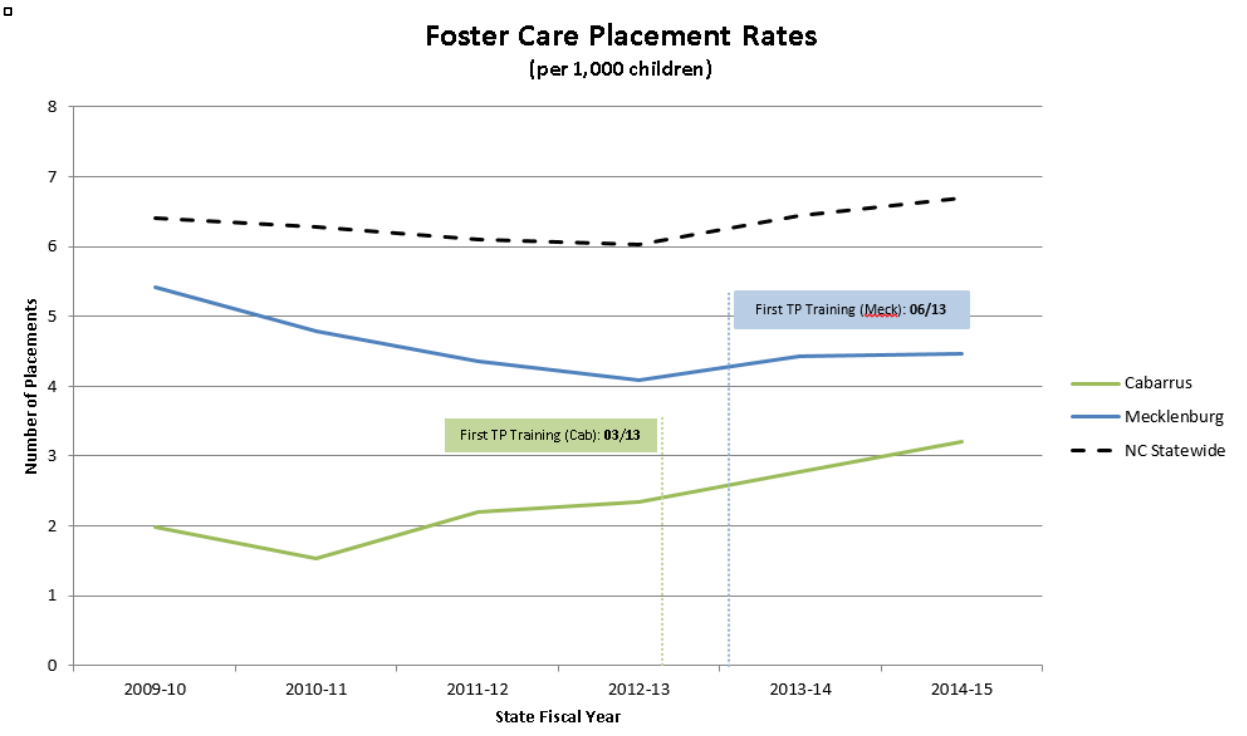


Figure 10. Foster care placement rates for Cabarrus and Mecklenburg counties and statewide for North Carolina, State Fiscal Years 2009-10 through 2014-15.

With respect to child maltreatment substantiations (see Figure 9), the trend for Cabarrus County suggests a drop two years in a row (SFY2013-14 and SFY2014-15), which occurred after Triple P training of practitioners was initiated in that county. The statewide trend seems to be somewhat flat during that same period. The trend for Mecklenburg County does not reflect a change in trajectory during that same period, although it should be noted that county practitioners' Triple P training started later and has not yielded as much intervention penetration as that in Cabarrus County. Data for the next two years may provide additional insight about the longer-term trends in both counties.

The trends for foster care placement (see Figure 10) show that observed rates for Cabarrus and Mecklenburg counties for SFY2013-14 and SFY2014-15 are similar to the trend for the statewide rate. Two caveats are noted. First, foster care placements for the older portion of the birth-to-17 age range (i.e., 12-17) may include placements not triggered by child maltreatment (e.g., youth getting into trouble for violent behavior), but such nuanced data are not available within the state data system to disentangle this issue or to examine birth-to-11 age group separately. Second, data for the next two years may provide additional insight about the longer-term trends for foster care placements in both counties.

At the time of this report, county and state data on hospital treatment of child-maltreatment injuries were not yet available from state evaluators.

Discussion and Recommendations

The purpose of the Triple P Implementation Evaluation project (TPIE) was to evaluate capacity and infrastructure for the *active* implementation of, and service delivery associated with, the Triple P system of interventions in two North Carolina counties. Across a two-year evaluation period in Cabarrus and Mecklenburg counties, data collected were intended to inform the planning process for impact and sustainability. Reflecting on the longitudinal evaluation results, several points are worth discussing.

First, **TPIE evaluators are pleased that county implementation capacity and agency implementation infrastructure assessments, with favorable indications of reliability, were developed as a byproduct of TPIE**. The PS-CCA-TP and IDA-TP offer assessments of capacity and infrastructure to support the implementation of Triple P across multiple levels of the county prevention system, consistent with the cascading logic model of implementation support presented at the beginning of this report. That the patterns of peaks and valleys across the implementation drivers scales (the blue bars in results graphs) are relatively similar across each county's PS-CCA-TP and IDA-TP results also offers some face validity to these instruments. That is, where county capacity to work with agencies to support the use of implementation best practices was stronger, agency implementation infrastructure and best practices were more in place. TPIE evaluators intend to work with the datasets collected throughout the two-year evaluation period to further test the reliability and validity of these assessment instruments. Their potential use as quality improvement tools for counties in North Carolina wanting to scale-up Triple P across their county prevention system is also an opportunity resulting from TPIE.

In reviewing county implementation capacity and agency implementation infrastructure results over the TPIE evaluation period, any discussion should begin with recognition of the progress these two county Triple P coalitions, in partnership with their primary funder – the North Carolina Division of Public Health – and program purveyor – Triple P America – have made since their inception. The work of successfully implementing and scaling evidence-based programs across county prevention systems is complex,

indefinite, and shaped by local county context. **The investment of time, energy, and human and financial resources that the county coalitions and their partners have made thus far to improve the wellbeing of children and families in Cabarrus and Mecklenburg counties through effective parenting and family support programs is laudable**.

Through the end of the TPIE evaluation period, each county had established a meaningful amount of county-level capacity to support the implementation and scale-up of Triple P, a diverse coalition of local agencies to deliver Triple P across multiple access points, a handful of strengths within agency infrastructure and best practices to support the growing number of practitioners to deliver Triple P, and in Cabarrus County, a promising reach of Triple P services into the county's population of children and families. **Progress to date appears stronger on the organizational side of implementation** (i.e., leadership and implementation teams at county and agency levels, county action planning and prevention system alignment, and organizational implementation drivers at county and agency levels) **and in the development of infrastructure and best practices to support practitioner recruitment and selection and practitioner training in Triple P**.

In addition to highlighting achievements to date, TPIE evaluation results reveal gaps within county implementation capacity and agency implementation infrastructure that might be the target of future developmental efforts. First, it is noteworthy that, within each county, agency implementation infrastructure appeared to lag county implementation capacity. That is, just because a county had developed a county implementation team with the resources and abilities to work closely with local agencies did not ensure that agency implementation infrastructure and best practices were well in place across the county. Therefore, **even if county implementation support teams are confident about their own development in a particular area, they may need to keep in mind that the local agencies they support are possibly earlier in their own developmental trajectories**.

This lag appeared greater in Mecklenburg County, where the county implementation team had historically lower capacity (particularly in terms of formally allocated time and effort), the county received substantially less state resources to support the scale-up of Triple P, and the county prevention system and population are much larger. Time 4 gains in Mecklenburg County implementation capacity related to practitioner coaching and fidelity assessment were also not yet mirrored within agency implementation infrastructure. It may be that the newly reported strength in Mecklenburg County implementation team capacity at Time 4 needs time to mature and possibly even additional implementation team member time and effort to make an impact at the agency-level. It is promising, however, that agency implementation infrastructure and best practices were showing a slightly favorable developmental trajectory in Mecklenburg, even if primarily attributable to the second and third cohorts of agencies to join the Mecklenburg County Triple P Coalition.

The Mecklenburg County Triple P Coalition also evidenced higher rates of agency and practitioner attrition and lower rates of practitioners having yet delivered Triple P during the TPIE evaluation period. **This suggests that the impacts of factors such as historically lower county implementation team capacity and less resources to support the scale-up of Triple P in a very large county may extend not only to the development of agency implementation infrastructure, but also to agency continuation of Triple P implementation and practitioner continuation of Triple P delivery within the county Triple P coalition**. In fact, interpreting that agency implementation infrastructure and best practices within Mecklenburg County are on a slow but positive developmental trajectory is cautiously made because

such gains could alternately be resultant from differential agency attrition (i.e., those agencies with less well-developed implementation infrastructure leaving the county Triple P coalition).

That stronger developmental gains are not evident in agency implementation infrastructure and sustainability planning in Cabarrus or Mecklenburg counties across time (with the exception of cohorts 2 and 3 in Mecklenburg) also needs consideration. Though the reasons for this lack of expected development over time are unclear, **county implementation teams may want to re-examine the ways in which they are working with local agencies to ensure the ongoing development of agency implementation infrastructure and best practices**. In particular, agency leaders and implementation team members may benefit from more developmentally focused and supportive behavioral coaching from county implementation team members around active implementation infrastructure and best practices. Likewise, county implementation team members may need support from their purveyor – Triple P America – and other active implementation technical assistance providers to ensure they are well grounded in developmental approaches to growing active implementation infrastructure and best practices to support Triple P.

Agencies also have a role to play in supporting their own development for implementing Triple P, which is largely maintained by having enough agency implementation team capacity to move agency implementation forward on a day-to-day basis. TPIE evaluation results suggest a need to increase agency implementation team capacity, both in terms of team membership numbers and in allocating formal time and effort to support implementation. Without at least three team members and adequate time and effort supporting daily implementation activities in an agency, the agency risks insufficient support for its Triple P practitioners and continuation of Triple P implementation could be precarious in the event of team member turnover. In line with this latter point, agency implementation capacity was significantly associated with agencies' continuation with Triple P implementation across the two TPIE counties. The presence of implementation teams has been associated with greater use and sustainability of innovative practices and programs in other research and evaluation samples as well (Fixsen et al., 2001; Saldana & Chamberlain, 2012). Increasing agency implementation team capacity may also accelerate improvements related to the three organizational implementation drivers across agencies (decision-support data systems, facilitative administration, and systems intervention); agency leadership and implementation teams largely ensure best practices related to these organizational drivers.

Another way in which agencies can support their own efforts to sustainably implement Triple P is to ensure that they have sufficient *Triple P practitioner capacity*. TPIE results indicated that agencies with only 1 practitioner were 9.8 times more likely to become inactive. Research by Klest (2014) likewise found that clustering three or more practitioners using the same evidence-based program within an organization had significant and favorable outcomes on practitioners' use of the program, their agency's integration of the program well into the organization, and their agency's continuation with the program.

Agency leaders and, in particular, agency implementation team members also need to make sure that they are well partnered with their county implementation team or there is a possibility that the county's practices and directions become misaligned with the agency's own practices and directions over time. Close alignment of agency leadership and implementation team members with the county implementation team may also support hospitable implementation climates within agencies. County implementation team members can work with agency leadership and implementation support staff to

problem-solve challenges to Triple P implementation, use agency-specific data for quality improvement, and ensure that Triple P implementation remains a priority within the agency. As demonstrated by TPIE evaluation results and results from other evaluation and research samples, a hospitable agency implementation climate is an important factor in the successful and sustainable implementation of evidence-based interventions (e.g., Damanpour, 1991; Glisson & James, 2002; Klein & Sorra, 1996; Panzano et al., 2004).

TPIE evaluation results clearly suggest that the two areas of greatest developmental need among county agencies are practitioner coaching and fidelity assessment infrastructure and best practices. During the course of the evaluation, TPIE evaluators became aware that at least two key components in Triple P's peer support network model (which helps ensure that practitioners receive ongoing coaching after accreditation) were largely missing across both counties. Specifically, county peer support networks did not make available expert coaches with experience delivering Triple P across diverse families and communities. Likewise, county Triple P practitioners were not expected to be observed delivering Triple P to local parents and families during county peer support network meetings (even if via audio or video samples). Similarly, many local agency representatives and county Triple P practitioners were not aware of the availability or use of Triple P session checklists for monitoring adherence to the intended delivery of Triple P session content during the first two TPIE assessment periods. Although *awareness* increased by the last two assessment periods, Triple P session checklist *use for fidelity assessment* largely did not.

Even should Triple P session checklists use grow, it is worth noting that self-reported adherence data from Triple P session checklists may be limited because they are vulnerable to bias inherent in any self-report. For example, fidelity data derived from observation could indicate that practitioners are completing fewer session activities than they are self-reporting via the session checklists due to the desire to "look good" when self-reporting (i.e., social desirability bias). Moreover, self-reported adherence data do not reflect practitioner *competency* in delivering Triple P interventions. In some cases, competent delivery of a Triple P session may involve adjustments or even *intentionally skipping* some session activities based on clients' preferences and presenting concerns. **The use of a broader array of Triple P fidelity assessments – while remaining practical and efficient for Triple P practitioners and their agencies – may be beneficial for these reasons**.

The development of infrastructure and best practices related to practitioner coaching and fidelity assessment may not only improve the quality of Triple P practitioners' Triple P delivery (Hattie, 2009; Kavanagh, Spence, Strong, Wilson, Sturk, & Crow, 2003; Schoenwald, Sheidow, & Letourneau, 2004) **but also their use of Triple P across time**. Joyce and Showers (2002) demonstrated that coaching teachers within their applied setting following initial training substantially increased their use of training in innovative teaching models. Aarons, Fettes, and colleagues (2009) and Aarons, Sommerfeld, and colleagues (2009) also demonstrated that fidelity monitoring of evidence-based practices in the context of supportive coaching in community service agencies may not increase burden or burnout among practitioners and may actually *increase* practitioner retention over time. These research findings may provide additional incentive for increasing practitioner coaching and fidelity assessment best practices among local agencies. The support of staff from Triple P America and, potentially, Triple P researchers and program developers in the United States and abroad may be helpful to county Triple P coalitions in these regards.

On this last point, the county Triple P coalitions and their partners will benefit from remembering that building – or continuing the development of – visible implementation capacity and infrastructure requires close, stage-based collaboration among leadership and staff at implementation sites, intervention developers and purveyors, community partners, funders and policy-makers, and active implementation technical assistance providers (Aldridge, Boothroyd, Fleming, Jarboe, Morrow, Ritchie, & Sebian, in press; Metz & Albers, 2014). To date, the county Triple P coalitions in Cabarrus and Mecklenburg have benefited from the support of the North Carolina Division of Public Health, local agency leadership and staff within agencies implementing Triple P, and Triple P America. **To build on the strengths achieved to date and address the gaps that remain, the county Triple P coalitions in Cabarrus and Mecklenburg counties will need ongoing support from these three existing partners. In addition, they may benefit from the support of a full range of co-creation partners**, including:

- Triple P researchers and developers in the United States and abroad;
- other local and state funders, including public agencies and private foundations (e.g., to diversify and sustain funding);
- local community partners, including youth and families being served by county Triple P services (e.g., to ensure ongoing cultural and community fit of Triple P interventions and implementation practices); and
- active implementation technical assistance providers (e.g., to increase county implementation team capacity to ensure the development of active implementation infrastructure and best practices across local agencies).

Finally, it may be worth discussing the **opportunity to leverage the capacity and infrastructure developed via each county Triple P coalition for other evidence-based prevention and wellbeing strategies**. Though each county Triple P coalition may want to first ensure that capacity and infrastructure for Triple P is stabilized and sustainable and that they have fully installed a range of Triple P programs, the county coalitions could make use of the capacity that has been developed to identify, implement, and scale-up other evidence-based prevention and wellbeing strategies. In particular, new strategies that compliment Triple P's parenting and family support strategies and child and family wellbeing goals might be explored. Additional candidates for implementation should be identified in response to county wellbeing needs analyses within each county and with the participation of key county and agency partners. However, additional programs and practices might target outcomes such as academic achievement, the prevention of adolescent substance use, and youth pro-sociality behaviors (e.g., civic engagement).

Recommendations

Before turning to recommendations that emerge from TPIE evaluation results, it is important to reinforce that the county Triple P coalitions in Cabarrus and Mecklenburg counties, in partnership with their funders at the North Carolina Division of Public Health (NC DPH) and their program purveyor, Triple P America, have made meaningful progress developing local capacity and infrastructure to implement and scale-up Triple P. To build on the strengths already demonstrated in each county, TPIE evaluators, offer the following recommendations for continuing to support scale-up of the Triple P system of interventions within and across Cabarrus and Mecklenburg counties. *Recommendations are made for both counties unless otherwise specified*.

County-Level

County implementation capacity

- *In Mecklenburg County*, **increase the amount of time and effort formally allocated to County Implementation Team members** to sufficiently attend to implementation and scale-up support needs across the county's large Triple P coalition and sizable population.
- Develop county implementation teams' resources and abilities to work with local agencies to **increase the use of best practices for coaching Triple P practitioners** after their accreditation and as they deliver Triple P to children and families. Best practices for coaching include, for example:
    - ensuring there is access to coaches that have expertise and experience delivering Triple P interventions across diverse families and communities;
    - having coaches use multiple sources of information to give feedback to practitioners (e.g., observational data, session records, interviews with those familiar with the practitioner's delivery of Triple P);
    - collecting data about whether or not practitioners' abilities to effectively deliver Triple P improve as a result of coaching; and
    - providing feedback to coaches about their coaching from multiple sources of information.
- Develop county implementation teams' resources and abilities to work with local agencies to **increase the use of best practices for assessing whether or not Triple P interventions are delivered as intended**. Best practices for fidelity assessment include the *practical, efficient*, *and systematic* use of multiple forms of fidelity assessment, such as combinations of:
    - assessing whether interventions are being delivered to intended recipients and using intended formats;
    - assessing practitioner skill and competence in delivering interventions (usually via live or recorded observation, which can be randomly sampled across time);
    - assessing for intended intervention dosage (i.e., the number of intervention sessions provided to reasonably expect outcomes for a particular intervention); and
    - assessing whether or not intended content is delivered from session to session.

  Recognizing agency Triple P practitioners specifically for participating in or completing fidelity assessment procedures is also an implementation best practice.
- Given development needs for implementation infrastructure and best practice among local agencies, **ensure that the county implementation team is working with local agencies to increase the use of organizational implementation drivers best practices within their agencies** (i.e., for decision-support data systems, facilitative administration, and systems intervention).
- **Continue to develop and then document plans to sustain** county leadership teams, county implementation teams, and the necessary financial and programmatic resources needed otherwise to support the ongoing implementation and scale-up of Triple P beyond the county service grants from the North Carolina Division of Public Health.

County implementation policies and practices

- Based on results indicating that agencies are at substantially higher risk for discontinuing implementation if they have only one trained Triple P practitioner, **consider adding an agency selection criterion that agencies send three or more practitioners to Triple P training**. This

recommendation does not preclude continuing to offer training to independent or private practitioners in the county.

- Based on results indicating that agencies are at substantially higher risk for discontinuing implementation if they have an unfavorable implementation climate for Triple P and less agency capacity to support Triple P, **consider adding agency selection criteria that**
    - **agency leaders are well bought-in and engaged** with Triple P implementation processes, and
    - **the agency will commit sufficient management time and effort to an appropriately skilled agency implementation team** that will liaise with the county implementation team and support local agency Triple P implementation activities and needs. *Sufficient* time and effort may vary across agencies depending on the agency's size, complexity, and number of Triple P practitioners. However, implementation teams, by definition, consist of *at least three or more individuals* (often with a team leader or point person) responsible for coordinating and supporting the day-to-day implementation of Triple P at the agency. Implementation teams can be formed by repurposing existing management teams (which may be preferable if possible) or developing a new one.
- **Monitor identified risk factors for agency discontinuation of Triple P implementation** (i.e., poor implementation climate for Triple P, lower agency implementation support capacity, having only one Triple P practitioner, and less formal agency planning for sustainability). Among those agencies with one or more risk factors, the county implementation team may provide more intensive implementation support.
- **Consider a stage-based approach to supporting the implementation of Triple P interventions across county practitioners and local agencies.** For example:
    - **Among Triple P interventions currently in the installation stage** of implementation:
        - continue to support practitioner recruitment and selection, training, and coaching to ensure competency and confidence to deliver these interventions as intended; and
        - provide intensive active implementation support to agencies that will be hosting these new interventions to ensure that agency leadership and implementation support staff, practitioner coaching (e.g., peer support networks with expert coaches), fidelity assessment, decision-support data systems, and system strategies (e.g., media strategies, system partners) are well in place to support and optimize these interventions once they move into initial implementation.
    - **Among Triple P interventions currently in the initial implementation stage**, provide intensive active implementation support to agencies hosting these interventions to ensure that:
        - practitioners have access to and are well-supported by coaches that have expertise and experience delivering these or related Triple P interventions across diverse families and communities,
        - fidelity data demonstrate increasing delivery of these interventions as intended,
        - early outcome data are promising for the impacts on county children and families,
        - emerging implementation barriers and system needs are addressed,
        - early successes are shared and solutions to problems are spread, and

        - practitioner, agency leadership and management, and community stakeholder buy-in for these interventions is well attended to and supported.
    - **Among Triple P interventions currently in the full implementation stage**, provide ongoing active implementation support to agencies hosting these interventions to ensure that:
        - reliable and multiple forms of fidelity data (e.g., intended recipients, practitioner competence, intervention dosage, session format and content) confirm that the majority of Triple P practitioners needed to deliver these interventions for communitywide impact are doing so as intended;
        - practitioners have access to and are well-supported by ongoing peer or other professional coaching support (which may be less intensive than coaching provided during the initial implementation stage); and
        - agency leadership and implementation support staff, fidelity assessment infrastructure, decision-support data system infrastructure, and larger system strategies (e.g., media strategies, system partners) are sustained to continue to optimize these interventions and their impact on county children and families.
- **Continue to increase the reach of current Triple P interventions within county populations of children and families.** To expect population-level outcomes in *Mecklenburg County*, in particular, a sizable increase in intervention reach is likely needed. Increasing the reach of Triple P interventions in each county will involve more than training additional practitioners, particularly increasing agencies' use of implementation best practices to retain and support current practitioners to use their Triple P training and deliver Triple P interventions as intended.
- **Explore how implementation capacity and infrastructure that has been developed for Triple P may be smartly and appropriately leveraged to support the implementation and scale-up of additional countywide, evidence-based prevention and wellbeing strategies.** TPIE evaluators suggest actively pursuing this recommendation *only after* the implementation capacity and infrastructure is well established and sustainable for Triple P. Also, each county may want to more fully install a range of Triple P interventions before considering other evidence-based strategies. However, *exploring* the pursuit of this recommendation may be timely and important for strategic planning purposes.
- To support putting these recommendations into place, **county leadership and implementation support staff may benefit from partnership with a full range of implementation co-creation partners** (e.g., Aldridge, Boothroyd, Fleming, Jarboe, Morrow, Ritchie, & Sebian, in press; Metz & Albers, 2014). Co-creation partners include:
    - local agency leadership and staff within agencies implementing Triple P;
    - county funders (e.g., NC DPH, local foundations and philanthropic companies);
    - state and local policymakers;
    - local community partners, including youth and families being served by county Triple P services;
    - Triple P America and Triple P researchers/developers in the United States and abroad; and
    - active implementation technical assistance providers.

Agency-Level

Agency implementation infrastructure

- **Ensure the presence of agency implementation teams with *three or more* appropriately skilled individuals** who are responsible for coordinating and supporting the day-to-day implementation of Triple P within the agency. Likewise, **increase the amount of time and effort formally allocated to current Agency Implementation Team members** to liaise with the county implementation team and sufficiently attend to implementation support needs within the agency. *Sufficient* time and effort may vary across agencies depending on the agency's size, complexity, and number of Triple P practitioners. Implementation teams can be formed by repurposing existing management teams (which may be preferable if possible) or developing a new one.
- **Increase the use of best practices for coaching Triple P practitioners** after their accreditation and as they deliver Triple P to children and families. Best practices for coaching include, for example:
    - ensuring agency Triple P practitioners have access to coaches with expertise and experience delivering Triple P interventions across diverse families and communities;
    - having coaches use multiple sources of information to give feedback to agency Triple P practitioners (e.g., observational data, session records, interviews with those familiar with the practitioner's delivery of Triple P);
    - collecting data about whether or not agency Triple P practitioners' abilities to effectively deliver Triple P improve as a result of coaching; and
    - providing coaches feedback on their coaching from multiple sources of information.
- **Increase the use of best practices for assessing whether or not Triple P interventions are delivered as intended to children and families served by the agency**. Best practices for fidelity assessment include the *practical, efficient*, *and systematic* use of multiple forms of fidelity assessment, such as combinations of:
    - assessing whether interventions are being delivered to intended recipients and using intended formats;
    - assessing practitioner skill and competence delivering interventions (usually via live or recorded observation, which can be randomly sampled across time);
    - assessing for intended intervention dosage (i.e., the number of intervention sessions provided to reasonably expect child and family outcomes); and
    - assessing whether or not intended content is delivered from session to session.

  Recognizing agency Triple P practitioners specifically for participating in or completing fidelity assessment procedures is also an implementation best practice.
- **Increase the use of best practices to gather, use, and share implementation and intervention data for decision-making** to improve the implementation of Triple P within the agency. Best practices for decision-support data systems include, for example:
    - systematically collecting data about implementation process quality and outcomes (e.g., the quality of coaching and expected practice outcomes related to coaching), not just implementation process outputs (i.e., the number of coaching sessions attended);
    - on at least a quarterly basis, sharing agency-specific Triple P data reports widely within the agency and with community stakeholders and appropriate partners outside the agency; and

  - using Triple P data for decision-making to improve Triple P implementation practices within the agency.
- **Increase the use of best practices to solicit, document, and use information about agency policy and practice facilitators and barriers** to improve the implementation of Triple P within the agency. Best practices for facilitative administration include, for example:
  - employing usability testing (i.e., short plan-do-study-act cycles with small groups) to test and adjust the implementation of Triple P within the agency;
  - systematically soliciting information from staff and from the children, families, and/or communities the agency serves about how well its policies and practices support the implementation of Triple P; and
  - using common themes in the information gathered to strengthen internal agency policies and practices to support the implementation of Triple P.
- **Increase the use of best practices to solicit, document, and use information about Triple P successes and larger systems needs** to improve and sustain the implementation of Triple P within the agency. Best practices for systems intervention include, for example:
  - systematically soliciting information from staff and from the children, families, and/or communities the agency serves about larger service system needs related to Triple P that may be outside of the agency's immediate influence or direct control;
  - on at least a quarterly basis, sharing the agency's Triple P successes with appropriate stakeholders, partners, champions, and opinion leaders outside the agency; and
  - establishing referral channels with other county agencies that are implementing Triple P interventions.
- **Continue to develop and then document plans to sustain** agency leadership teams, agency implementation teams, and the necessary financial and programmatic resources needed otherwise to support the ongoing implementation and delivery of chosen Triple P interventions beyond the county service grants from NC DPH.

Agency implementation policies and practices

- Based on results indicating that agencies are at substantially higher risk for discontinuing implementation if they have only one trained Triple P practitioner, **ensure that the agency hosts and maintains three or more Triple P practitioners**.
- Based on results indicating that agencies are at substantially higher risk for discontinuing implementation if they have an unfavorable implementation climate for Triple P, **agency leaders may benefit their agency's implementation process by:**
  - demonstrating their ongoing commitment to the implementation of Triple P within the agency,
  - creating appropriate opportunities for change within the agency to support Triple P implementation, and
  - nurturing agency changes once they are underway.
- To support putting these recommendations into place, **agency leadership and implementation support staff may benefit from partnership with a full range of implementation co-creation partners** (e.g., Aldridge, Boothroyd, Fleming, Jarboe, Morrow, Ritchie, & Sebian, in press; Metz & Albers, 2014). Co-creation partners include:
  - internal agency staff and practitioners;

- agency funders (e.g., state and local public funders, community foundations and philanthropic businesses, third-party payers);
- state and local policymakers;
- local community partners, including youth and families being served by county Triple P services;
- Triple P America support staff; and
- county implementation leadership and support staff (i.e., from Cabarrus Health Alliance or Mecklenburg County Health Department).

Other System Partners Supporting Triple P Scale-Up

To put into place some or all of the recommendations made in this report, the county Triple P coalitions in Cabarrus and Mecklenburg counties will need ongoing support from:

- **The North Carolina Division of Public Health** (e.g., to identify ways to sustain funding);
- **Local agency leadership and staff within agencies implementing Triple P** (e.g., to identify practical and efficient ways to assess practitioners' fidelity to Triple P, to continue to identify and address local agency and larger systems challenges to the successful implementation of Triple P); and
- **Triple P America** (e.g., to increase the use of coaching best practices within county and agency peer support networks).

In addition, they may benefit from the added support of:

- **Triple P researchers and developers** in the United States and abroad (e.g., to develop practical and efficient fidelity assessment procedures for use in the field);
- **Other local and state funders such as public agencies, private foundations, and third party payers for services** (e.g., to identify diversified and sustainable funding);
- **State and local policymakers** (e.g., to remove systems barriers and spread systems solutions);
- **Local community partners**, including youth and families being served by county Triple P services (e.g., to ensure the cultural and community fit and success of Triple P interventions and implementation policies); and
- **Active implementation technical assistance providers** (e.g., for implementation capacity and development support).

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