

Washington State Triple P Initiative
2014-2015 End of Year Report
October 2015

Introduction

The Division of Behavioral Health and Recovery (DBHR) applied Mental Health Block Grant funds to support a collaboration between the University of Washington's Division of Public Behavioral Health and Justice Policy (UW PBHJP) and Tacoma-Pierce County Health Department (TPCHD) to implement the Triple P Positive Parenting Program (Triple P) in Tacoma from October 1, 2014 until September 30, 2015 (FY14-15).

Briefly, the Triple P system of interventions is an evidence-based approach towards promotion of positive parenting and prevention of child abuse and neglect. The Triple P system consists of five intervention levels, including universal prevention (level 1), "light touch" indicated prevention (levels 2 and 3), and interventions for more significant challenges (levels 4 and 5). A detailed description of the suite of Triple P programs is available at www.triplep.net. A previous population-level study of Triple P implementation in South Carolina revealed that the Triple P system may 'move the needle' on indicators of child abuse, including rates of CPS referrals, placements into foster care, and hospitalization for intentional injury (Prinz et al., 2009). And, a randomized controlled study by McCormick and colleagues indicated that training primary care physicians in Triple P can greatly increase their confidence and self-efficacy in delivery of parenting interventions and have positive impacts on disciplinary practices of families who see Triple P-trained practitioners (McCormick et al., 2014). Given that effective parenting is associated with resilience across a range of domains (including recovery from trauma, self-regulation, and academic success) and coercive or neglectful parenting is a significant risk factor for outcomes including early initiation of substance abuse, conduct problems, and early school failure, focusing on ensuring parents have the skills and self-efficacy to be effective in their roles as parents is an important component of building resilient and healthy communities.

This Triple P demonstration project is an extension of the previous rural demonstration project in Omak, Othello and Ocean Beach (Kerns, McCormick, & Negrete, 2014). The intention of this urban demonstration is to create a robust network of Triple P practitioners, who can offer Level 2 through Level 4 services to parents. Similar to the rural demonstration project, this project targets primary care practitioners for training. A unique strategy to enable billing through Medicaid for Triple P services (when primary care practitioners receive accreditation in Triple P) was initiated during the rural demonstration project. The current project aims to increase use of this mechanism.

The project is a partnership between TPCHD and UW. TPCHD employees lead implementation efforts at the local level, specifically engaging and following trained practitioners as well as building service delivery and referral pathways. UW project provides technical assistance to TPCHD staff and evaluates the implementation of Triple P in Tacoma. The UW staff spent the majority of FY14-15 providing technical support to TPCHD, specifically for practitioner engagement and Triple P training coordination. Technical assistance activities included orientation of TPCHD to Triple P, constructing recruitment and training protocols for TPCHD use, coordinating training events, and playing an active role in designing the local implementation plan. The UW and TPCHD created a cost-

sharing plan to pay for Triple P trainings and materials throughout FY14-15. UW and TPCHD held weekly meetings to discuss project planning and execution. A UW staff member attended each Triple P training to provide additional support to TPCHD staff and to answer questions about the evaluation component of the project.

Two evaluation activities were initiated during this first year. Baseline data were collected from all practitioners participating in all initiative-funded Triple P trainings (data are presented in the results section). Additionally, UW staff collected agency-level data for a Social Network Analysis (SNA). This type of analysis investigates the structural factors that impact Triple P implementation in engaged organizations and community level changes in working relationships between organizations participating in the Triple P trainings. While the baseline survey was completed by the majority of agencies, the social network analysis is currently underway and results are not available for this report.

Methods

The project was reviewed by the Washington State and University of Washington Institutional Review Boards and determined to not meet criteria for research. This project is considered program evaluation, and thus this portion of the evaluation is not subject to IRB regulatory oversight.

Practitioners

TPCHD, with the support of UW, recruited local practitioners to attend the Triple P trainings. Eligible practitioners worked in the urban areas of Pierce County, with emphasis in Tacoma. While different practitioners participated in the training, special emphasis was placed on two practitioner populations: Family Support Workers (FSWs) and billable primary care practitioners (PCPs).

- FSWs are contracted employees with the Health Department and receive referrals for Triple P services. FSWs are crucial to the referral pathway between Triple P brief interventions and more intense Triple P interventions.
- Billable medical practitioners are able to utilize the Medicaid billing codes created by HCA. These practitioners include primary care physicians, physician assistants (PAs and MEDEX), and Advanced Registered Nurse Practitioners (ARNPs). These practitioners are at the frontlines of child behavioral problems, often the first professional contact for families with young child. These practitioners not only identify behavioral and parenting concerns but also manage these concerns and refer families to mental health or behavioral health services when appropriate.
- Other Triple P practitioners were recruited from the local community based on recommendations from TPCPH and First Five. These practitioners represented diverse practice settings and are described in more detail below.

Trainings

Triple P trainings typically consist of three formal events: initial training, pre-accreditation and accreditation. The standard training session lasts between one to three days in length depending on the training level. A one-day “pre-accreditation” session is held approximately one month after the initial training. This session help practitioners prepare for accreditation activities. Finally, a $\frac{1}{2}$ day accreditation session is held 6-8 weeks post training. During accreditation, practitioners demonstrate core competencies of Triple P delivery using a

standardized format and submit a quiz on the Triple P program. Practitioners must pass competencies demonstrations and the quiz to become an accredited Triple P practitioner. TPCHD and UW staff offered three types of Triple P trainings during FY 14-15:

- **Brief Primary Care Triple P (Level 2):** In this two-day training, practitioners learn to deliver a 1-session parenting consultation using a tip sheet. This training is ideal for practitioners in primary care-based settings. It is also appropriate for other practitioners who interact with families as part of their daily work. Typical practitioners are healthcare workers, educators and childcare staff.
 - **We offered two Brief Primary Care trainings during this year.** One was focused on primary care practitioners and the other was focused on other community-level practitioners.
- **Standard Triple P (Level 4):** In this three-day training, practitioners learn to deliver a 10-session parenting consultation using a family workbook. This training is ideal for practitioners who work more intensively with families on a long-term basis. Typical practitioners include behavioral health therapists, social workers and public health nurses.
 - **We offered one Standard Triple P training during this year.**
- **Group Triple P (Level 4):** In this three-day training, practitioners learn to deliver an 8-session group-based parenting intervention. While content and level of service intensity is very similar to Standard Triple P, this training prepares practitioners to deliver content in a group-based format. This training is ideal for practitioners who work more intensely with families on a long-term basis and have the capacity to lead groups as part of their work functions. Typical practitioners include behavioral health therapists, social workers and public health nurses.
 - **We offered one Group Triple P training this year.**

Measures

In the first year of this project, we administered several measures to collect baseline data from training participants, including practitioner report of skills and training satisfaction and the Washington State Triple P Implementation Project Evaluation Survey. We also collected agency-level data from organizations that sent one or more practitioners to training. These organizations completed the Social Network Analysis Evaluation Survey – Baseline. All measures are described below and preliminary data is reported in the Results section.

Practitioner Report

Triple P training includes two standardized evaluation measures to administer at the beginning and end of every training. UW staff has an agreement with Triple P America (TPA) to use the results from these measures in our evaluation. Participants signed consent forms allowing for this information sharing.

Parent Consultation Skills Checklist (PCSC). We measured practitioner self-reported skills with the Parent Consultation Skills Checklist (PCSC), a standardized tool developed by Triple P. The PCSC assesses a practitioner's proficiency in a number of core skill domains (assessment, active skills training, dealing with process issues and clinical application of positive parenting strategies) and their confidence in their parent consultation skills. All practitioners, regardless of the Triple P training, completed this measure. The measure varies in length depending on Triple P training level. All items are rated on a 7-point scale ranging from 1 (not at all proficient) to 7 (very proficient).

- The Brief Primary Care measure consists of 16 items.
- The Level 4 Standard measure consists of 24 items.
- The Level 4 Group measure consists of 20 items.

The PCSC has high internal consistency ($\alpha=0.96$). Maximum score for the Primary Care and Group PCSC is 140 and is 168 for the Standard PCSC, with higher scores indicating greater proficiency. Practitioners completed this assessment by hand at three time points: pre-training, post-training and at accreditation.

Workshop Evaluation Survey (WES). The Workshop Evaluation Survey is a standardized tool developed by Triple P. The WES contains 15 items. All items are rated on a 7-point scale ranging from 1 to 7, with higher scores indicating more favorable responses. There is no standard value assigned to the numbers in this measure. Practitioners completed the measure by hand at the end of training and at the end of the accreditation session.

Washington State Triple P Implementation Project Evaluation Survey.

To maintain consistency between this initiative and the Rural Demonstration Project, UW staff used a similar baseline evaluation survey with Tacoma practitioners. Please refer to the Appendix A for the complete questionnaire. The survey contains five sections.

- The first section contains questions about practitioner demographic information and the population the practitioner serves.
- The second section contains questions from the Evidence-Based Practice Attitude Scale (EBPAS). The EBPAS is a 15-item measure intended to assess the willingness of practitioners to adopt evidence-based practice (EBPs) based on the appeal of the EBP, requirements imposed by their organization, supervisor, or system and the practitioner's degree of openness to innovation and perceived importance of using research-based interventions in their practice. Previous reports have demonstrated adequate internal consistency for this measure. In our evaluation, the overall Chronbach's alpha reliability was adequate, at $\alpha = .715$.
- The third section contains questions about child serving systems and supports available in the practitioner's community. These questions intend to assess the frequency of communication between child servicing agencies and practitioners as well as community knowledge of parenting support services and access to evidence based parenting supports.
- The fourth section contains questions about the behavioral health referral process in the practitioner's community. Study staff based these items on a referral technical assistance plan for addiction counseling competencies (http://kap.samhsa.gov/products/manuals/taps/21c_3.htm). The overall Chronbach's alpha reliability for the referral measure is $\alpha = .753$.
- The final section contains questions about the communication and collaboration between child serving agencies and primary care clinics in each community. The items used in this section were derived from a *Pediatrics* article (Taskforce on Mental Health, 2009) identifying strategies to coordinate mental health services with primary care services. The overall Chronbach's alpha reliability for the Communication & Collaboration measure was $\alpha = .895$.

All practitioners completed paper versions of this baseline surveys during the first day of their initial Triple P training. As an incentive, the UW gave \$10.00 gift cards to practitioners for participation.

Assessment Timing

Table 1 provides an overview of evaluation and data collection activities in the first contract year (FY14-15).

During this year, project staff offered four Triple P trainings. Practitioners completed the baseline survey as well as pre-post training and accreditation assessments during FY14-15. Table 1 depicts the timeline for the assessments that occurred in FY14-15.

Table 1. Data Collection Timeline 2015

	Level 2 Brief Primary Care	Level 4 Standard	Level 4 Group
June 2015	PSCS Pre/ Post training WES Post training Time Point 1 (Pre-training survey)	PSCS Pre/ Post training WES Post training Time Point 1 (Pre-training survey)	
July 2015	PCSC Accreditation* WES Accreditation*	PCSC Accreditation* WES Accreditation*	PSCS Pre / Post training WES Post training Time Point 1 (Pre-training survey)
August 2015			
September 2015	PSCS Pre/ Post training WES Post training Time Point 1 (Pre-training survey)		PCSC Accreditation* WES Accreditation*

*Accreditation data has not been received yet.

Procedures

The first six months of the project involved a mixture of project planning, staff orientation and preliminary organizational engagement. Both TPCHD and UW hired new personnel during this year: Research Study Assistant at UW and a Program Manager at TPCHD. By March 2015, project partners determined the Triple P training schedule and cost-sharing plan for training expenses. Each partner ordered and paid for their assigned trainings. All Triple P events - trainings, pre-accreditation, and accreditations - were held at the Tacoma-Pierce County Health Department's Auditorium. Please see Table 2 for training schedule and payment assignments.

Table 2. Trainings schedule and coordination for 2015

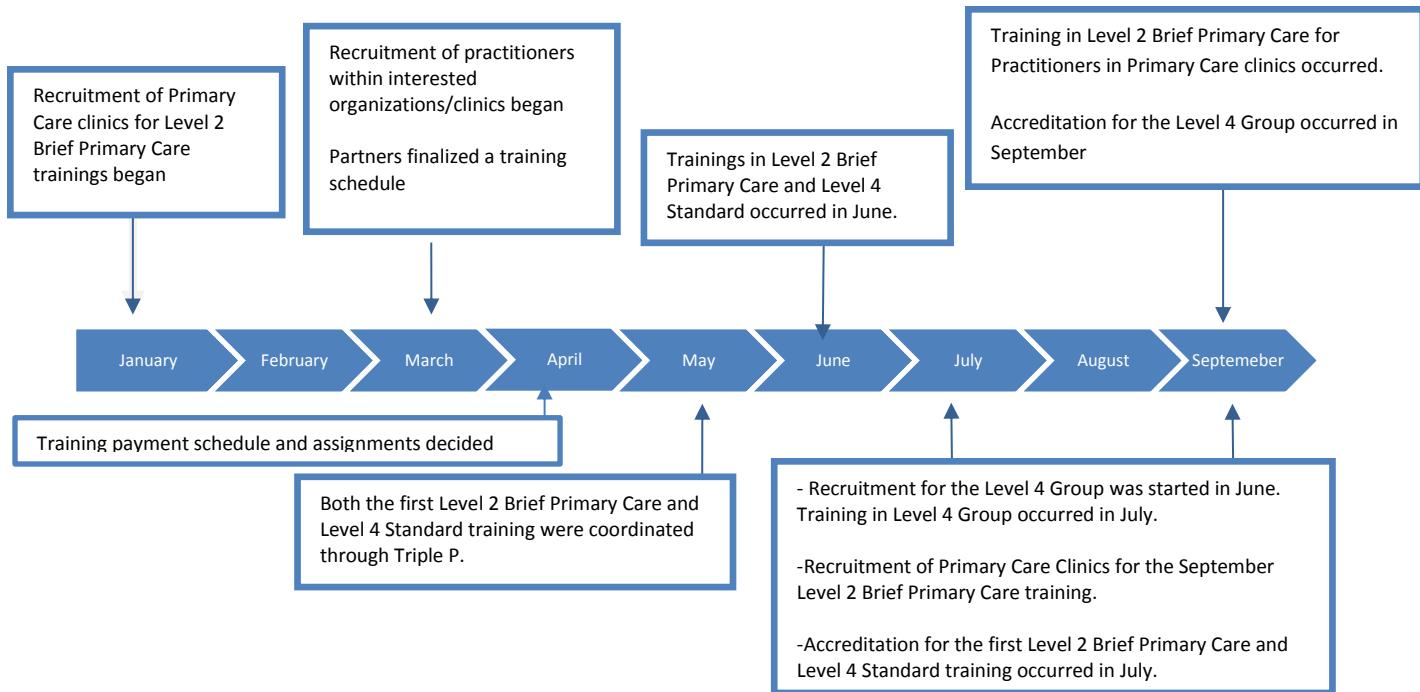
	June 2015	July 2015	September 2015
Tacoma-Pierce County Health Department	Level 4 Standard		Level 2 Seminar*
University of Washington	Level 2 Brief Primary Care	Level 4 Group	Level 2 Brief Primary Care

*Project staff rescheduled the Level 2 Seminar for the second contract year, FY15-16.

During March to September, project partners recruited practitioners for initial training dates in June, July and September. UW project staff provided TPCHD with practitioner and agency readiness tools and trained them to use these tools in recruitment (see Appendix B). The readiness tools provide an overview of the Triple P model, an outline of Triple P activities by level and specific questions that assess the goodness of fit between the training level and the practitioner's job functions. Additionally, UW project staff created a best practices document for the use of these tools as well as a protocol that outlines the project partner activities in

recruitment, training coordination and implementation support (see Appendix B). Figure 1 illustrates the major project activities from January to September 2015.

Figure 1. DBHR Triple P Demonstration Initiative Recruitment, Training, Coordination, and Evaluation Timeline: Jan-Sept 2015



Baseline Characteristics of Practitioners

Here we are able to provide information about the baseline characteristics of the practitioners who participated in the training events. In the future, we will be able to report the results of client-level data from those families seen by primary care physicians. However, at the present time, we are only able to provide limited data on participant characteristics.

Participation in training

Across trainings, 72 practitioners attended the trainings in Level 2 Brief Primary Care, Level 4 Standard, or Level 4 Group Triple P:

- fifty-six (56) practitioners from Pierce County
- nine (9) practitioners from the rural communities (Ocean Beach and Othello), and
- six (6) practitioners from non-project communities.

Because this report reflects the evaluation of the Tacoma population, the analysis will only include practitioners from Pierce County. Of the 56 trained practitioners in Tacoma, 44 (79%) attended and passed accreditation. Two training participants are currently in the process of becoming accredited, through alternative processes. One

participant has determined they will not be delivering Triple P services, and has decided to not become accredited.

56 practitioners completed the pre-post training evaluation and 52 (93%) completed the UW Baseline measure. Table 3 provides the breakdown of participants across training cohorts and training activities.

Table 3. Triple P trained practitioners across levels and activities

	June, Level 2 Brief Primary Care	July, Level 4 Standard	July, Level 4 Group	September, Level 2 Brief Primary Care	Total Triple P Practitioner Population
Completed Training	19	13	15*	16	56
Became Accredited	16	13	15	**	44

*Seven practitioners were trained in both Level 4 Standard and Level 4 Group

** Accreditation for this training cohort is schedule for November 7th 2015.

From responses to the baseline UW Survey, we are able to characterize our practitioner population as a whole and also examine primary care practitioner-specific results. Participating practitioners were overwhelmingly female (92%). Just over a third (42.3%) of training participants are community health workers. Over one-quarter of the practitioners (29%) can practitioner services in Spanish. Almost half (48.1%) have caseloads with 80-100% of clients on Medicaid. Almost two-thirds of the practitioners (63.5%) have a caseload with the majority of clients on Medicaid. Over one-third (39%) of our practitioners can deliver services in another language. Practitioners have a wide range of experience, with an average of 11.40 ($sd=10.612$) years of parent consultation experiences and indicating spending an average of 15.28 ($sd=15.54$) hours a week in parent consultation. Exactly half of practitioners (50%) reported having experience with parenting interventions prior to training. Table 4 below details the demographic data of Triple P trained practitioners by community. We have created two Level 2 cohorts to differentiate community-based participants' results from primary care practitioners' results.

Table 4. Triple P-trained practitioner demographics

	Level 2 Brief Primary Care, Community (n= 22)	Level 2 Brief Primary Care, PCP (n= 11)	Level 4 Standard (n= 13)	Level 4 Group (n= 6*)	Total (N=52)	Missing
Gender						
Male	1 (4.5%)	2 (18.2%)	1 (7.7%)		4 (7.7%)	
Female	21 (95.5%)	9 (81.8%)	12 (92.3%)	6 (100%)	48 (92.3%)	
Profession						
Mental Health Professional			1 (7.7%)		1 (1.9%)	
Public Health Nurse	2 (9.1%)				2 (3.9%)	
Physician		6			6	

	Level 2 Brief Primary Care, Community (n= 22)	Level 2 Brief Primary Care, PCP (n= 11)	Level 4 Standard (n= 13)	Level 4 Group (n= 6*)	Total (N=52)	Missing
(54.5%)				(11.5%)		
Case Management						
Community Health Worker	7 (31.8%)		9 (69.2%)	6 (100%)	22 (42.3%)	
Physician Assistant, Nurse Practitioner, or Nurse Supervisor	1 (4.5%)	4 (36.4%)			5 (9.6%)	
Program Director/Manager/ Supervisor	4 (18.2%)	1 (9.4%)	3 (23.1%)		8 (15.4%)	
School Teacher	2 (9.1%)				2 (3.9%)	
Other	6 (27.3%)				6 (11.5%)	
Language Capacity (in addition to English)					20 (38.5%)	32 (68.5%)
Spanish	4 (18.2%)	7 (87.5%)	3 (23.1%)	1 (16.7%)	15 (28.8%)	
Other (Igbo, Russian, French, ASL)	1 (4.5%)	3 (27.3%)	1 (7.7%)		5 (9.6%)	
Medicaid Clients					7 (13.5%)	
0-20%	2 (11.8%)		1 (9.1%)	1 (16.7%)	4 (7.7%)	
21-40%	2 (11.8%)	3 (27.3%)			5 (9.6%)	
41-60%	3 (17.6%)				3 (5.8%)	
61-80%	5 (62.3%)	1 (9.1%)	1 (9.1%)	1 (16.7%)	8 (15.4%)	
81-100%	5 (29.4%)	7 (63.6%)	9 (81.8%)	4 (66.7%)	25 (48.1%)	
Median Yrs. of experience in parent consultation	10.00	15.00	10.50	10.50	10.00	2
Median number of hrs./week spent in parent consultation	2.00	20.00	34.50	21.00	8.00	3
Previous Experience w/Parenting Interventions (BH)					9 (17.3%)	
Yes	8 (36.4%)	8 (72.7%)	7 (53.8%)	3 (50.0%)	26 (50.0%)	
No	11 (50.0%)	1 (9.1%)	3 (23.1%)	2 (16.7%)	17 (32.7%)	

*Seven individuals were trained in both Level 4 Standard and Level 4 Group. Their data included in the Level 4 Standard cohort.

Table 5 outlines the professional backgrounds of the participating practitioners. The majority of participants were from social service settings or primary care/health care, though overall trained practitioner sample

contains a wide variety of practitioners, representing different potential service delivery sectors. As would be indicated by training level, most of the Level 2 Brief Primary Care practitioners were from traditional healthcare and education settings including but not limited to primary care clinics, or daycares/preschools, libraries and children's centers. The Level 4 trainings contained practitioners from social service organizations, mental health agencies and NGOs.

Table 5: Work Setting of Trained Participants by training level

Work Setting*	Level 2 Brief Primary Care, Community	Level 2 Brief Primary Care, PCP	Level 4 Standard	Level 4 Group	Total
Daycare or preschool	4				4
Mental Health system	1		1		2
Social service system	4		10	3	17
Elementary schools	4		2	1	7
Churches/synagogues/other faith based setting	1		2	1	4
Non-governmental agency	2		5	2	9
Primary Care/ Healthcare system	1	11		2	14
Other	12		1	4	17

*Participants were able to select all options that apply

In the baseline evaluation survey, practitioners reported the number of children (between the ages of 2 and 12 years old) served on a weekly basis and estimated the number of families who could benefit from services targeting child behavior problems and/or parenting problems in a typical week. The majority of practitioners (62%) reported that one (1) to eleven (11) families could benefit from targeted services. When practitioners indicated a range, a middle number was selected. Some practitioners offered responses such as 50% or 'a lot' that we could not quantify – and we categorized those responses as "unsure". Table 6 details the practitioner's estimations of benefit.

Table 6. Approximate number of families who could benefit from targeted services (N=52)

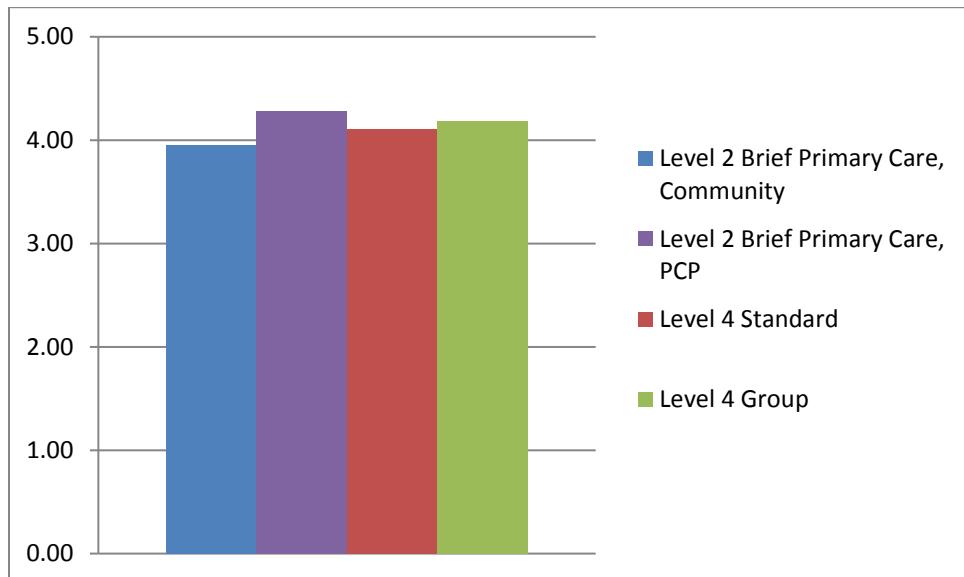
Number of families a week	Pre-training
0	1 (1.9%)
1-6	14 (26.9%)
7-11	17 (32.7%)
12-15	3 (5.8%)
16-25	4 (7.7%)
26 – 100	4 (7.7%)
N/A	1 (1.9%)
Unsure	4 (7.7%)
Missing	4 (7.7%)
Total	52

The Baseline UW evaluation survey asked practitioners about their attitudes towards evidence-based services, their experience with child-serving systems in their community, the behavioral health referral system in their

community and the communication between child serving agencies in their community. Staff aggregated practitioner scores are based on their training level or, in the case of individuals who were cross-trained, on the first training that they attended.

Triple P trained practitioners responded to questions about their perceptions and utilization of evidence-based parenting programs. When implementing new evidence-based practices (EBPs) in a community, practitioner attitudes can facilitate or create barriers in the dissemination and implementation of the new EBPs. Practitioners answered items on the EBP scale using a 5-point scale, with 1 indicating non-favorable attitudes to EBPs and 5 indicating very favorable attitudes to EBPs. Figure 2 depicts each cohort's attitude towards EBPs at baseline.

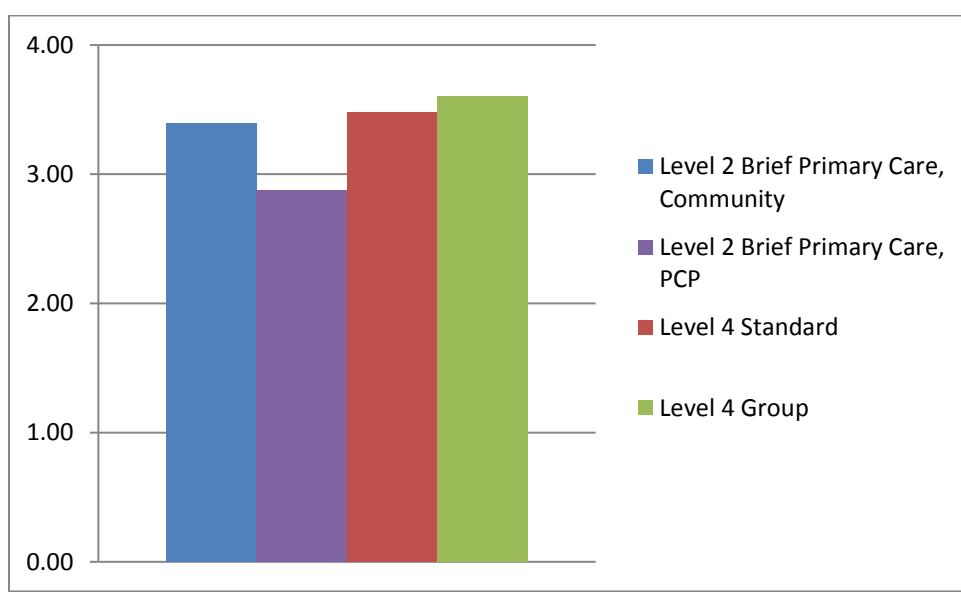
Figure 2. Practitioner attitudes toward adoption of EBP



Across the training cohorts, practitioners should similar, positive attitudes towards EBPs. The overall rates were commensurate with rates found in our previous evaluation.

Practitioners also reported their perceptions of the communication and collaboration between child serving organizations and primary care. Practitioners responded to these communication and collaboration items on a 5-point scale, with 1 indicated strong disagreement and 5 indicating strong agreement. Higher scores indicate stronger agreement with statements indicative of positive communication and collaboration. Scores below a 3 indicate concerns with communication and collaboration. Figure 3 depicts each cohort's perception of inter-agency communication and collaboration at baseline.

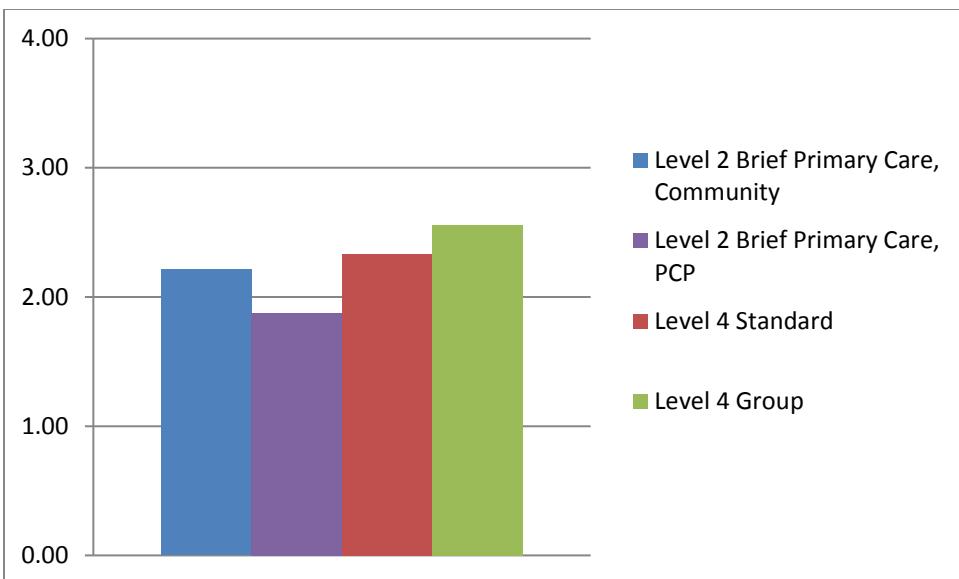
Figure 3. Perceptions of Communication & Collaboration



All cohorts, except Level 2 trained PCPs, rated communication and collaboration somewhat favorably. No cohort reached a score of 4, which would indicate agreement that collaboration and communication is strong between organizations. PCPs had lower ratings overall, and improving communication and collaboration between PCPs and other community agencies should be an implementation focus in the future.

Practitioners answered questions about child serving systems and supports generally. The answered questions on how much child serving systems communicate behavioral health needs to the community, the extent to which parents know where to get support in the community and the availability of evidence-based parenting programs in the community. Practitioners answered each question using a 4 point scale, with 1 meaning an activity never happens and 4 meaning an activity always happens. Figure 4 depicts the extent to which practitioners believe child-serving systems communicate child behavioral health needs to the community. Participants generally rated that child serving systems and supports are often available to families in the community.

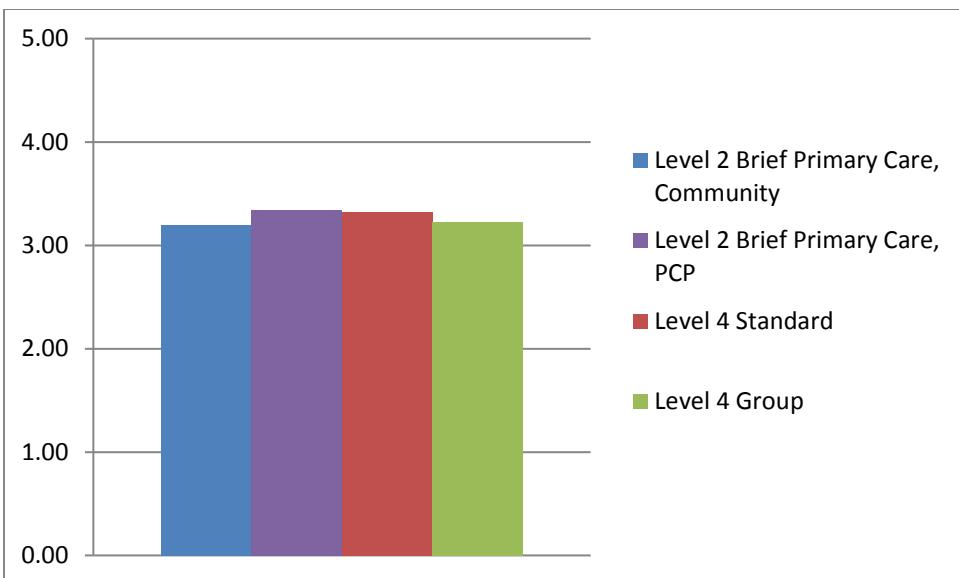
Figure 4. Communication of Child Behavioral Health needs



All cohorts, except the Level 2 PCPs, had responses over a score of 2. A score of 2 denotes that an activity “sometimes” happens, and a score of 3 denotes that an activity “often” happens. Level 4 Group providers were reported the highest frequency of this communication, and PCPs reported the lowest frequency, not even reaching an average score of 2.

Figure 5 depicts practitioner perceptions about community knowledge of parenting and behavioral supports and services offered in the community. Scores range from 1 (strongly disagree) to 3 (neutral) to 5 (strongly agree). In general, respondents rated community awareness of resources in the neutral range.

Figure 5. Practitioner perception of community knowledge of resources



Practitioner Self Efficacy

56 Tacoma practitioners completed the pre and post training PCSC. Triple P America will be sending the Accreditation data on the 44 accredited Tacoma practitioners to UW staff, and UW staff will include this data in the FY15-16 final report. Data analysis on the pre-post training assessments includes training participants who completed all assessments (52): PCSCs and UW measures.

As part of the PCSC, practitioners rated how adequately trained they feel to conduct parent consultations. Practitioners responded on a 7-point scale, with a 1 being “definitely not adequately trained” and 7 being “very adequately trained”. Table 7 contains mean, aggregate scores across training cohort and time points.

Table 7. Practitioner Degree of Preparedness to Conduct Parent Consultations

Level of Triple P	Time Point	Mean (SD)	N	t	df	Sig (2-tailed)
Level 2 Brief Primary Care, Community	Pre-Training	4.18 (1.44)	22	-4.057	21	.001
	Post-Training	5.50 (0.86)				
Level 2 Brief Primary Care, PCP	Pre-Training	4.18 (1.47)	11	-3.525	10	.005
	Post-Training	5.64 (0.50)				
Level 4 Standard	Pre-Training	4.77 (1.59)	13	-1.336	12	.206
	Post-Training	5.38 (0.74)				
Level 4 Group*	Pre-Training	4.17 (1.72)	6	-2.193	5	.080
	Post-Training	5.83 (0.98)				

*Seven individuals were trained in both Level 4 Standard and Level 4 Group. Their data included in the Level 4 Standard cohort.

Our sample is relatively small, and we have divided this sample into even smaller cohorts. The small numbers limit our analysis, as significant changes are hard to detect with small samples. Even with this limitation, all groups showed a strong improvement over time, typically at least one standard deviation of improvement or greater. Both Level 2 training cohorts showed statistically significant improvement from pre- to post training.

Practitioners also rated their level of confidence in conducting parent consultations about child behavior. They rated their confidence on a 7-point scale, with 1 being “not at all confident” to 7 being “very confident”. Table 8 depicts mean, aggregate scores across training cohorts and time points.

Table 8. Practitioner Confidence in Conducting Parent Consultations

Level of Triple P	Time Point	Mean (SD)	N	t	df	Sig (2-tailed)
Level 2 Brief Primary Care, Community	Pre-Training	4.09 (1.77)	22	-2.927	21	.008
	Post-Training	5.14 (1.13)				

Level 2 Brief Primary Care, PCP	Pre-Training	4.18 (1.40)	11			
	Post-Training	5.55 (0.82)	11	-3.012	10	.013
Level 4 Standard	Pre-Training	5.15 (1.21)	13			
	Post-Training	5.23 (0.93)	13	-.365	12	.721
Level 4 Group*	Pre-Training	4.00 (1.55)	6			
	Post-Training	5.50 (0.84)	6	-2.423	5	.060

*Seven individuals were trained in both Level 4 Standard and Level 4 Group. Their data included in the Level 4 Standard cohort.

All cohorts demonstrated improvement across times. The improvement in both Level 2 cohorts and the Level 4 Group cohort were statistically significant.

Lastly, practitioners rated their proficiency in parent consultation skills. Each item is rated on a 7-point scaled with 1 being “not very proficient” in the skill to 7 being “very proficient” in the skill. We aggregated items for each practitioner and calculated the mean aggregate score for each training cohort. Table 9 details the mean scores across training cohorts and training time points.

Table 9. Practitioner Self-Efficacy in Conducting Parent Consultations

Level of Triple P	Time Point	Mean (SD)	N	t	df	Sig (2-tailed)
Level 2 Brief Primary Care, Community	Pre-Training	3.86 (1.21)	22			
	Post-Training	5.43 (0.92)	22	-6.674	21	.000
Level 2 Brief Primary Care, PCP	Pre-Training	3.53 (0.82)	11			
	Post-Training	5.56 (0.54)	11	-6.816	10	.000
Level 4 Standard	Pre-Training	4.98 (1.23)	13			
	Post-Training	5.44 (0.85)	13	-2.128	12	.055
Level 4 Group*	Pre-Training	4.44 (0.64)	6			
	Post-Training	5.98 (0.59)	6	-3.992	5	.010

*Seven individuals were trained in both Level 4 Standard and Level 4 Group. Their data included in the Level 4 Standard cohort.

Practitioner Satisfaction

Fifty-two practitioners responded to the Workshop Evaluation Survey conducted at the completion of the initial Triple P training. In this survey, practitioners responded to questions about their preparation for the training,

the goodness of fit between the Triple P skills and their work functions, their skill in delivering Triple P and there overall satisfaction with the training. Practitioners responded on a 7-point scale, with 1 denoting low levels of agreement or satisfaction and 7 denoting high levels of agreement or satisfaction. Table 10 details the mean responses to these questions.

Table 10. Practitioner awareness, satisfaction, and confidence

Item	Level 2 Brief Primary Care, Community		Level 2 Brief Primary, PCP		Level 4 Standard		Level 4 Group	
	M (SD)	N	M (SD)	N	M (SD)	N	M (SD)	N
Were you adequately informed about and prepared for this training or accreditation?	5.27 (1.61)	22	6.18 (0.87)	11	5.15 (1.41)	13	6.17 (0.98)	6
Is this level of Triple P appropriate for your work?	5.18 (1.37)	22	6.45 (0.82)	11	6.23 (0.93)	13	7 (0.0)	6
Do you feel you now have the skills to implement Triple P in your work with families?	5.59 (1.14)	22	5.73 (0.79)	11	5.25 (0.97)	12	6.33 (1.03)	6
In an overall sense, how satisfied were you with the workshop?	5.95 (1.05)	22	6.36 (0.81)	11	6.08 (1.12)	13	6.83 (0.41)	6

All cohorts had mid to high levels of agreement and satisfaction. The Level 4 Group cohort reported the highest levels of confidence and satisfaction.

Social Network Analysis

The UW invited agencies involved in the Triple P initiative to participate in the Social Network Analysis. Agency contacts nominated an individual to respond to the SNA measure. Initial organizational contacts were designated by either individuals who were initially contacted by Tacoma-Pierce County Health Department during Triple P training recruitment or practitioners who received Triple P trainings. Each agency received an introductory email detailing the study's aims, providing a sample version of the survey, and requesting an agency respondent for the survey. Agency respondents should be familiar with their agency's organizational relationships and their agency's referral pathways. The agency respondent did not have to be a trained Triple P practitioner, though many of the respondents had received Triple P training. REDCap generated emails with survey links to each agency respondent. UW staff set up automated survey reminders for those who had not started the survey and reminder emails with REDCap generated return codes for those who had started but not finished the survey within two weeks.

Nineteen (19) organizations sent individuals to participate in the Triple P trainings. All 19 organizations were invited to participate in the Social Network Analysis survey. Seventeen organizations (89%) agreed to participate

in the survey and received links. Fourteen organizations (82%) have started the survey and thirteen organizations (76%) have completed the survey.

Network Data-Collection Instrument. The measure was adapted from Provan, Veazie, Staten, and Teufel-Shone (2005). The measure consists of three sections: in Part A, respondents review a list of 74 agencies participating in the Triple P initiative. Respondents then identify organizations with whom they have working relationships. In Part B, respondents identify the type of contact they have with organizations identified in Part A. The types of contact include: sharing information, sharing resources and sending or receiving referrals. Respondents then provide detail about either the quality of the relationship or the amount of contact. In Part C, respondents rate the overall quality of the working relationships, using a measure of collaborative capacity (adapted for the Triple P program from the Wilder Collaboration Factors Inventory). The full data collection measure is in Appendix C.

Method. The Social Network Analysis Evaluation baseline survey was administered online via a data collection tool called REDCap, a secure web application for creating and managing online surveys. Due to the methodological sensitivity of a social network analysis, and the need for complete response, UW staff created a survey tutorial video for respondents to view prior to starting the survey. The 6-Month Follow-Up survey will be administered online via REDCap six months from the completion date, roughly between March-April 2016.

In compensation for their time, participating organizations were offered approximately \$100 worth of Triple P materials. To thank those who completed the survey on behalf of the organization, individuals were also offered a \$5 Starbucks Gift Card for those who are allowed the receipt of small gifts.

Discussion

The current evaluation summarizes the baseline characteristics of participating Triple P practitioners. During this first project year, 56 unique practitioners in Tacoma were trained in Triple P and 44 (79%) of those practitioners became accredited in Triple P. Our sample is diverse, containing professionals from a host of settings including primary care. Billable PCPs account for 20% of the Triple P trained population. Data analysis showed that all training participants benefited from the Triple P training. All training cohorts demonstrated an increase in skill and confidence from pre-training to post-training and reported that Triple P training to appropriate to highly appropriate for their work. As evidenced in the post-training satisfaction survey, practitioners reported medium to high levels of satisfaction with the training. The Level 4 Group cohort's aggregate satisfaction score was a 7, the highest possible score on the measure. These results are significant because we have found in prior evaluations that the extent to which providers feel prepared and confident to deliver Triple P is directly and strongly associated with the likelihood that they will use the Triple P program with families.

From the baseline evaluation survey, we can glean some information about the practitioner population. Across training cohorts, practitioners reported positive attitudes towards evidence-based practices. Generally, practitioners rated communication and collaboration between child-serving agencies and primary care somewhat favorably. PCPs, however, had the lowest ratings on this scale. Since this project aims to strengthen the communication and referral pathways between PCPs and child serving agencies, this initial lower assessment by PCPs demonstrates the need for strong implementation efforts and supports for those practitioners. As in the Rural Demonstration Initiative, PCPs are a distinct practitioner population without the larger training cohort. In

this report, we show the PCPs require focused implementation efforts to improve their working relationships with other child-serving agencies. When reporting on child-serving agencies communication of child behavioral needs, PCPs rated this communication with the lowest frequency. Other respondent cohorts report that child-serving agencies sometimes communicate child behavioral health needs to their community. PCPs said this happen less than sometimes.

While this report provides some critical baseline information about training participants, we are looking forward to expanding the evaluation during Year 2 in several important ways. To start, we will prioritize finalizing the social network analysis. This information will provide organizational-level information related to implementation of Triple P. As service delivery information is provided by our project partners, we will be able to further examine the extent to which various individual and agency-level factors are associated with use of the model. During Year 2, we will also begin to document change over time, examining how practitioner responses to the questionnaires evolve as they become more familiar with the intervention. Finally, during Year 2, we will initiate a quasi-experimental study evaluating the family-level impacts of delivery of Triple P within primary care settings.

The current evaluation results should be considered in light of several limitations. First, all results are based on self-report data. While this is an important strategy for understanding the feelings and experiences of practitioners, expanding our evaluation efforts to include parent/caregiver report and agency-level report (via Social Network Analysis) will be critical. We have a relatively small sample size, and we further divided the sample based on training level. Therefore, our power to detect statistically significant effects was compromised.

In summary, this report synthesizes the initial activities and baseline characteristics of a comprehensive strategy to address needs of parents and families in Tacoma. A diverse set of practitioners have participated in the initiative, and the initial training was overall successful in increasing their self-confidence in service delivery. We believe many of the ‘active ingredients’ for effective implementation were established during this first year.

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